

Article 8

Girls at Risk: Community Approaches to End Female Genital Mutilation and Treating Women Injured by the Practice

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Introduction

More than two million girls each year—or approximately 5,500 girls every day—undergo female genital mutilation (FGM), the partial or total removal of the female external genitalia (see box on page 70). It is estimated that some 100-140 million girls, the great majority of whom live in Africa, have been subjected to this traditional practice, which is associated with serious health consequences. Short-term complications include hemorrhage, wound infection, urine retention, shock, and sepsis. Long-term complications include formation of keloids (scarring) and cysts; obstructed labor, which can lead to perineal lacerations, bleeding, infection, and brain damage to infants; fistula formation; and sexual and psychological problems. Some women die from the procedure. In the Central Africa Republic, Egypt, and Eritrea alone, reliable survey data indicate that one million women have suffered the adverse health effects of genital cutting (Carr 1997). In recent years, there has been increasing recognition among many African governments, women’s organizations, and the international community that FGM violates women’s bodily integrity, health, and human rights.¹ In cultures where FGM is practiced, however, it is viewed as having important social, cultural, hygienic, and even economic functions. The most common reasons given by communities that practice FGM are that it prevents female promiscuity, preserves virginity and promotes cleanliness. Parents of girls in these communities believe that circumcision¹ is necessary to avoid social rejection and increase the chances that their daughters will marry, thereby improving their well-being and the family’s financial position. They fear that uncircumcised girls will become “loose” women whose genitalia are abhorrent and frightening to men and even dangerous to newborns and health workers during childbirth.

“When we first started working in the project communities, we could not speak of female “genital mutilation.” Parents felt they were doing the right thing for their daughters by circumcising them. We slowly established a dialogue about what actually occurs during the procedure and how this differs from male circumcision. Eventually, we were able to introduce the concept that removal of genitalia was mutilation rather than mere cutting. Some of our earliest advocates for FGM emerged from these community dialogues.”

—Samson Radney, Sr. Program Officer,
PATH-Kenya

¹ From the perspective of traditional parents and communities, girls are circumcised, not mutilated. Therefore, when referring to the practice from the perspective of these parties, we refer to FGM as circumcision.

In some societies, cutting of the genitals is traditionally viewed as the key element of a rite of passage from childhood to adulthood for both males and females. The rituals surrounding the cutting give an adolescent girl an opportunity to learn about her future role as a

wife and mother and the accompanying celebration provides the father with an opportunity to exhibit and share his wealth and thereby increase his status in the community. In other societies, FGM is done during infancy and not as a rite of passage. At any age, a major motivation for the cutting is to maintain gender norms of chastity and obedience for females.

Most societies that practice FGM view it as an important part of their cultural identity. In addition to the fear that their daughters will not be marriageable, both parents and daughters fear being ostracized by their community and peers if they were to stop the practice. Maintaining social cohesion and group membership is a powerful motivating force that drives the continuation of the practice. However, there are some signs of change that indicate the potential for eventual abandonment of the practice. Although any cutting of a healthy female organ is a threat to the girl's health and a violation of her rights to bodily integrity, in some countries a move away from the practice of infibulation (Type III), the most

severe form of FGM, toward less radical forms of cutting (Types I and II) is being observed. Yet, despite the progress in educating communities about the health risks of FGM, many people do not attribute the health complications it causes to the procedure. For example, if a young girl dies after circumcision, it may be attributed to evil spirits, or to her mother's infidelity. A wound infection may be considered the consequence of an FGM procedure having been witnessed by a menstruating woman. A high percentage of women in many African countries still undergo some form of the procedure, as shown in Table 1.

Health workers themselves are often unaware that the health problems of their patients are related to FGM. They are not taught how to handle complications related to FGM that may affect reproductive health, pregnancy and delivery, as well as a woman's sexual life. Where the practice is the norm, health workers may have never seen uncut adult female genitalia and may lack understanding of how the practice unnecessarily removes healthy tissue. Two issues must therefore be addressed: 1) identifying effective strategies to prevent FGM from occurring, and 2) helping health workers learn about FGM's health consequences and preparing them to treat women who have been harmed by FGM.

Defining Female Genital Mutilation

The World Health Organization classifies FGM into four broad categories:

Type I or Clitoridectomy: removal of the clitoral hood with or without removal of part or all of the clitoris.

Type II or Excision: Removal of the clitoris together with part or all of the labia minora.

Type III or Infibulation: Removal of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching and/or narrowing the vaginal opening, leaving a small hole for urine and menstrual flow.

Guiding Principles for Programs Working to End the Practice of FGM

Community-based approaches to ending the practice of FGM have had considerable success in some countries in Africa. One of the most comprehensive strategies is described in detail below and another promising approach is summarized. Some guiding principles are common to all community-based approaches:

Facilitate Dialogue

Even in situations where many community members may be against the practice of FGM, few feel empowered to speak out publicly against it. When initiating a new program, the resistance to “interference by outsiders,” whether Westerners or non-local citizens, can rapidly spread. It is important to avoid a “blame campaign” that vilifies those who practice FGM. An important initial step is to identify existing community-based groups that are interested in the subject, through which dialogue on FGM can be internally driven. Discussion of FGM should include multiple dimensions such as gender issues, human and legal rights, ethics, culture, and physical, sexual and psychological health.

Promote Cultural Strengths

By understanding the role that FGM plays in the culture, and maintaining the healthy aspects of that role through other practices, the community’s fear that change will lead to social disintegration will be minimized. An example of this approach is the Alternative Rites of Passage (ARP) ceremony described below. It is also important to understand the various socio-cultural dimensions and pressures that can affect the ability of individuals to change. Community leaders are essential facilitators of change. They can help give legitimacy and support to individuals who choose to alter traditional norms and practices, neutralizing accusations that they are undermining cultural identity.

The Alternative Rites of Passage Program: Community Action to Eliminate FGM

An innovative and participatory approach to help communities confront and abandon FGM was initiated in four (later divided into seven) districts in Kenya beginning in 1993 and continues to the present day. The program is a collaborative effort between Maendeleo Ya Wanawake Organization, (MYWO), and Program for Appropriate Technology in Health (PATH). MYWO is Kenya’s largest women’s organization with more than two million members nationwide. It is committed to working at the grassroots level to improve the health and well-being of Kenyan women. As an international reproductive health non-governmental organization (NGO) with expertise in behavior change communication and

Table 1 – Prevalence of FGM: World Health Organization Data, 2001

Country	Prevalence (%)	Year	Source ^a
Benin	50	1996	DHS ¹
Burkina Faso	72	1999	DHS ¹
Cameroon	20	1998	DHS ¹
Central African Republic	43	1994	DHS ¹
Chad	60	1996/97	DHS ¹
Côte d'Ivoire	43	1994	DHS ¹
Dem. Rep. of Congo (formerly Zaire)	5	Unknown	Cited in ²
Djibouti	98	Unknown	Cited in ²
Egypt	97	1995	DHS ¹
Eritrea	95	1995	DHS ¹
Ethiopia	85	1984/1990	Cited in ³
Gambia	80	1985	Cited in ³
Ghana	30	1998	DHS ¹
Guinea	99	1999	DHS ¹
Guinea-Bissau	50	1990	Cited in ³
Kenya	38	1998	DHS ¹
Liberia	60	1986	DHS ¹
Mali	94	1996	DHS ¹
Mauritania	25	1987	Cited in ^{2,4}
Niger	5	1998	DHS ¹
Nigeria	40-50	Various years	Cited in ^{5,4}
Senegal	20	1999	DHS ¹
Sierra Leone	90	1987	Cited in ⁵
Somalia	98-100	1982-1993	Cited in ⁵
Sudan	89	1990	DHS ¹
Tanzania	18	1996	DHS ¹
Togo	12	1996	Cited in ⁶
Uganda	5	1995/6	DHS ¹
Yemen	23	1997	DHS ¹

¹ National Demographic Health Survey; available from Macro International Inc, Calverton, Maryland, USA

² Toubia N. 1993. "Female Genital Mutilation: A Call for Global Action"; available from Rainbo

³ World Health Organization. 1998. "Female Genital Mutilation. An overview"

⁴ A national survey has been carried out by the DHS and the report is forthcoming.

⁵ Makhlof Obermeyer C. 1999. "Female Genital Surgeries: The Known, the Unknown, and the Unknowable;" *Medical Anthropology Quarterly*; 13(1): 79-106

⁶ Locoh T. 1998. "Pratiques, opinions et attitudes en matière d'excision en Afrique." *Population* 6: 1227-1240

community-based education, PATH has provided long-term technical and financial support to the project.ⁱⁱ

The overall goal of the FGM eradication program is to mobilize communities to stop the harmful practice of genital cutting for girls and women in order to protect their health and human rights. Its five specific objectives aim to: 1) raise awareness about the harmful effects of FGM; 2) promote a positive image of uncircumcised girls; 3) develop an ARP for girls to replace initiation by cutting; 4) enhance MYWO's technical capacity to plan, manage, implement, and evaluate FGM eradication programs; and 5) document the experiences and share this information with the larger community in Kenya and other FGM-practicing countries.

Community Education

As part of its essential intervention strategy, the project engaged the community in group discussions and debates in public arenas and in schools.

The content went beyond education about the negative consequences of FGM on physical, psychological and sexual health, to address the significant difference between female and male circumcision, legal and human rights to bodily integrity, and the moral concerns that FGM should pose for parents and health providers who circumcise. Input from the community (religious and political leaders, health workers, teachers, parents and girls,) was

used to develop a variety of print materials. The factual information and ethical messages provided through these multiple channels enabled families to examine the issues from various angles, and to decide not to circumcise their daughters. The program leaders, recognizing that parents needed support to cope with community pressure to circumcise, recruited other community members to serve as anti-FGM advocates, peer educators or as family support groups.

While the education program sought to create advocates against FGM, the second component of the behavior change initiative was an ambitious effort to create viable alternative rites of passage—rites that maintain cultural and social functions that are important for girls and their parents—without genital cutting. Because of the perceived potential for this approach to achieve lasting behavior change, PATH and MYWO dedicated significant effort and resources to this initiative.

Rites of Passage

Traditionally, girls receive elaborate social recognition and support at the time of FGM, not only for coming of age, but also for facing the physical pain of circumcision without complaint. Young girls anticipate and enjoy the attention, new clothes, exotic food, gifts, and peer companionship that are part of the rite of passage. Circumcised girls are viewed as role models that are believed to exhibit courage and pride. Mothers also look forward to this event because it represents the culmination of multiple achievements. It illustrates, for example, that a mother has reared her daughter well and is finally preparing her for marriage; it gives her the opportunity to host family, friends, and prospective in-laws in her home and to demonstrate her organizational skills and wealth; it leads to invitations to similar ceremonies by those who celebrate with her; and it places her at the center of attention of her peers and the community elders. For fathers, the rite of passage associated with FGM is a time to show off their daughters and their wealth, and to negotiate with prospective in-laws for bride price. For grandparents, it is a time to reflect on the family's progress and status, to hand-down ancestral teachings, and to feel proud that the new generation is following in their footsteps.

However, these traditional attitudes towards the ceremonies are no longer universal. Some people in the project areas suggested that circumcision ceremonies had become prohibitively expensive and a source of tension as families try to impress one another. Some families have abandoned the ceremony and are simply having the circumcision done on an individual basis in a hospital or by a health professional who comes to the home. Some parents are opting for less severe forms of FGM or even faking circumcision of their daughters. Some community members recommended that circumcision should be allowed to die

a natural death without continuing the celebrations. Some, but not all, agreed that alternative rituals could provide a “way out” to the many families who are willing to stop the practice but are afraid to do so for fear of being shunned by society. In sum, there was ambivalence about both continuing the practice of FGM and substituting an ARP for it. Even among those who valued the custom, genital cutting was not always the part of the tradition they valued most.

With this diversity of opinion and need in mind, MYWO and PATH developed a plan to create alternative rites of passage traditions. The strategy was designed to:

- allow parents who had already decided not to circumcise to come “out of the closet”;
- provide an alternative rite for families educated by the project who were afraid of community pressure;
- establish a strong non-circumcising community to coexist with the traditional community; and
- maintain the positive, educational and life-affirming features of the traditional ritual where it existed.

Community Involvement in Designing the Alternative Rites of Passage

Leaders of the initiative consulted with MYWO staff and volunteers in the two communities and met with mothers, girls, community leaders, and fathers to gather input on whether and how to implement this program. What reproductive health and life skills information did girls need? What kinds of gifts should be given? What type of celebration should be held? Who should participate? Staff and volunteers in Meru District, one of the original project districts, immediately saw the feasibility of the initiative. The Meru team designed a program, including all aspects of the traditional coming-of-age ceremony—seclusion, information sharing, and celebration—but no cutting of the genitalia. The alternative ceremony was called Ntanira Na Mugambo—“circumcision by words”.

The initial candidates for the first ARP were daughters of women who had either already stopped circumcising their daughters and wanted to declare their position publicly, or daughters of women who were knowledgeable about the harmful effects of the practice but were still hesitant to stop. In order to avoid family conflict during the recruitment process, one of the ground rules for participating in the program was that both parents (where applicable) must be in agreement and participate in the decision not to circumcise their daughter. Thus, women who wanted to have their daughters initiated through the alternative rite would have to convince their husbands to participate, publicly declaring that they have stopped circumcising their daughters.

The Ritual: A Week of Seclusion and Orientation

Traditionally, a newly circumcised girl was kept in the house, fed, and instructed on various issues of family life during one week of healing. As the first step in the alternative rite, the mothers decided to have their daughters go through a similar period of seclusion—a week of intensive instruction, guidance, and counseling on modern family life skills and traditional wisdom. The new ritual included education on self-esteem; decision-making; personal hygiene; relationships with parents, peers of the same and opposite sex, and elders; dating and courtship; marriage; peer pressure; male and female reproductive anatomy; menstruation; conception and pregnancy prevention; health risks of teen pregnancy; sexually transmitted infections (STIs), including HIV and AIDS; harmful traditional practices, emphasizing FGM and the myths and misconceptions about it; male circumcision; and son preference.

MYWO and PATH staff carried out the first training of girls during the seclusion. This was followed by training a group of volunteers which included school teachers, nurses, mothers and local government officials, to serve as future trainers during the week of seclusion. Aniceta Kiriga, one of the trainers who is also a mother of one of the participating girls, explained, *“During seclusion, we teach them about respect, how to behave, the challenges of being a woman, about relationships with men and many, many other things.”*

In addition to the formal discussions, each girl had a sponsor—typically an aunt or godmother—who had informal, after-dinner talks with the girls, either in groups or individually. These discussions focused on positive aspects of their culture, such as respect for elders, and various religious teachings. Girls and their sponsors also wrote and rehearsed anti-FGM songs and dramas in preparation for the coming-of-age ceremony.

The first ceremony was hosted at the District Chief’s compound. Everyone dressed up for the occasion and over 500 people came (compared to the 15-to-30 people who typically attend ceremonies held at the homes of wealthy families). The chief opened the ceremony in the morning. The District Officer also gave a statement of support, saying: *“...cultures you can not change overnight. But, we have to accept that society is dynamic and must change.”* After receiving gifts (dresses, hats, shoes, and cosmetics) from their parents, sponsors, and the MYWO/PATH project, the girls performed songs, recited poetry, and danced. Their mothers followed with their own singing and dancing. They also invited fathers, younger sisters, and members of the community to participate in the dancing and feasting, to celebrate “circumcision by words” and to condemn cutting. Mothers also received “bugidia” (sugars or gifts) from community members and families whose ceremonies they had attended and supported with gifts in the past. Some community members came initially out of curiosity and later joined in the jubilation—in essence sanctioning the occasion. Finally,

the girls were given certificates filled with community wisdom (reinforcing messages on respect and how to avoid unwanted sexual relations) and were declared mature, marriageable, and acceptable to the society.

The first alternative rite was a victory for the peer educators, for MYWO and for PATH. But the main beneficiaries were the girls. They had been defended by their fathers and brothers as well as by their mothers. They had been trained and honored. One 14-year-old graduate said, *“I feel I am mature now. I feel more courageous. I was taught how to cope...with situations. I am very proud.”*

Earlier community studies had found that in order to overcome isolation and stigma, uncircumcised girls benefited greatly from knowing at least one other uncircumcised girl in the community. For this reason, families who participated in the first alternative ceremony, along with community supporters, became the first nucleus of a support group. Members agreed to work with each other to ensure that well-intentioned extended family and neighbors did not overturn the families’ decisions. Members also agreed to advocate for and recruit additional families for the next rites of passage ceremonies.

When the alternative rite was first tried in Meru, only 12 families with a total of 30 girls participated in the seclusion. Many people in the community were skeptical and thought the new tradition would fade away immediately. The ceremony gained a great deal of attention, however, and afterwards MYWO started receiving inquiries from enthusiastic individuals and groups wanting to participate in a similar program. Within a year, 200 families from 11 locations in Meru had participated in an ARP.

The program has continued to gain popularity in Meru and has expanded to other districts, including Kisii, Narok, and Nyamira. Each district has tailored the rite of passage to its distinct culture. In Kisii district (which has the highest FGM prevalence among the project districts, early ages of circumcision, and a high number of circumcisions performed by health care providers), the girls were secluded in relatives’ homes while the family homes were decorated with flowers and banana trees and food was prepared for the guests. The beautifully dressed girls were symbolically carried back to their mothers and were accepted into the home by their fathers or other responsible males in the home. Because of the girls’ young age, the community decided not to include sexuality education in the seclusion orientation.

The initiates report that the training has helped raise their self-esteem and confidence to resist community pressure. One girl, aged 20, described what the rite of passage meant to her. *“It is very important to me because some of the things I learned in the seminar I never knew before. It is a ‘right’ of passage which I need also to enjoy as others enjoy. It is an achievement if I may say!”*

In addition, initiates in all districts continue to form support groups. In Meru, one of the first activities of the support group took place during the marriage of one of the girls. The initiates and their families flocked to the church to demonstrate that “uncircumcised girls are marriageable.” The initiates’ support group sees its role as protecting, defending, and supporting all girls from the community, whether or not they are threatened with circumcision. The younger sisters and cousins of the graduates have expressed their eagerness to be initiated through this alternative system. Besides supporting each other, the girls are increasingly supported by boys. Boys participating in a seminar held recently in Tharaka Nithi universally declared that they no longer consider female circumcision a prerequisite in a marriage partner.

According to a recent evaluation of the ARP, very few of the nearly 5,000 *graduates of an alternative rite has reversed their stand and chosen to be circumcised*. The original group of Meru trainers have now formed an independent NGO named after the first alternative rite, Ntaniro Na Mugambo, which also means “*bringing to age with advice*,” and with MYWO they plan to maintain the group decision: “*circumcision by words*,” not by the knife. Alternative rites of passage ceremonies can be adopted outside Kenya as part of an FGM eradication initiative and for sexuality education in rural and semi-rural communities. Once community sensitization about FGM has taken place, alternative rites are especially appropriate in countries where initiation rites are common, whether or not they are associated with a circumcision procedure. Countries in which the alternative rites may be applicable include Uganda, Tanzania, and some parts of Ethiopia, Ghana, Burkina Faso, and Chad. Alternative Rites of Passage ceremonies are not well-suited to communities where rites of passage did not exist in the past or disappeared long ago, or where girls are circumcised during infancy as in Mali, Burkina, and most of Eritrea.

Another community-based “breakthrough”: TOSTAN

The word *tostan* means *breakthrough* in the Wolof language. Another example of a highly successful effort to eradicate FGM was initiated through the efforts of TOSTAN, a Senegalese NGO whose primary function for the past ten years has been to implement a community-based, basic education and literacy program in rural areas of Senegal. TOSTAN conducts an 18-month modularized education program, primarily for women, that covers such topics as sanitation and disease transmission, child health, women’s health, human rights, project planning and implementation, and bookkeeping techniques. However, the core of its program is to teach women problem-solving skills, self-awareness and assertiveness through guided group discussions and outreach.

A dramatic outcome of TOSTAN’s educational program, particularly the sessions on women’s health and human rights – was the decision made by a group of village women

participants to take up the issue of FGM as a violation of women's health and human rights. Through community-based education and advocacy, and with the important support of male political leaders, these women mobilized all the people in their villages to declare that they would stop practicing FGM. TOSTAN is now taking its program throughout Senegal and its methodology has received international attention and support. Since September 1996, when the village of Malicounda Bambara pledged to refrain from FGM (an event known as "The Malicounda Commitment"), 42 other villages—some of which have marriage-ties to each other—decided that they would ban circumcision in their communities. The program has reached more than 31,000 African people.

TOSTAN attributes its success to several elements. Trained facilitators make learning enjoyable through a participatory, village-based approach using song, theater, storytelling, games, poetry, and creative writing. Education and training—in literacy, human rights, preventative hygiene practices, problem-solving, and management and leadership skills—empower villagers to begin making different choices in their lives. Facilitators build a trusting relationship with villagers through the course of the training program, which is taught in native languages. Beliefs are not imposed on villagers, but information is presented which allows them to make informed choices. The backbone of the program is problem-solving through a five-step process:

1. Identifying and analyzing the problem;
2. Studying possible solutions and adopting one based on availability of time and financial, material and human resources;
3. Planning the solution: What needs to be accomplished and by when? Who is responsible? What human, material and financial resources are necessary? What are the possible obstacles?
4. Implementing the plan; and
5. Evaluating the results.²

Providing Reproductive Health Services for Women Subjected to FGM

Most international effort has been directed toward eradication of FGM, with less attention to serving the neglected health needs of the estimated 100 to 140 million women who have been subjected to the practice. In many parts of Africa, the great majority of all women have been circumcised by the time they reach adolescence (see Table 1). The most severe form of FGM (infibulation) involves the stitching of the two sides of the vulva opening with thorns or sutures, leaving only a small hole through which to pass urine and menstrual blood. The procedure thus has both immediate and long-term health conse-

² Based on material available about the program on the TOSTAN website, www.TOSTAN.org.

quences, some of which may not become apparent until the woman becomes sexually active or is about to give birth. For these reasons, FGM has been called “the three feminine sorrows”, due to the pain at the time of circumcision, on the wedding night, when the opening may tear, and at the birth of a baby, when the opening may tear open and then be sutured shut again (Fourcroy 1998).

Although eradication efforts are beginning to have an impact, there is a pressing need for competent and compassionate treatment of women who have experienced the negative health consequences of FGM. Health practitioners in areas where FGM is practiced also need to be enlisted as allies in the effort to eradicate it. In some areas, such as Kenya, as health concerns about FGM have been raised in the community, parents have increasingly sought circumcision in hospitals and from health providers, and many health providers have been willing to accommodate their requests. The World Health Organization (WHO) has unequivocally condemned the practice, including its “medicalization” by any health professional in any setting, including hospitals (WHO 1995). Yet a health provider may be faced with an ethical dilemma in turning away a parent intent on having a daughter circumcised, knowing that the procedure is then likely to be done under unsafe and unsanitary conditions. As health providers are engaged in efforts to end the practice of FGM, they become more aware not only of the health consequences of FGM, but also of the broader human rights of choice and bodily integrity.

Health providers should offer appropriate, sensitive treatment to women harmed by FGM, but their exposure to FGM and knowledge of the health issues and treatment is likely to vary greatly. At one extreme, providers may have rarely seen an uncircumcised woman and may not make the connection between the procedure and the presenting symptoms and complications. At the other extreme, many developed-country health providers may be confronted for the first time with FGM when treating migrant women who were circumcised in their country of origin. Reports that FGM is being clandestinely practiced within the U.S. and other developed countries have also surfaced.

Providing appropriate and high-quality services to women who have experienced FGM requires awareness that the physical complications of FGM, including the reduction or destruction of sexual response, can contribute to a range of psychological effects, including depression, anxiety and post-traumatic stress disorders. FGM is usually conducted without anesthesia when girls are quite young, and often in the presence of others undergoing mutilation. The trauma of the event often remains with women throughout their lifetime (WHO 1995).

Women whose vaginal openings have been sutured may have been subjected to repeated forced penetration during intercourse, which can result in laceration of the perineum. Scar

tissue in the vagina makes it difficult to conduct vaginal examinations and interferes with diagnosis and treatment of urinary tract infections, ectopic pregnancies (often fatal if not detected in time) and fibroids. Difficulty in making proper examinations during labor may lead to incorrect monitoring of the stage of delivery and fetal presentation. Labor may be prolonged and/or obstructed, which may lead to tearing of the perineum, hemorrhage, and uterine inertia, rupture or prolapse. The result may be fetal brain damage or death. The dead fetus may be retained in the uterus or vagina following miscarriage, leading to fistula formation, severe pain, persistent bad odor and ostracism. Postpartum wound infection can lead to puerperal sepsis. Urinary tract infections caused by urinary retention may be recurrent. Physicians and midwives who treat circumcised women should be aware of the potential for these complications to develop and that special precautions during labor and delivery are sometimes needed.

Scar tissue from suturing the vulva can make sexual intercourse difficult or impossible. A de-infibulation procedure (reopening of the vaginal tissue) is often necessary before marriage can be consummated or a birth can take place. Where FGM is practiced, the opening is often re-sutured after the birth (although it is illegal to do so in the U.S. and some other western countries where women subjected to FGM may have migrated).

According to the Royal Australian College of Medicine, which has published a useful manual on treatment of FGM complications, and surgical instructions for de-infibulation,³ there is very little information about the experiences of older circumcised women. However, it is likely that cutting and resuturing the vulva, especially if repeated after many births, leads to more severe symptoms than typically occur after menopause, such as incontinence accompanying vulval atrophy. The American College of Obstetricians and Gynecologists (ACOG) has also recently published an educational module on clinical management of FGM (ACOG 1999). These helpful resources are more available and accessible to developed-country practitioners. Adaptations for developing-country settings and service providers are greatly needed.

Lessons Learned in FGM Programming

Many agencies have been involved in efforts to end the practice of FGM. The following recommendations are based on a survey that PATH conducted with 365 national and international organizations and analysis of data from 88 agencies that had conducted anti-FGM programs (Mohamud et al. 1998).

³ This section is based on information from The Royal Australian College of Obstetricians and Gynecologists' FGM Treatment Booklet.

Policy and Advocacy

Governments and donors should increase their financial and technical support for the growing number of agencies involved in efforts to promote abandonment of FGM:

- Governments must enact and/or use anti-FGM laws to protect girls and educate communities about FGM and human and legal rights.
- Governments need to be active in both policy and implementation.
- To be sustainable, FGM eradication programs must be institutionalized, primarily into relevant government ministries.
- Health providers at all levels need to receive training and financial support to treat FGM complications.
- Governments, donors, and NGOs must coordinate their activities with all agencies working on elimination of FGM.
- Given the importance of advocacy, international agencies must assist NGOs and governments to develop their advocacy skills.

Communication for Change

Those who implement anti-FGM programs must include all stakeholders in the design, implementation, and evaluation of programs and tailor their approaches to specific audiences. This requires a variety of approaches implemented in a strategic fashion:

- Young women, both as potential victims and key change agents, should be a particular focus of anti-FGM programs. Adolescent males are also valuable change agents.
- Urban elites must also be included in anti-FGM programming. The urban, educated population may be more amenable to FGM elimination. Elites are also tied to rural communities and relatives in the villages emulate their behaviors.
- NGOs and other organizations working at the community level need to assess and build on the positive community values that underpin FGM, while working with the population to eliminate the practice.
- While circumcisors should be included in programming, anti-FGM program implementers should not focus on developing alternative employment strategies for circumcisors. Focusing on the demand-side (e.g. changing the attitudes and behaviors of parents and grandparents who favor FGM) has a more direct influence on reducing the practice of FGM. Some new efforts underway may show that if sustained, alternative employment for circumcisors could play a complementary role.
- Information campaigns must be designed in a strategic, systematic way and include all stakeholders. Communication materials need to be research-based and targeted to spe-

cific audiences and communities, instead of being mass-produced for an entire country. Anti-FGM programs should build on and expand their work with the mass media, particularly into creative areas such as folk media and drama.

- Training programs that are comprehensive, both in the range of people they train and in the range of topics they cover, need to be designed collaboratively with members of communities affected by the practice.

Research and Evaluation

To increase the effectiveness of their programs, and the ability to document their success, anti-FGM program implementers should:

- Ensure that program design and implementation are based on sound formative research with key audiences and stakeholders; and
- Make process, outcome, and impact evaluation a high priority.

A Multi-generational and Multi-sectoral Approach is Needed to End FGM

Working with health providers, schools, religious institutions, the private sector, and other sectors to integrate health and human rights messages into day-to-day discussions (across generations and genders) will promote abandonment of this harmful cultural practice. Fostering open discussion about FGM to examine values and dispel myths is important, especially because of the fears of social ostracism that drive the continuation of the practice. Controversy is inevitable, but can be channeled in productive ways through provision of accurate information that the community can collectively assess.

With the continued, concerted effort of activists working with local and national NGOs such as MYWO and TOSTAN, and with the technical and financial support of international health and human rights agencies and donors, the practice of FGM will ultimately be abandoned. For the foreseeable future, the reproductive health community must also reach out to serve the health needs of the more than 100 million women of all ages who have undergone the procedure.

Contact Information

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Endnotes

ⁱ In 1990, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) called on governments to eradicate this practice while the Convention on the Rights of the Child (CRC) calls on governments to ensure children's rights to the highest standard of health and medical care and to protect them from all other forms of exploitation prejudicial to any aspect of the child's welfare. These calls were followed by the 1993 World Conference on Human Rights in its Vienna Declarations and Program of Action calling for the "eradication of any conflicts which may arise between the rights of the women and certain traditional or customary practices." The Vienna Declaration also urges states to repeal existing laws and regulations and remove customs and practices which discriminate and cause harm to the girl child. Additionally, the 1994 International Conference on Population and Development (Cairo Conference) and the 1995 Fourth UN Conference on Women (Beijing Conference) are more explicit in their condemnation of FGM. The Cairo Program of

Action regards FGM as a fundamental violation of basic rights and states that it is a practice that seeks to control women's sexuality. It also calls on governments to discourage and prohibit FGM, support its elimination, and provide treatment, education and counseling. The Beijing Platform of Action is similar in its regard of FGM as a form of sex discrimination that begins early in life.

ⁱⁱ This project is funded by a consortium of donors. Long-term funders include the Wallace Global Fund, formerly Population Action International's Special Projects Fund, the Public Welfare Foundation, the Moriah Fund and the Ford Foundation. The Threshold Foundation, AusAid, The Global Fund for Women, and Save the Children/Canada funded some of the activities, such as the alternative rites of passage.

ⁱⁱⁱ Some critics of FGM criticize faking circumcision on the grounds that it may reinforce people's perceptions that the custom is acceptable and that it continues.

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Resources

American College of Obstetricians and Gynecologists (ACOG). *Female Circumcision/Female Genital Mutilation: Clinical Management of Circumcised Women*. (August 1999). ACOG's Task Force on Female Circumcision/Female Genital Mutilation developed this slide/lecture presentation and companion manual for use as a formal 60-minute presentation in undergraduate medical education and ob-gyn residency programs. It includes 56 slides, accompanying speaker's notes, learning objectives, and a resource listing. Cost: \$95 for ACOG members; \$125 for non-members. Order online in the "Multimedia" section of ACOG's Resources Catalog (<http://sales.acog.com/>).

Amnesty International covers the topic of clitoridectomy, including procedures, why and where practiced, mental and physical effects on women. <http://www.amnesty.org/ailib/intcam/femgen/fgm1.htm>

Center for Reproductive Law and Policy, *Reproductive Freedom In Focus*, publication on

Legislation on Female Genital Mutilation in the United States, *Female Genital Mutilation: A Matter of Human Rights, An Advocate's Guide to Action*, and other documents related to FGM as a violation of human rights. www.crlp.org

Equality Now publishes a magazine called *Awaken*, to support organizations and individual activists working to stop FGM. *Awaken* highlights activism, news from around the world relating to the issue, potential sources of funding, and each issue includes a "Man Power" column to promote a dialogue among men on the eradication of the practice. *Awaken* is published in English, Arabic and French to promote its accessibility to grassroots groups and individuals in communities where FGM is practiced, and it is distributed free of charge to these groups and individuals and to anyone who donates \$50 or more to Equality Now's global campaign for human rights. www.EQUALITYNOW.org

International Planned Parenthood Federation (IPPF) offers an extensive bibliography of FGM-related journal articles and books on its Website, www.ippf.org/fgm.

Rainbo is an international not-for-profit organization working on issues within the intersection between health and human rights of women, focusing on FGM. Rainbo explores means of preventing FGM and other forms of gender-based violence. It does so by providing technical assistance to international and donor agencies and collaborates with local organizations to develop and advance effective programs and policies to deal with these crucial issues in Africa and in African immigrant and refugee communities. <http://www.rainbo.org/>

Reproductive Health Outlook (RHO), PATH's Website, has a section devoted to harmful traditional practices, including FGM, and program examples of efforts to eliminate FGM from Côte d'Ivoire, Egypt, Kenya, Nigeria, Senegal and Uganda. It also profiles the story of Waris Dirie, a Somali supermodel who is now a UN Special Ambassador campaigning against FGM. www.rho.org

Rising Daughters Aware provides information to FGM affected-women, their physicians and other health care providers, social workers and

legal professionals. It operates a peer support network for women who have experienced FGM and offers full text versions of the RACOG FGM treatment manual (below) and other useful materials. <http://www.fgm.org/>

Royal Australian College of Obstetricians and Gynecologists' FGM Treatment Booklet is a thorough, culturally sensitive manual including instructions, attention to psychological and social issues which can be downloaded from the Rising Daughters Aware Website, www.fgm.org/RACOGonline.html. Also available directly from RACOG, www.racog.edu.au/

Royal College of Midwives, RCM Position Paper (excerpts) No. 21 Female Genital Mutilation and the Role of the Midwife (available

through Rising Daughters Aware, www.fgm.org).

TOSTAN is an international NGO based in Senegal Africa geared toward educating the people and ending female genital cutting. The Website contains several articles on FGM and on other work of TOSTAN.

<http://www.tostan.org/>

WHO Women's Health Website contains the latest prevalence information on FGM, a video, links to the WHO FGM fact sheet and numerous other useful documents and links.

<http://www.who.int/frh-whd/FGM/index.htm>.

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www.yapi.org