FGM/C as a development issue

A training manual to mainstream actions for the abandonment of FGM/C into development programs and projects in Kenya

Rainbo
Health & Rights for African Women

AIDOS

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PREFACE

In order to accelerate the process for the abandonment of FGM/C, a critical mass of people needs to be reached. Being FGM/C a gender issue that violates the human rights of women and girls and has harmful consequences on their health, it has a negative impact on the development process. The World Bank, the IMF and most donors have committed to aligning their assistance to the Poverty Reduction Strategy Papers (PRSPs) which offer a platform to anchor strategies to combat FGM/C. Several countries (e.g. Benin, Burkina Faso, Ethiopia, Ghana, Mali and Niger) have already developed PRSPs which directly address this issue. FGM/C is embedded within these papers in the context of gender, equality, discriminatory or harmful practices. PRSPs developed by Yemen, Cameroon, Senegal and Uganda present thematic entry-points for addressing the topic of FGM/C as a violation of human rights, violence against women, reproductive health, participation, empowerment and education.

However, gendered poverty analysis in many of the PRSPs is still limited. Despite the fact that "women are at the centre of sustainable social and economic development, poverty reduction and environmental protection", as noted in the Communication from the Commission to the European Parliament and the Council of 8 March 2007 on Gender Equality and Women Empowerment in Development Co-operation, "gender inequality is part of the daily experience of a large proportion of the world's women", as confirmed also by the persistence of FGM/C documented by recent Demographic and Health Surveys (DHS).

In order to make PRSPs gender sensitive and effective, all stakeholders must address the gender and human rights implications of FGM/C in a holistic manner, recognising that the violence against women is indivisible from and interdependent with gender-based discrimination in all its forms. The challenge for development co-operation will be to identify entry points for a gender-sensitive development strategy which also integrates components on FGM/C.

Therefore, FGM/C should be addressed as a component in all development programmes and projects carried out in the areas where it is practised. It should be dealt with not as a specific issue but integrated in the activities dealing with gender issues, women's and girls' rights and empowerment, education, women's participation in society and the labour force, income generation, reproductive and sexual health, safe motherhood, children's health, HIV/AIDS prevention, etc. And in order to do so, there is the need to sensitise those who are responsible for making the PRSPs operational.

"FGM/C as a development issue. A training manual to mainstream actions for the abandonment of FGM/C into development programs and projects" was developed within the framework of the project "Innovative tools for the abandonment of the practice of female genital mutilation/cutting (FGM)" co-financed by the European Union under the EIDHR, European Initiative for Democracy and Human Rights – Prevention of Torture and implemented in partnership with RAINBO.

This manual is meant to be used by skilled trainers for training of government officials and directors and program officers of NGOs, in order to make them understand correctly the facts, root causes and socio-cultural dimensions of the practice, be knowledgeable about the most innovative and successful interventions and be able, with the technical assistance of local specialised NGOs and institutions, to design programs/projects which also address FGM/C, thus giving a strong contribution in reaching the necessary critical mass for its abandonment.

The modular structure and the contents of the various activities is the work of a group of experts from both organisations, and is based on the prototype "Mainstreaming the fight against FGM/C. A training manual", developed by AIDOS with the financial support of the

World Bank, and the “Women’s empowerment and community consensus (WECC) programming model”, developed by RAINBO.

The manual, while it is original in its approach and contents, draws from the experience of several other organisations and individuals, including researchers, anthropologists, sociologists and activists, whose work has been analysed and utilised. AIDOS would like to thank all the institutions and NGOs that have contributed materials, and especially Tostan, the Population Council, PATH, the Population Reference Bureau, Macro International, the Centre for Reproductive Rights (CRR), WHO, UNICEF, UNFPA, GTZ. They have been indicated in the references to the various activities.

Nowadays, the number of essays, researches, articles that address FGM/C from a variety of points of view is considerable. References to relevant additional readings are included at the end of each activity, as appropriate. A bibliography is therefore not included, and we refer trainers and readers to the “Research and Documentation” section of the web portal www.stopfgmc.org, compiled by AIDOS Documentation Centre and the STREAM – Sharing technologies and resources for engaged and active media Network, for information on available publications on FGM/C.

The modules on gender and sexual and reproductive health and rights have been adapted from “Reproductive Health for All: Taking Account of Power Dynamics between Men and Women”, a manual that AIDOS developed under the EC/UNFPA Asia Initiative on Reproductive Health, in collaboration with the Women’s Health Project of the University of Witwatersrand, South Africa.

The final version of the manual is the result of the feedback received by individuals belonging to a wide range of organisations and institutions who participated in the training workshops organised in Kenya, Sudan and Tanzania, and cannot be named here, but to whom we give our deepest acknowledgements.

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The Italian Association for women in Development is a non governmental, non profit organisation established in Rome in 1981 by a group of women development professional and activists with the intent of carrying out the goals of the UN decade for women: equality, development, peace. Its mission is to support the concept and the methodology of women's empowerment by reinforcing women's organisations and NGOs in developing countries, enabling them to respond to women's needs and to manage their interventions autonomously.

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

RAINBO is an African led international nongovernmental organisation working on issues of women’s empowerment, gender, reproductive health, sexual autonomy and freedom from violence. RAINBO specifically strives to enhance global efforts to eliminate the practice of Female Genital Mutilation (FGM) through facilitating women’s selfempowerment and accelerating social change. RAINBO is based in London and its work is aimed at influencing European development assistance to Africa whilst taking advantage of the closer proximity to Africa.

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MODULE 1

INTRODUCTION

Purpose of this manual

The manual has been developed by AIDOS and RAINBO in the framework of the project “Innovative tools for the abandonment of the practice of female genital mutilation/cutting (FGM)”, co-financed by the European Commission, as a contribution to the on going activities for the abandonment of the practice of FGM/C. It has been developed for the training of senior planners and managers in government, non governmental organisations and funding agencies, working in the areas of sexual and reproductive health, women’s empowerment, poverty eradication, in order to raise their consciousness about the need to address FGM/C in development programmes and projects as an issue of gender, human rights and sexual and reproductive health and rights. At the end of the course they will be able, with some technical assistance of local specialised NGOs and institutions, to integrate the fight for the abandonment of FGM/C into on going and future programmes/projects.

Who the manual is for

The manual has been developed for skilled trainers. It is anticipated that the trainers will follow and adapt as appropriate the modules and activities presented. Trainers are required to have a good understanding of gender and human rights issues and be knowledgeable of FGM/C in their own community. Trainers should be experienced in participatory adult learning methods and able to facilitate group learning. Trainers require also good knowledge of project planning in order to assist participants to integrate FGM/C in their programmes/projects as an issue of gender, human rights and health.

Target group for training

The target group for the training is senior planners and managers in government, non governmental organisations and funding agencies, who are responsible for designing and implementing development programmes and projects within planned poverty reduction strategies, in order to make them understand correctly the facts about FGM/C and knowledgeable about the most innovative and successful interventions. Programme officers would also benefit from the training. While this week long training course is not intended for policy makers and politicians, certain activities can be used in a short advocacy intervention for such an audience. Many of the methods are also appropriate for and can be adapted by NGOs and Government officials for use at community level.

1 Content and methods

Because FGM/C as well as gender are very sensitive subjects and the consciousness of people needs to be raised in order to change attitudes and values, it is important that participants in the course have the opportunity to share their own experiences, ideas beliefs and cultural values as much as possible. This helps to reduce anxieties. The methodology used in the manual is highly participatory, with small group discussions, buzz discussions and discussions in plenary and role-play. Most of the content is generated by the participants themselves, who are guided by the facilitators. The lectures are kept to a minimum.

Note to trainers

Trainers should prepare by reading through the entire manual. References to key readings that will enhance the conceptual framework within which the trainer works have been included. Trainers should take the time to read these.
Trainers who are not sure about certain activities may want to do a trial run to test them out. Each activity has a section called “Materials”, the trainer should read this and ensure that he/she has all that is required.
“Handouts” and “Overheads” have been included and the format of the manual is such that the trainer should simply photocopy these for participants. If a trainer adapts the course, he/she needs to prepare locally specific overheads and handouts.
“Handouts” and “Overheads” are also included in the attached CD-Rom as PDF files. In particular the “Overheads” files are meant to be projected using a laptop and LED projector, but they can also be photocopied and distributed directly participants.

Activities:

Activity 1: Getting to know the issues and each other
Activity 2: Names and clarifying hopes and expectations
Activity 3: Developing a group contract

Total Time: 2 hours

Activity 1

GETTING TO KNOW THE ISSUES AND EACH OTHER

Time: 30 minutes

Why do this activity?

This activity has two purposes. The first is to get participants comfortable with each other and to create a light-hearted and relaxed atmosphere. It helps to break down barriers and hierarchies between participants. Also, by the end of the exercise, each participant will have spoken to at least six other participants, making speaking again easier.

The second purpose of this activity is to get participants thinking about the issues that the course focuses on. Participants may have walked into the course worrying about personal family matters, or thinking about a proposal they have to submit to a donor. This step helps to orient everyone.

While it may seem strange to begin the course before people have formally introduced themselves (activity 2), in reality beginning with this activity means that even the formal introductions in activity 2 are heard better by participants, and they feel more relaxed in doing them.

How to do this activity

Plenary

Divide the participants into two groups. Get one group to form an inner circle and the other group to form an outer circle. People from the inner circle turn to face someone in the outer circle. You need even numbers of participants.

This is how the whole exercise works: You will give the group a word. The people on the inside circle must then talk about that word - anything that they want to say about that word - for half a minute. Their partner (facing them on the outside circle) may not interrupt. When you call or ring a bell to show the time is over, the partner has one minute to talk about the same word from her/his perspective. When that time is over, ask the people in the outside circle to all take a step to the right, so that they are facing a new person. You start the process again with a new word. Continue in this fashion.

Note that you should choose words that will be particularly meaningful to

this group of people, given the kind of work that they do, the social/cultural environment they live in etc. You want to choose words which push participants to talk about things they may not usually talk about. At the same time you do not want to cause great embarrassment or discomfort.

You should start with words that are more neutral and move on to words that require reflection on questions of human rights and values. Some words are suggested below :

- Mobile phones
- Rural life
- Education
- Religion
- Marriage
- Human rights
- Violence against women
- Poverty
- HIV/AIDS
- Father
- Beauty

You should do between six and eight words, depending on how much time you have and how well you think the exercise is working. The exercise usually makes people laugh. They get very frustrated when you tell them to stop, and you have to be very firm that it is time to move on to their partners' chance.

When you stop, you can ask the group if they enjoyed the activity. Then ask them to take their seats.
Explain to the group that the issues they have been discussing are the issues that will be covered in this course.

Say that now that you are all comfortable with each other, it's time to make formal introductions. Go on to activity 2 to do the introductions.

Materials:

- A watch or clock so that you can stop participants after each minute.
- A bell so that participants can hear you when you tell them to stop talking.

Activity 2

NAMES AND CLARIFYING HOPES AND EXPECTATIONS

Time: 45 minutes

Why do this activity?

This activity will help people to get to know each others' names and some basic information about each person. This information will help participants and the facilitator understand how the course content is relevant to each individual's work situation.

If this course is being run with participants who all know each other well, then the facilitator might rather want to explore more personal questions.

This activity will also give participants an opportunity to talk about what they are hoping to gain from this course. This will allow the facilitator to ensure that participants' expectations match the content of the course, and where expectations cannot be met by the course, she / he can make this clear, so that participants do not have unrealistic expectations and land up being disappointed by the course.

How to do this activity

Plenary

Write down the following questions on a flipchart:

- Name?
- Organisation you work for?
- What work do you do there?
- What are you leaving behind while you are attending this course?

Ask participants firstly to write their names (as they want to be addressed during the course) in a thick pen on a piece of cardboard folded in half. They should put this up in front of them so everyone can read their names.

Then give them five minutes to think about their answers to the questions you have written up. Explain that you do not want a lot of detail, but just a few sentences to help us know each other.

In relation to the question "What are you leaving behind while you are

attending this course?", tell the participants that you want to know what personal or work-related things will be worrying them.

Then go around the room giving each person a chance to answer the questions.

When they are all done, tell participants that you asked them to share what they are leaving behind so that they could be aware of what is on their minds.

Take five minutes to introduce yourself, then the co-trainer and assistant to the training course should also introduce themselves. Tell participants also what you are leaving behind.

Now, however, they must really leave these things behind. They have a special opportunity to focus on one issue for the week of the course. They should use this time to focus on the course and on what lessons they can learn from it to take back to the workplace.

Materials:

- X number of pieces of cardboard folded across the middle so that they can stand on a table. These are for participants to write their names on.
- Felt-tip pens so that the names can be read by everyone in the room.

Activity 3

DEVELOPING A GROUP CONTRACT

Time: 45 minutes

Why do this activity?

Often participants in one course come from different work cultures with different ways of behaving in group settings - for example, some institutions and NGOs may allow free and open discussion while others might have a culture in which only the management speak. Also, in many organisations, those in decision-making positions have a greater right to speak and generally to take up space in a meeting than those who are not managers.

However, this course is about building a culture of equity/equality. This means that the course itself has to be run in a way which accords all participants equal respect and an equal chance to express their opinions.

For this reason, it is necessary to set up some ground rules for how the course will be run, and to make sure that everyone on the course is happy with and agrees to abide by these rules. Since the course promotes the idea of participation, it is important that these ground rules are developed in a participatory way, which is why this activity involves everyone in developing the group contract.

There may be other things, such as whether or not people can smoke in the workshop room or whether they should keep their cell phones switched off, which need to be agreed upon in advance, so that little irritations do not undermine people's ability to enjoy the course or to concentrate during the course.

How to do this activity

Plenary

Ask participants to write using three different coloured cards:

• Their expectations from the course;

• Their anxieties about the course process;

• What they can contribute to ensure that the group works well during the course.

Then paste these different cards at three different places. This might include things like:

Note to facilitator

Expectations

• Learn more about FGM/C issues focusing on gender dimensions / human rights;
• Being gender sensitive while planning and implementing a project;
• Learning relationship of FGM/C with gender, human rights and health issues.

Anxieties

• Fear that they will be too shy to participate;
• Fear that there will be too much work;
• Women who fear that men will not listen to the women;
• Men who fear that men will be accused of being bad people;
• Fear of being attacked for having a different view from other participants;
• Fear that personal stories told in this workshop will then be spread to workmates or social friends.

Contributions

• No individual should dominate discussions;
• People should raise a hand if they want to speak and wait for the facilitator to ask them to do so;
• No personal attacks; people should respect each others' right to speak;
• Everything personal that is said in the course will be kept confidential;
• We are all responsible to speak when we have something to say;
• We are all responsible for our own learning.

Explain the group that through their contributions, their anxieties as well as some of their expectations can be met.

Write the list of contributions on a new piece of paper. Once the group is happy with the list, you can label it "Group Contract" and ask if everyone is happy to abide by this agreement.

The group contract should be pasted on the wall and stay up for all to see throughout the course.

During the course, if there are problems with group dynamics, remind participants of the relevant commitments in the group contract.

Plenary

Concluding presentation
On the first day of a course it is not easy for participants to take in a lot of detail about the course as a whole. But they do need to know where the course aims to go, so that they do not get anxious in the first day or two that their needs will not be met.

Providing an outline of the course and its methods also gives the facilitator an opportunity to go back to the expectations raised by the participants in activity 2 and to show where different expectations will be met.

Overheads

Put up the Overhead 1 on Overall Course Objectives. Go through each of these objectives, spelling out the content of each objective and clarifying any questions participants may have on each objective.

Then put up the Overhead 2 on Structure of the Course. Explain that the course is not structured so that there is one section for each objective. Some objectives are dealt with throughout the course, such as building a common understanding of key concepts, and re-evaluating their own programmes.

Explain that the course structure aims to build concepts, one upon the next.

Briefly explain what each module does. As you do this, refer back to participants expectations of the course, raised in the previous activity, so you can show where the course addresses these.

Materials:

- 3 sets of coloured cards
- Flip chart
- Paper
- 3 boards
- Felt-tip pens
- Something to stick the flip chart to the wall with.

Overheads:

- Overhead 1: Overall Course Objectives
- Overhead 2: Structure of the Course

OVERALL OBJECTIVES OF THE COURSE:

1. To make participants understand that FGM/C is:

a) a gender issue
b) a violation of human rights that impacts on the development of women and communities
c) a serious infringement of sexual and reproductive rights of women/girls

2. To analyse the cultural environment, the reasons behind the practice and the causes of the persistence of the practice

3. To understand the positive and negative effects of various types of interventions to prevent FGM/C for different target groups

4. To share innovative tools for programming activities aimed at mainstreaming the abandonment of FGM/C into development programmes/projects

5. To recognise the importance of research, monitoring and evaluation for programmes/projects in the field of FGM/C

7. To understand the role that legal and policy measures can play in the framework of development interventions to stop FGM/C

STRUCTURE OF THE COURSE:

MODULE 1

Introduction

MODULE 2

Gender, and gender planning

MODULE 3

Understanding FGM/C in changing society

MODULE 4

Decision making processes and women empowerment

MODULE 5

Mainstreaming FGM/C prevention in development projects

MODULE 6

Building blocks for programming

MODULE 2

GENDER AND FGM/C

Module objective:

To have a common understanding of the concept of 'gender' and related terms (gender equity, gender analysis, gender planning), and how they relate to FGM/C.

Why this module?

The module builds a common understanding of how gender relations are constructed, maintained, and reinforced. It further increases sensitivity to a broad range of gender issues at personal, interpersonal, institutional and community levels by bringing out traditional and modern cultural assumptions and the impact they have on both men and women. It is of vital importance to address gender inequities because of the impact these have had on women's and men's health.

The module identifies the social, cultural, economic, and political factors which impact on gender relations and the fact that FGM/C is a gender issue. Before undertaking any programming, it is essential to understand the nature of the problem. Without understanding the causes of a problem, it is not possible to target interventions appropriately.

For this reason, the first module of this course aims to build the ability of participants to undertake a gender analysis, to understand the rationale behind gender planning and how this relates to FGM/C.

Activities:

Activity 1: Differentiating sex from gender (1 hour and 15 minutes)
Activity 2: Division of labour (1 hour)
Activity 3: Access to and control of resources (1 hour)
Activity 4: FGM/C and sexual and reproductive rights (1 hour)

Total time: 4 hours and 15 minutes

Activity 1

DIFFERENTIATING BETWEEN SEX AND GENDER

Time: 1 hour and 15 minutes

Why do this activity?

This activity defines the concepts of sex and gender. The process helps participants to conceptualise and understand that there are two kinds of differences between women and men, namely sex and gender. Sex is the physical, biological difference between women and men. Gender is not physical; gender refers to the expectations society has of people because they are female or male.

While women and men's biological systems are different, and particularly their reproductive systems, many ideas about women's role in society have been shaped by culture so that many functions related to childcare and domestic work generally have come to be seen as 'women's work'. In addition, they have been given a lower value in society than work done by men. This is part of a broader ideological process in which men are given a higher social value than women - as reflected in many societies' preference for boy children.

There are many and diverse ways in which this poorer valuation of women impacts on their health and on health service provision. However, before considering these, participants need an understanding and ability to analyse where biology ends and society begins. This activity aims to achieve this objective.

Objectives

- To understand which differences between women and men can be explained on the basis of biology or 'sex' differences
- To understand which differences between women and men are based on social values or 'gender norms'
- To recognise that norms and values which are socially constructed can be changed

How to do the activity

Step 1: 15 minutes

Plenary

Ask two volunteers to think, as far back as possible in time, of one incident when they first realised that they were expected to behave differently and were treated differently from boys, if they are girls, and vice versa. Invite them to share it with the group. Emphasise that they are asked to remember differences about behaviour, not physical differences. If they are thinking of changes in puberty that is physical, perhaps they are not thinking back far enough.

They must try to remember:

- what the incident was about
- how old they were
- who was involved
- where the incident took place
- how they felt about it

Step 2: 20 minutes

Plenary

Ask the group if they have heard of the words ‘sex’ and ‘gender’. Give a simple definition of each: “Sex” refers to the biological differences between men and women; “Gender” refers to the way that society expects men and women to behave. Write each of these definitions on the top of separate sheets of flipchart paper and put them on the wall.

Handout

General statements about women and men.

Ask participants to read the ten statements and to write ‘S’ against those statements that they think refer to sex and ‘G’ against those that refer to gender. For example, the statement ‘Women suffer from menstrual pains, men do not’ is an ‘S’ statement, because women are born with wombs and men do not have wombs, therefore they don’t menstruate.
Ask participants randomly or one after the other to read the statements aloud and define it as an “S” for “sex” statement or as a “G” for “gender” statement. Then check with the rest of the group: how many have chosen “S”, how many “G”, and why? Try to reach a consensus, bearing in mind that for some statements both “S” and “G” apply.

Plenary discussion

Talk about each statement as you go along, asking people to motivate why they think this is a sex or gender statement. Push the group to reach consensus on whether this is a ‘sex’ or ‘gender’ statement. This process helps to draw out all of the complexities of the issue. Write the statements up on the flipchart under the appropriate definition as you go along. Participants might conclude that some statements are both sex and gender - if so, write them so they straddle both pieces of paper.

Statements 1, 4 and 6 are ‘S’, the rest are ‘G’.

Step 3: 20 minutes

Handout

Now the group moves onto how ‘sex’ and ‘gender’ link to health issues. Distribute Handout: “Health-related statements about women and men”. Again ask the group to mark the handouts as either ‘S’ or ‘G’ and again you distribute and read out the questions, getting everyone to indicate how hey understood the statements. Through group discussion develop a group consensus and again list the statements on the appropriate sheet as statements that refer to either sex or gender. In this case statements 2, 3, 8 are ‘S’; Statement 5, 7 are both ‘S’ and ‘G’, the rest are ‘G’.

Step 4: 20 minutes

Plenary

Consolidate the activity by using the overhead ‘Sex and Gender’ to help participants develop a clear understanding about the difference between sex and gender, or use the flipchart definitions already showing. This section will also give them a deeper understanding of the concept of gender. While running this discussion, draw on examples given by participants during activity 1. These examples will allow you to illustrate different characteristics of gender. You can do this as follows:

Cover up the bottom part of the overhead, so that participants can only see the definitions of gender and emphasise how they have defined the differences between sex and gender in the previous two exercises, and how. That there are very few characteristics that are biologically determined; most are socially constructed. You will now try to unpack the different characteristics of ‘gender’ based on the previous discussions.

Now show overhead 2 and go through one concept at a time, starting with ‘Relational’. Explain the word to participants, using the explanations in the box below. Give an example from the stories participants told in Activity 1. Then ask the participants to give their own examples of how gender manifests in that characteristic. For example, under ‘historical’ participants may point out that whereas in the past women were expected to do all the cooking, over time men have started to cook too; or that in the past girls were not sent to school whereas now they are - these are changes over time and illustrate that gender roles are historically specific.
Go through each of the characteristics on the overhead one at a time in this way.

Note to facilitator

The following are characteristics of gender

Definition: Gender refers to the way that the society expects men and women to behave. Sex refers to the biological differences between men and women.

Relational: It is relational because it refers not to women or men in isolation, but to the relationships between them and how these relationships are socially constructed.

Hierarchical: It is hierarchical because the differences established between women and men, far from being neutral, tend to attribute greater importance and value to the characteristics and activities associated with what is masculine and to produce unequal power relations.

Historical: It is historical because it is nurtured by factors that change over time and space and thus can be modified through interventions.

Context specific: It has contextual specificity because there are variations in gender relations depending on ethnic groups, class, culture etc. It is therefore necessary to recognise diversity in the analysis of gender relations.

Institutional: It is institutionally structured because it refers not only to the relations between men and women at the personal level, but also within social institutions such as schools or health systems and in the overall social system that is supported by values, religion, legislation etc.

Gender relationships are personal and political: Personal, because gender roles that we have internalised define who we are, what we do and how we think of ourselves. Political, because gender roles and norms are maintained and promoted by social institutions and challenging these implies challenging the way society is currently organised.
Indicate to them that in the next session you will explore how gender relationships have to do with access to and control of and over resources and benefits.

Note to facilitator

Materials:

- Flipchart and overhead transparency.
- Copies of the Handouts for each person.
- Two sheets of flipchart paper with the simple definitions of sex and gender written at the top.

Overheads:

- Overhead 1: Sex and Gender Characteristics of Gender

Handouts:

- Handout 1: “Sex or gender? - General statements”
- Handout 2: “Sex or gender? - Health-related statements”

Readings:

- ARROW, “Section 2: Framework for Change”, *Women-centred and gender sensitive experiences, changing our perspectives, policies and programmes on women’s health in Asia and the Pacific: Health Resource Kit,* Kuala lumpur, Asian-Pacific Resource and Research Centre for Women,1996.
- INSTRAW, *Gender Concepts in Development Planning,* UN, 1995 7-35

SEX AND GENDER

'Sex' refers to biological differences between men and women.

'Gender' refers to socially constructed differences between men and women.

CHARACTERISTICS OF GENDER

Relational

Hierarchical

Historical

Context specific

Institutional

Gender relationships are personal and

Political

SEX OR GENDER? - GENERAL STATEMENTS

Read the statements and write ‘S’ against those that you think refer to sex and ‘G’ against those that refer to gender.

1. Women give birth to babies, men do not.

2. Little girls are gentle, boys are rough.

3. In Kenya, two-thirds of the land is cultivated by women who are heads of household.

4. Women can breast-feed babies, men can bottle-feed babies.

5. In the Umoja village men are hired to haul firewood. Women workers are able to send their children to school, eat well and reject male demands for their daughters’ circumcision and marriage.

6. Men’s voices break at puberty, women’s do not.

7. In Kenya the agriculture sector uses 70 % of women workers, only 24 % are engaged in wage employment.

8. 32% of Kenyan women have undergone excision. In some areas this percentage is as high as 99%.

9. In one study of 224 cultures, there were five in which men did all the cooking and 36 in which women did all the house building.

10. Girls are prevented from riding bicycles, boys are not.

Adapted from: Williams, S., Seed, J. and Mwau, A., *The Gender Training Manual,* Oxford, Oxfam, 1994: 87-89.

SEX OR GENDER?
HEALTH – RELATED STATEMENTS

Read the statements and write 'S' against those that you think refer to sex and 'G' against those that refer to gender

1. The majority of hospital managers in most countries are men and most of the ward managers are women.

2. In Kenya young adult women appear to be the group most frequently affected by AIDS.

3. Women suffer from pre-menstrual tension, men do not.

4. More health research funds go to research on men than on women.

5. Women are more susceptible to sexually transmitted diseases than men.

6. When infertility occurs in a couple, it is often presumed to be the fault of the woman.

7. The rates of behaviour disorder and hyperactivity for boys is 2-3 times the rates for girls.

8. Women have ovarian cancer, men have prostate cancer.

9. Infibulated women suffer from menstrual blood retention.

10. In Kenya life expectancy for men is higher (50.5 years) than for women (48.7 years).

Adapted from: Xaba, M. and Varkey, S., *Women's Health Project Gender and Health Course: Facilitator's Guide. Women's Health Project. School of Public Health.* University of the Witwatersrand. Johannesburg 2000.

Activity 2

DIVISION OF LABOUR

Time: 1 hour

Why do this activity?

The concept of ‘gender’ is complex consequently the following activities aim to deepen understanding of this concept. This activity provides them with tools for gender analysis, to understand the concepts of ‘division of labour’ and ‘gender roles’. The ability to analyse the division of labour in a specific social context, including differences in payment between men and women, is a central building block for gender analysis. It allows participants to see that women’s work and men’s work are differently valued. The underevaluation of women’s work is one aspect of women’s overall lower social status. The failure of men to share in domestic work means that women often work extremely long hours, especially where they are also engaged in wage work or agricultural activities. The activity allows participants to identify how women’s domestic roles give them an unequal and stressful burden to carry which may have negative implications for their health.

Objectives

- To identify the different roles that men and women play
- To identify the different values associated with these roles
- To be able to use the concepts of ‘division of labour’ and ‘gender roles’

How to do the activity

Step 1: 30 minutes

Distribute Handout: “The 24-hour day”.

Handout

Small group work

Ask the participants to form groups of about 4 - 6 people. Each group should choose one social group of which they have personal knowledge to imagine like farmers, poor town dwellers, middle class where both husband and wife work, etc. Ensure that each group has chosen a different social group.
Ask them to imagine a typical day in the lives of a wife and husband from the social group they have chosen.
Using the framework provided in the handout, ask the group to list the tasks performed by the wife and husband in a household over 24 hours on a sheet of flipchart paper. The participants need to fill in the activity the person is doing at the time indicated, whether it is paid work, and what the pay is per hour.
Once they have filled in the table, they need to calculate the number of hours each person works, and the total pay they receive per day. Put the tables from all the groups on the wall.

Step 2: 10 minutes

Walk around the room with participants and make a note of common points from the charts on the wall.

Step 3: 10 minutes

Bring the groups to plenary. Using the questions below, draw out the common points from the tables.

Plenary discussion

1. What was your first impression when you saw the woman’s and man’s chart?

2. What differences do you notice in the way in which men and women spend their day?

3. What differences do you notice in the way in which men and women spend their spare time?

4. What do you notice about what work is paid and what work is not paid?

5. What are some of the consequences of this for men’s and women’s income?

6. What are some of the consequences of these differences for women’s health?

7. What are some of the consequences of these differences for men’s health?

8. What are some of the consequences for society?

9. Discuss factors that could distribute the workload more evenly and how to address any other imbalances.

The sort of points that may come out are:

• Women and men do different things during the day.

• Women usually work longer hours.

• Men usually have more leisure time.

• Women have more varied tasks, sometimes doing more than one thing at a time.

• Even when women work outside the home, they also do a substantial amount of household work as well.

• Men's work is usually outside the home.

• More of women's work is unpaid compared to men's work.

• Women are usually paid less money than men for the paid work that they do.

Main points

Main conclusions to draw out

To conclude this section, you should introduce participants to the concept of the 'division of labour'. This refers to the different socially constructed roles of men and women. Thus women taking responsibility for cooking, and men for cattle, is an example of a 'division of labour' which is normal in many societies. The different tasks that are considered 'men's work' and 'women's work' are called 'gender roles'. Girls are raised expecting to perform such gender roles as cleaning the house, while boys are raised expecting to perform such gender roles as fixing cars or looking after cattle. In contemporary society, people often make the distinction between 'productive' and 'reproductive' roles. 'Productive' work refers to work which is outside of the home and contributes to the economy; 'Reproductive' work refers to work which allows people to grow up and contribute to the economy. This means not only the work in raising children, but daily cooking, cleaning, ironing and the like which are necessary to allow workers to go out each day to "produce". While increasingly women do productive work as men do, they still take most of the responsibility for reproductive work.

The division of labour into gender roles is not only about differences between what society expects men and women to do. It is about the social understanding of the value of the roles that women and men play.

The division of labour between women and men in most cultures is unequal; gender roles are not equally valued. Men's roles are considered more important than women's roles. This is reflected in how many women's roles are not paid for and how even in the workplace, women's work tends to be paid less than men's work. Thus gender roles are a part of the overall cultural values of a society and hence one aspect of gender norms.

The long hours that women work, and the lack of recognition of the value of this work can undermine both women's physical and mental health.

This suggests that the time has come for men to start sharing reproductive work with women, like domestic tasks and care of children.

Draw out how the division of labour between women and men in most cultures is unequal, such that women's excessive workload has a negative impact on their health. That is, unequal gender roles are damaging to women's health.

Main points

Step 4: 5 minutes

Give out Handout: "The lie of the land"

Handout

Ask one participant to read the cartoon.

Action

The purpose of this cartoon is to illustrate that researchers, women themselves and men - all members of society - often fail to see that domestic labour, 'Reproductive work' constitutes work.

Step 5: 5 minutes

Give out Handout: "Working Women". Allow time for participants to read it.

Handout

Materials:

- Flipchart paper.
- Felt-tip pens.
- Something to stick pieces of paper to the wall with.
- Copies of Handouts for each participant.

Handouts:

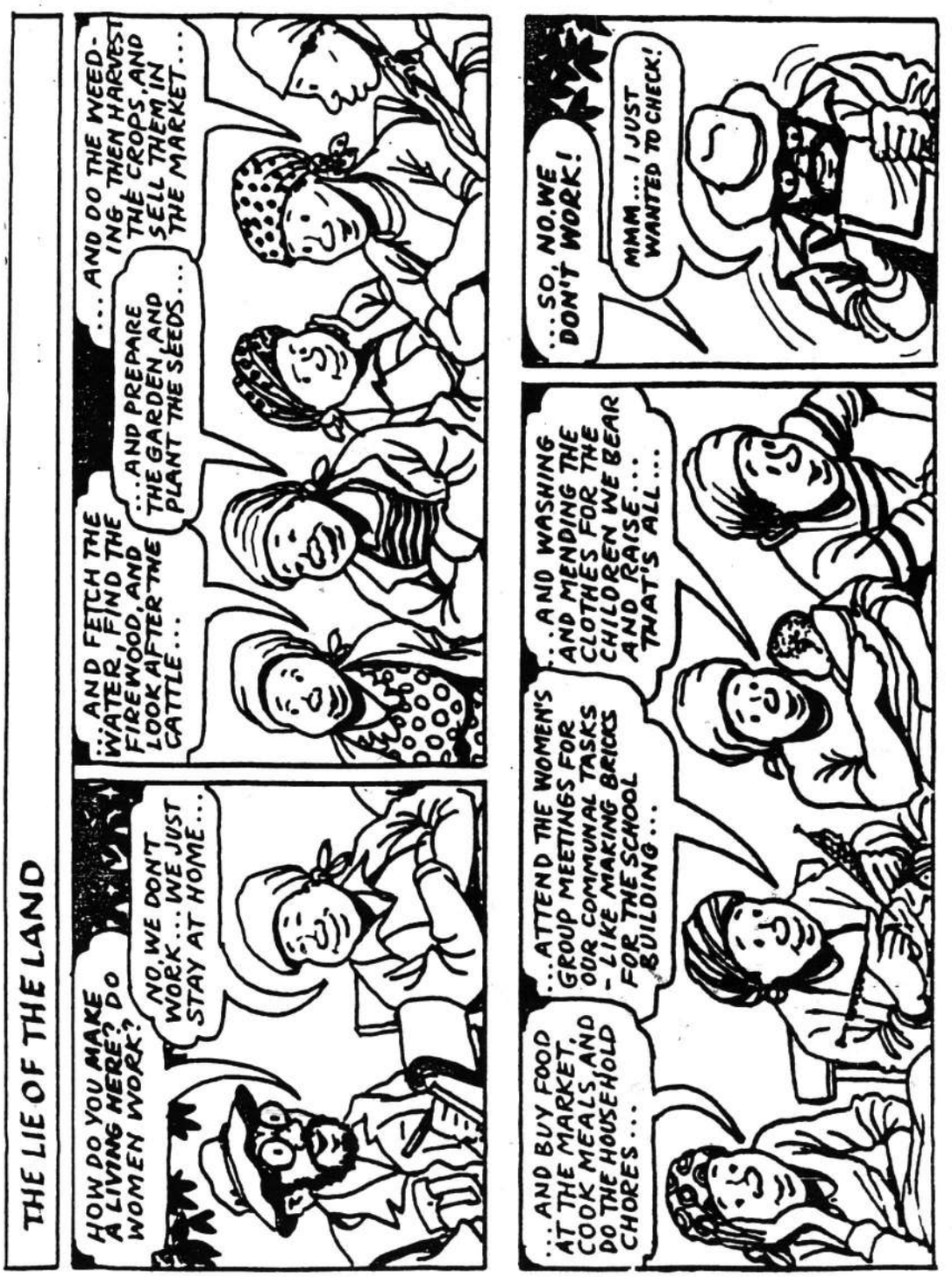
- Handout 1: "The 24-hour day"
- Handout 2: "The lie of the land"
- Handout 3: "Working Women"

THE 24-HOUR DAY:

HOURS	MAN'S ACTIVITY	PAID YES/NO	WAGE PER HOUR	HOURS	WOMEN'S ACTIVITY	PAID YES/NO	WAGE PER HOUR
1 am				1 am			
2 am				2 am			
3 am				3 am			
4 am				4 am			
5 am				5 am			
6 am				6 am			
7 am				7 am			
8 am				8 am			
9 am				9 am			
10 am				10 am			
11 am				11 am			
12 noon				12 noon			
1 pm				1 pm			
2 pm				2 pm			
3 pm				3 pm			
4 pm				4 pm			
5 pm				5 pm			
6 pm				6 pm			
7 pm				7 pm			
8 pm				8 pm			
9 pm				9 pm			
10 pm				10 pm			
11 pm				11 pm			
12 pm				12 pm			
TOTAL HOURS WORKED		TOTAL DAY'S EARN-INGS		TOTAL HOURS WORKED		TOTAL DAY'S EARN-INGS	

Social Group:

THE LIE OF THE LAND



Source: William, S., Seed, J. and Mwan, A., *The Gender Training Manual.* Oxford, Oxfam, 1994.185

WORKING WOMEN

WOMEN AND GIRLS ARE KENYA'S BREADWINNERS

- Women in rural Kenya work on average about 56 hours a week, men only about 42. Children between the age of 8 and 16 also work many hours. If time spent for education is counted, girls spend about 41 hours a week in economic activity, boys 35 hours.

- Women shoulder the heaviest burden in household work, including gathering firewood and water collection: 10 times the hours men work. This carries over to girls, whose household work takes about 3.7 times the hours boys work.

- Women in households that farm such cash crops as tea and coffee work the most of any rural women - 62 total hours a week. As Kenya's farming becomes more cash-oriented, women tend to shoulder more work, not less.

Source: Githinji 1995, as quoted in UNDP, Human Development Report 1995, Box 4.1, Page 92

MORE PAID WORK DOESN'T REDUCE UNPAID WORK

- Bangladesh had one of the largest increases in the share of women participation in the labour force: from 5% in 1965 to 42% in 1995. This has been important for export growth, with women as the main workers in the garment industry. But women still spend many hours in unpaid work. A survey of men and women in formal urban manufacturing activities shows that women put in on average 31 hours a week in unpaid work- cooking, looking after children, collecting fuel, food and water. They spend 56 hours in paid employment. Men spend an average of 14 hours a week in unpaid activities such as house repair, and 53 hours of paid employment. Thus women in formal sector employment work an average of 87 hours a week, as compared to 67 hours a week by men.

- In OECD countries men's contribution to unpaid work has been increasing. But a woman who works full-time still does a lot of unpaid work. Once she has a child, she can expect to devote 3.3 more hours a day in unpaid household work. Married women who are employed and have children under 15 carry the heaviest work burden - almost 11 hours a day.

Source: Zohir 1996 and UNDP 1995 as quoted in UNDP, Human Development Report 1999, Box 3.3, Page 81

Activity 3

ACCESS AND CONTROL OVER RESOURCES

Time: 1 hour

Why do this activity?

This activity identifies how men and women's different roles, affect their access to resources - whether economic, political / decision-making, informational, personal, or of time. It unravels how different types of resources, as a result of gender norms in society, are distributed in favour of men, and thereby limit women's ability to develop to their full potential, and in many cases actually undermine women's health. This tool, linked with assessing divisions of labour from the previous exercise, is necessary to build participants' ability to identify different dimensions underlying gender inequality and the practice of FGM/C.

Objectives

- To describe the range of resources which people use
- To identify the different impact of having access to a resource as opposed to control over a resource
- To identify the patterns of women and men's access to and control over resources in their country and community

How to do this activity

Step 1: 5 minutes

Handout

You should have decided what roles you want participants to play - see Handout: "Role play".

Ask for two people, preferably a man and a woman to volunteer to role play. Take them to one side and give each of them their role and ask them to think about how they will play this role. Do not let the other participants see the roles. Tell the actors that they will have about 5 minutes for the role play.

Then tell the group that they will be watching a role play. Remind them that a role play is when participants act different parts. They are not presenting their own views, but the roles that they have been asked to play.

Step 2: 10 minutes

Ask the actors to perform the role play. Do not allow them more than 5 minutes.

Note to facilitator

Ask the actor playing the woman:

'How did you feel playing this role?' and let him/her respond.

Ask the actor playing the man:

'How did you feel playing this role?' and let him/her respond.

Ask the group:

'Is this a real situation? Do things like this happen?' and let them respond.

Run a short plenary discussion asking the group:

'In the role play, what resources were being contested?'

Draw out from the role play which resources the man has control over and which, if any, the woman has control over. At this point the participants may not be familiar with the language of 'access and control' which you will introduce in the next step, so keep the points simple. The sorts of points which may come out of the role play include:

Main points

The woman had access to the land. It was her husband's land. However, she did not have the right to ownership or control over the vegetables she grew on the land. Although she usually sold the vegetables and kept the money, her husband had the right to sell them and keep the money if he wanted to because he owned the land.

Also gender norms in their community were that men had control over decision-making in the home. So the man had the right to decide what to do with money from the sold vegetables.

The man had access to information about where to get good prices for vegetables which the woman may not have had since she was based at home and did not move around as the man did.

In Kenya, although a growing number of women have acquired land through co-operatives or land buying companies, in general most women do not have the means to buy land or houses. Under the statutory laws inheritance rights have been given recognition, but these laws still do not include equal inheritance rights for widows and their application is still quite limited. It underscores the centrality of law in allocating legal rights and the gender dimensions in access to, control over and ownership of land. While highlighting existing imbalances in land ownership and the role of law in addressing them, the law has limits in engendering social transformation and there is a need to use other strategies to bridge the gap between law and practice.

(IFPRI - International Food Policy Research Institute, 2006)

Step 3: 40 minutes

The issues which came up in the role-play give you an entry point for this step, which is a more formal process of guiding participants though understanding one of the central reasons why the social construction of gender is about discrimination rather than just difference.

Begin by discussing the meanings of 'access' and 'control' and why having access to a resource is different from controlling it.

Overhead

Put up Overhead: "Relationship between control over resources and power".

Definitions

Access is the ability to use a resource.

Control is the ability to make binding decisions about the use of a resource.

The distinction between access to and control of certain resources is important because the ability to use a resource does not necessarily imply the ability to make decisions about the use of that same resource. For example, a woman may use land to grow food on. But the land may belong to her husband who decides whether to keep or sell the land, and who owns the products of his wife's agricultural work from that land. A woman may have access to a donkey for transport, but if she does not decide who can use the donkey and when, then she does not have control over it. If, for example, she needs to go to a clinic using the donkey, but her father-in-law who owns the donkey wants to use it to go to visit friends, then the woman's needs may be ignored - thus she has access to the donkey, but not control over its use.

Indicate that the fact that women and men are socially assigned different roles and responsibilities (the division of labour between women and men) has direct implications for the level of access to and control over resources they have, which in turn affects their health and their ability to access health services.

Overhead

Use this overhead to make the point that people who control resources have greater power in society than those who do not. Indicate that one feature of the gendered division of labour is that different roles are associated with differential access to and control over resources. It is predominantly men who have control of most resources, and women who do not, although the actual way this works differs between societies.

These overall resources include those necessary for the promotion and protection of one's health as well as the health of others.

Go on to look at the different types of resources - give participants handout: "Range of resources". Alternatively, or in addition you can use the overhead provided.

Handout

Take participants through each dimension of the handout, leaving time for them to give examples of the different types of resources which are at stake.

The capacity to have access to and control over resources develops and strengthens internal resources that can enhance personal development hence these resources have been included.

Examples of how access to, or control over resources might impact on health

Economic resources

A woman may have access to funds through her husband who earns a wage or sells the household's agricultural products for money. However, if it is her husband who decides if she can have the money she wants, then she does not have control over this resource. This means that if she wants to go to a clinic, but there are fees for services, then her husband and mother-in-law determine her access to health care, or to transport to get there even if services are free.

A woman may have the right to live (access) in a house which belongs to her father, husband or son. However, in many situations women are legal minors. When the man who owns the house dies, the woman does not inherit. Her right to continue living in the house depends on the family of the husband. Thus she does not control her own security in relation to her home.

It is not only women who may have lesser control over economic resources. Age may determine when a man gains control over resources; class determines the quantity of economic resources that some men can access and control, in comparison to other men. Workers, for example, usually do not own the factories where they work, hence they have access to a means of earning income, but they do not control that means of earning income. Amongst daily workers, however, it is usually women who earn less income, since 'women's work' is given less value in society than 'men's work'.

In Kenya, although women constitute 53% of the labour force, their participation in wage employment in the modern sector has remained low and they have access to less than 30% of wage employment (UNDP, 1999). A number of factors restrict women's access to formal employment. These include traditional roles, occupational segregation by gender, and lack of access to technology and credit, among others. In the informal sector, female-owned enterprises have been found to employ fewer workers and have less capital compared with male-owned ones (CBS, KREP and ICEG, 1999).

Political / decision-making resources

Women tend to have less access to political resources, such as the opportunity to stand for parliament. Women also have less access to and control over decision-making about who goes to parliament. Most political parties are dominated by men at leadership level, thus it is men who will decide whether or not a woman can stand to be elected for parliament.

In 2007, in Kenya the Members of Parliaments are 204 out of which only 18 are women.

This applies likewise to decision-making positions in private sector companies, in trade unions. In all cases the leadership tends to be men and it is they who control decision-making.

Control over decision-making determines priorities in any institution: those who control local government may determine whether money

Note to facilitator

should be spent on outreach from health centres or on a new sports field. If there are few women in decision-making positions, women's needs and priorities may not be heard. However, gender is not the only determinant of who controls decision-making resources. National leadership tend to be urban so that rural people in general have less control over political decision-making; rural women even less so.

The right to make decisions within the home is also a resource. In most homes, men have control over decisions about how the household's income will be spent and how the women and children will behave.

Information / education

Women often have less access to information and education than men. For example, in most parts of the world boys have substantially greater access to education than girls. Although in Kenya the differences between the illiterate rates for girls aged 15 (and less) and for boys are almost the same, there is still a gap in the science and technology educational sector. In countries where many men are migrant workers, they may have greater access to information from newspapers than women in rural areas.

Given decision-making roles within the household, it is usually not women who control decision-making about their children's access to education and whether girls will have the same educational opportunities as boys; or about what sorts of information comes into the household like whether money is spent on TV or radio or newspapers.

Decisions about which radio stations are listened to or which TV programmes are watched, are also often controlled by men, when both men and women are in the household. This may influence women's access to satisfying recreation or information such as about political processes and opportunities for participation, or skills training provided through the media. Women's lesser access to the internet, the fastest growing information resource, compounds their marginalisation.

Who has control over information? Production of information is one of the most powerful positions in society. Most of these positions are held by men. Likewise in governments or NGOs which play educational roles, one needs to know who is deciding what information the public needs, and how to communicate that information. Are they aware that women and men of different ages may have different health information needs? Do they use their control over media to ensure messages which promote equity/equality between women and men, or do they use their power to reinforce existing gender norms?

Time

Time is a resource in so far as one can make choices about how to use it. The previous activities on the division of labour between men and women showed the unequal allocation of time spent on work (in addition to the problem that women's labour in the home is not given any monetary value). In addition, time is not elastic; there are only so many hours in a day. If all of these hours are spent on work, this means there is less time for leisure, for further education, or for community activity. Thus women's lack of control over time further limits their options in life.

Control over time also arises in relation, for example, to access to health services. If a person has little time, they are less likely to use it for accessing health services. Also, the opening times of a health service may determine whether or not it can meet various groups' needs. For example, if men or women are employed in the formal workforce, and the clinic is only open during the hours at which they are at work, then they will not be able to access the clinic, unless their workplace allows them control over their time - to work flexible hours, for example, so they can access a health centre.

Internal / personal resources

Discrimination can undermine a person's sense of their own value. For example, if a woman does not have control over her own body - if the gender norms are such that she cannot decide when to have a child - the feeling of worthlessness can make it hard for her to take control over other dimensions of her life. If a women or a child is beaten up by her husband or other family members, this reinforces society's view that she is of little value and does not need protection. This undermines her ability to act, rather than being permanently acted upon by others. Thus a sense of self-esteem, of value and of confidence are crucial resources to allow a person to take advantage of what opportunities there may be for personal development.

Even in a context where a person has little control over any of the above resources, if she has a sense of her own value, she is more likely to get involved in group activities, such as a women's group, which could further build her ability to take control over her life.

Step 4: 5 minutes

Handout

Distribute the Handout: 'Differential access to and control of resources between men and women in selected African countries'.

Tell participants that the issues identified in the role play and through this activity's discussions are similar all over the world. The overhead illustrates differences in access to and control over resources between a number of countries. This shows that the problem is not peculiar to specific countries.

Materials:

- Copies of Handouts for each person.

Overheads:

- Overhead 1: "Relationship between control over resources and power"

Handouts:

- Handout 1: “Differential access to and control of resources between men and women in selected Asian countries”
- Handout 2: “Range of resources”
- Handout 3: “Role-play on access to and control over resources”

Reading:

- Gurumurthy, A., *Women’s Rights and Status. Questions of analysis and measurement,* Gender in Development Monograph series 7. UNDP 1998.

RELATIONSHIPS BETWEEN CONTROL OVER RESOURCES AND POWER

DIFFERENTIAL ACCESS TO AND CONTROL OF RESOURCES BETWEEN MEN AND WOMEN IN SELECTED AFRICAN COUNTRIES

	Primary enrolment*		Secondary enrolment*		Percent illiterate >15 years		Early marriage		Rural area labour force		Numbers of Parliamentarians	
	W	M	W	M	W	M	W	M	W	M	W	M
Kenya	112	116	48	50	30	22	25	–	75%	–	18	204
Tanzania	104	108	5	6	38	22	41	–	74%	–	95	221
Sudan	56	65	33	35	48	29	27	–	–	–	21	400

* Gross enrolment ratios indicate the number of students enrolled in a level in the education system per 100 individuals in the appropriate age group. They do not correct for individuals that are older the level-appropriate age due to late starts, interrupted schooling or grade repetition.

Sources: UNFPA 2007, Government of Kenya, Tanzania, Sudan.

RANGE OF RESOURCES

Economic Resources

Financial Resources
· Remunerative Work
· Credit
· Money

Basic Needs
· Food
· Housing
· Transportation

Services
· Child care facilities
· Health services
· Social security, health insurance
· Facilities to carry out domestic tasks

Technical
· Technology
· Equipment
· Skills training

Political Resources

· Positions of leadership and mobilisation of actors in decision-making positions
· Opportunities for communication, negotiation and consensus-building

Information/Education

· Inputs to be able to make decisions to modify or change a situation, condition or problem
· Formal
· Non-formal education
· Opportunities to exchange information and opinions

Time

· Hours of the day available for discretionary use
· Flexible paid hours

Internal / Personal Resources

· Self-esteem
· Self-confidence
· The ability to express one's own interests

Women, Health and Development, Workshop on Gender, Health and Development, Washington D.C. Pan American Health Organisation, 1997: 45

ROLE PLAY ON ACCESS TO AND CONTROL OVER RESOURCES

Role 1:

You are a woman. You work on your husband's land growing vegetables for the family to eat. Your husband does not work on the land. He works in the village. Your family eats some of the vegetables and the rest you sell at the market and this gives you some spending money. Otherwise you have no money of your own. Your husband does not give you money, he simply brings food and other necessities from the village. You need to have some money available, so that you can buy small things for your children or for yourself, or pay for the clinic when you need to go. Your husband comes home and tells you that a friend of his has offered to sell your vegetable crop in a bigger town.

Role 2:

You are a man. You have a job in the village. Your wife grows vegetables. A friend of yours has offered to sell the vegetables in a bigger town for good money. You want to do this because you need more money to buy a gift for your best friend's wedding.

Activity 4

FGM/C AND SEXUAL AND REPRODUCTIVE RIGHTS

Time: 1 hour

Why do this activity?

Talking about sexual and reproductive health and rights is sometimes a source of misunderstanding, especially in some communities where many physical needs are considered taboos. Understanding the meaning of sexual rights or reproductive rights is the first step to gender equality. Sexuality is a central part of human experience and should contribute towards our sense of well-being, and towards strengthening our intimate relationships. However, inequalities between men and women in sexual decision-making frequently undermine the quality of sexual relationships, and at worst put women in danger of ill-health, and also, of death. But both men and women, can be endangered by the inability of individuals to communicate openly about sex and sexuality. Inequality between sexual partners can also put the partner with less power - usually women - into a position where they are afraid to talk to their partners - for example to discuss the need to practice safe sex with their partners.

At the Fourth World Conference on Women (FWCW) held in Beijing in 1995, the international community asserted that:

“The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences (par. 96)”.
This position is frequently referred to as ‘sexual rights’ although the actual words ‘sexual rights’ are not in the Beijing Platform.

Many NGOs are more familiar with the concept of ‘reproductive rights’ than ‘sexual rights’ in fact the international community, through the United Nations has agreed on a concept of reproductive rights which all countries should try to ensure for their citizens and define it as well as possible. This concept is in both the International Conference on Population and Development (ICPD) Programme of Action and the FWCW Platform of Action.

An infringement of those rights is the practice of FMG/C, that is the expression of gender inequality and the cause of some sexual and reproductive diseases, sometimes with fatal consequences.

2 Objectives

- To distinguish between reproductive rights and sexual rights
- To understand why FGM/C is a violation of sexual and reproductive rights

How to do the activity:

Step 1: 10 minutes

Handout

Distribute to the participants the Handout 1 “Reproductive Rights and Sexual Rights” which provides the definition of Reproductive Rights and Sexual Rights. Give them 10 minutes to read it individually and underline the most relevant concepts. The time indicated is more than the participants need.

Step 2: 40 minutes

Plenary

Ask the participants the questions in the Note to the facilitator and have a short discussion in plenary after each question, following the related indications. You have to verify if the participants have understood the difference between Reproductive Rights and Sexual Rights and why the practice of FGM/C is a violation of these rights.

Step 3: 10 minutes

Plenary

Use Handout 2 to open a plenary discussion on “Who does a woman’s body belong to?”. People have to answer the following questions:

- Does a woman’s body belong to her husband?

- Does a woman’s body belong to her doctor?

- Does a woman’s body belong to her boss?

- Does a woman’s body belong to her government?

- Does a woman’s body belong to her religion?

- Does a woman’s body belong to herself?

Note to facilitator

This short discussion is used to verify if the message that the woman’s body belongs to herself has got through.

Plenary

Questions

1. Why is the issue of freedom from 'discrimination, coercion and violence' central to the concept of sexual and reproductive rights?

For many people sexual relations are associated with violence. Rape in marriage, for example, is not recognised by all countries as a violation. In fact, in some countries it is not clear among young people, especially young men what constitutes "choice"; if a young woman says she does not want sexual intercourse, the young man may not believe her, and may push her into intercourse anyway. Incest is another major problem facing both young boys and girls. All of these situations, initially breach 'sexual rights' and may also lead women to become pregnant, in which case they are also breaches of women's reproductive rights. The concept of reproductive rights is intended to cover all of these situations, emphasising that women should never become pregnant against their will or without having had the opportunity to make a decision as to whether or not they want and are able to take responsibility for a child. Moreover FGM/C being imposed on girls without their consent is an act of coercion that can have harmful consequences for their future sexual and reproductive life.

2. Why are 'mutually respectful and equitable gender relations' a prerequisite for reproductive rights?

Reproduction usually results from sexual relations between men and women. Without mutual respect between them, there may not be the possibility of open communication about each of their reproductive desires, and about the implications of having or not having a child for each of them, as well as for any children they may already have, and for any other family members for whom they may be responsible. The impact of having children is usually very different for women than for men. There are health implications for the woman, and mutual respect is required for the man to play a role in ensuring as little negative health impact as possible on the woman. A woman's husband or partner should ensure that she has enough food; that she has access to health services; that she does not carry out any work that may endanger her health during pregnancy etc. In addition, having a child raises the question of who will undertake childcare, both earning the necessary funds and looking after the child on a daily basis. This should be the responsibility of both the man and woman, and mutual respect and equitable gender relations are necessary for them to be able to openly discuss the best ways of meeting the child's needs, such that burdens and benefits are equitably shared between them.

3. What is the meaning of sexuality?

Sexuality refers to the expression of sexual sensation and related intimacy between human beings, as well as the expression of identity through sex and as influenced by or based on sex. Sexuality is a central part of human experience and should contribute towards our sense of well-being, and towards strengthening our intimate relationships. However, inequalities between men and women in decision-making frequently undermine the quality of sexual relationships, and at worst put women in danger of ill-health, and indeed, of death.

4. Why are sexual rights different from reproductive rights?

Whereas reproductive rights concern the right of people to choose if, when and how many children to have, sexual rights are relevant at all times of people's lives, at all ages, since children can suffer sexual abuse, and people are sexually active into old age, when they are no longer concerned with childbearing.
You have to facilitate the understanding of the difference and the link between them.

Plenary

Questions

5. What do you think that a sexual rights approach is aiming to achieve? And a reproductive rights approach?

The sexual rights approach is aiming to identify how gender inequality makes sexual relationships dangerous for women, since they become vulnerable to abuse and disease. The reproductive rights approach is aiming to achieve freedom for women to decide whether or when they want and are able to, give birth and take responsibility for a child and, like sexual rights, to fight against gender discrimination, coercion and violation. The two kinds of rights approaches promote gender equality and argue that women and men can have control over their bodies, sexuality and family planning. The approaches aim to involve both decision-makers and people at community level in building a culture of sexual rights and reproductive rights at the individual level and in social institutions such as the educational, justice and health systems.

6. What are the barriers to promoting sexual and reproductive rights at community level?

In identifying barriers to promote sexual rights, consider barriers at the individual level (such as women's own sense of self, their confidence etc. and men's sense of how they should behave sexually in order to meet their own expectations of masculinity) as well as social barriers, such as cultural assumptions about how men and women should behave sexually according to cultural taboos. Also consider institutional barriers such as whether there is legislation against sexual violence against women, whether there is sex education in the school curricula etc.
Reproductive rights face social and institutional barriers (sometimes governmental) in which man is considered the only one who can take decisions on reproductive health including family planning. Also consider social barriers like how respect for a woman depends on the number of her children, how maternity gives her a role in the community. Both the penal code and Kenyan constitution recognize violence against women as a violation of human rights although de facto violence is still permitted especially in rural and depressed areas.
For decades, women seeking reproductive health services in Kenya have been suffering serious human rights violations, including physical and verbal abuse and detention in health facilities because of their inability to pay. Women who have only recently given birth are often forced to sleep on the floor or share a bed with others, are underfed, and suffer verbal abuse from staff over their failure to pay. In a particularly notorius case of abuse, a woman described being sexually abused and subjected to genital mutilation when she gave birth at a private facility.
These negative experiences have lasting psychological and physical repercussions on women and shape their subsequent decisions regarding health care use. Some women try to save enough money so that they need not return to the facility where they were mistreated, while others avoid health care facilities altogether by giving birth at home or no longer seeking contraceptive services.

7. What could your organisation do to promote sexual rights or/and reproductive rights?

Organisations can commit to incorporating the concept of sexual rights or/and reproductive rights in their current work. Organisations can advocate for governments to change laws and policies so that they are in keeping with international agreements. They can argue for governments to implement existing policies. Organisations can build community awareness about concept of sexual rights and build the capacity of women and men to protect their own sexual rights and act responsibly towards their sexual partners, or/and build community awareness about of reproductive rights especially related to maternity, family planning, sharing responsibility. Organisations can offer health services which promote sexual or/and reproductive rights.

Plenary

Questions

8. In which respect FGM/C violates the reproductive rights of women?

Reproductive rights are not only about the right not to have a child if you do not want to, but also to have a child if you want to. FGM/C can cause infertility which prevents a woman from having the desired children and is very often the cause of husbands divorcing and all the negative effects on her life. FGM/C causes difficulties in intercourse, pregnancy and delivery. FGM/C is usually the cause of reproductive and sexual illness with consequences on women's sexuality, sexual experiences, health, maternal mortality, infant mortality, etc.
You have to facilitate the understanding of how FGM/C violates these rights

9. Do you think that FGM/C represents a violation of the sexual rights of women?

Yes: cutting the clitoris is done for the purpose of diminishing the sexual pleasure/activity of women and therefore represents a violation of their right to enjoy sexual life as naturally inscribed in their bodies.

10. Which are the health consequences of FGM/C?

There is reliable evidence connecting FGM to obstetric complications. The WHO study on Female Genital Mutilation and Obstetric Outcome in Six African countries: Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan involved 28,393 women at 28 obstetric centres. This showed that women who have had FGM are significantly more likely to experience difficulties during childbirth and their babies are more likely to die as a result of the practice. Serious complications during childbirth include the need to have a caesarean section, dangerously heavy bleeding after the birth of the baby and prolonged hospitalization following the birth. The study shows that the degree of complications increase according to the extent and severity of FGM.

11. How can your organization use sexual and reproductive rights to promote the abandonment of FGM/C?

Organisations can commit to incorporating the concept that the practice of FGM/C is a violation of sexual and reproductive rights in the work they currently do. Organisations can advocate for governments to change laws and policies so that they are in line with international agreements. They can encourage for governments to implement existing policies. Organisations can work with women' and community-based organizations to identify and elaborate campaigns for the sensitization and information on FGM/C related to sexual and reproductive rights.

Materials:

- Copies of handouts for each participant

Handouts:

- Handouts 1: "Reproductive rights and Sexual rights"
- Handouts 2: "Who does my body belong to?"

Reading:

• United Nations & MDGs
http://www.un.org/millenniumgoals/

• World Bank & MDGs
http://www.developmentgoals.org/

• Gender & MDGs
http://www.mdgender.net/

• World Bank documentation on achieving MDGs in relation to health, HIV/AIDS, water & sanitation and education

• World Bank PRSP website
http://www.worldbank.org/poverty/strategies/index.htm
Whitehead A., Failing women, sustaining poverty: Gender in PRSPs, Report for the UK Gender and Development Network, 2003
http://www.christianaid.org.uk/indepth/0306gad/gad_intro.htm

• Female Genital Mutilation: Integrating the Prevention and the Management of the Health Complications into the Curricula of Nursing and Midwifery. A Teacher's Guide. WHO, Geneva, 2001

• Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African Countries
http://www.stopfgmc.org

• Excerpts from GTZ, *"FGM, MDGs, PRSP and the Agenda 2015: What are the linkages"*, 2005

REPRODUCTIVE RIGHTS & SEXUAL RIGHTS

REPRODUCTIVE RIGHTS

"Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free from discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government and community supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor quality reproductive health information and services; the prevalence of high risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives.
Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have different reproductive and sexual health issues which are often inadequately addressed".

Source*: ICPD PoA, paragraph 7.3 and repeated of Platform of Action in the Fourth World Conference on Women, Beijing, 1995, paragraph 95.*

SEXUAL RIGHTS

"The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationship between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences."
In the concept of sexual rights there is the concept of the right to decide if, when and how to have sexual relations, and the concept of the right of women and men to control their own bodies and sexuality.

Source*: Platform of Action of the Fourth World Conference on Women, United Nation, Beijing 1995: par. 96*

2 Handout 2 Activity 4

MODULE 3

UNDERSTANDING FGM/C IN A CHANGING SOCIETY: LOOKING AT POWER DYNAMICS

Module objective:

- To define the cultural environment in which actions will take place by tracing the origins and historic evolution of FGM/C
- To understand reasons behind the practice, both "self-explained" and "real"
- To analyse the causes of persistence of the practice, where "modernity" and "tradition" meet.

Why this module?

In 1995 DHS - Demographic and Health Surveys (Macro International) started to collect data on FGM/C prevalence and attitudes towards prosecution and/or abolition of the practice. The results continue to show significat levels of prevalence: Egypt 97%, Guinea Conakry 99%, Mali 92%, Eritrea 89%, Burkina Faso 77%, Ethiopia 80%, Sudan 90%, Kenya 32% and Tanzania 18%. This despite prevention campaigns were conducted since the mid-Eighties in some of the surveyed countries.
Why these campaigns have been not as successful as expected, and how to better design them, has been the object of several studies and discussions among donors and UN agencies over the last 10 years.
Behind the practice there seem to be profound reasons that prevention programs need to address in order to be successful. This module aims to understand these reasons and bring that knowledge into programming.

Activities:

Activity 1: Myths and realities behind the practices (1 hour and 35 minutes)
Activity 2: Is FGM/C a religious practice? (1 hour)
Activity 3: Is FGM/C a women's affair (1 hour and 55 minutes)

Total time: 6 hours

Activity 1

MYTHS AND REALITIES BEHIND THE PRACTICE

Time: 1 hour and 35 minutes

Why do this activity?

This activity prompts program officers to explore the broad range of reasons, both social and cultural, for the persistence of FGM/C. As harmful as the practice might be, with immediate and late side effects that reduce girls and women's health over the life cycle, (in particular whit the worse forms FGM/C type III or infibulation and type II including "sealing" as in several ethnic groups in Western Africa), and with increasing knowledge and information on these available, the practice has not stopped. In fact research shows that FGM/C persists and is being practiced on progressively younger girls and even babies health personnel is increasingly involved to avoid immediate consequences such as infections and pain, and less invasive forms, such as clitoridectomy and excision (type I and II) substituting type III.

Objectives

- To understand the reasons for the persistence of the practice by looking at how people explain why it should take place
- To recognize the gender power dynamics lying behind justifications given for performance and perpetuation of FGM/C
- To define the cultural aspects that should be addressed in mainstreaming FGM/C prevention activities into development programs and projects

How to do this activity

Step 1: 20 minutes

Handout Distribute the form in Handout 1 to each participant

Buzzing Divide the group in pairs inviting each participant to talk to his/her direct neighbour.

Ask each participant to share with her/his partner one **common statement** made in his/her community and/or area to justify the practice of FGM/C. In particular each person should take maximum 10 minutes to present the statement according to the **"5 Ws"** usually used in the lead of a news article, which means that they have to define:

WHAT is said, the statement/reason usually given in his/her respective environment to SUPPORT the practice of FGM/C and its continuation nowadays

WHY explaining why this statement is made

WHO by whom it is usually made

WHEN in which particular moment this statement is made most commonly (for ex. during girls' infancy, at puberty, before marriage…)

WHERE not only "where" geographically (in which particular area), but in particular of is it made at home, among friends, in the school, in the church/mosque, etc.

Remind the group that for the report and discussion in plenary, each participant will share the statement made by his/her colleague to everyone present. The facilitator will ring the bell when the first 10 minutes are over, to ensure that the second partner gets enough time to share his/her statement with his/her colleague.

Step 2: 30 minutes

Draw the table below on a flipchart.

Plenary

The plenary discussion should cover some of the following:

What …is said	**Who**	**Why**	**Where**	**When**
…/…				

Reconvene the plenary.

Invite each participant to share with the group the *justification* for the performance/continuation of the practice given by his/her colleague, including explaining by *whom* the statement is made, *why*, *when* and *where*.

Collect all forms and paste them on the wall.

Statements might include:

- Circumcised women fetch a higher brideprice for their families.
- Every human being is born with a double identity: excision is used as an instrument to define femininity, cutting off the male part.
- If not cut, a woman will not get married.
- Excised women are always in good health and rarely fall ill.
- The clitoris and the *labia minora* are removed to make the genitalia more beautiful.

Note to facilitator

- The clitoris will continue to grow and hang in an embarrassing way against the thighs, like the penis.
- Uncircumcised women have an excessive sexual appetite and will end up becoming prostitutes.
- It confirms ethnic identity: women who are not cut will feel alienated from their communities.
- People in the community and family will not eat the food prepared by uncircumcised women.
- A man will not be able to sexually satisfy an uncircumcised woman and she will be betray him and look for other men for sexual pleasure.
- It is a rite of passage to adulthood, to womanhood.
- It preserves virginity until marriage and chastity during marriage.
- The clitoris increases male excitement, leading to premature ejaculation.
- The vulva opening is reduced to increase male pleasure.
- It is done to prevent *lawa lawa* (Tanzania), a disease that gives vaginal discharge.
- The cut part of the external genital are used for amulets and rituals for the miners in order to get more tanzanite (Tanzania).
- It is a tradition, and we have to respect it.
- It is requested by the traditional African religion.
- If she is not circumcised, she will not be able to attend the animals, open the door for the cattle, or serve food to her family members.

WHO: These statements are made primarily by:

grandmothers
mothers
elder family members
peers: other girls in particular
men
elder men
everybody
the community at large

Girls and young women are the main target of such statements, as these are used to make them accept to undergo the practice.

WHEN:

They are made during the education and socialization process of girls, in order to prepare them to be “good” women. They intensify when puberty is approaching and during adolescence. Or, are made before and in preparation for marriage. This shows how FGM/C is an integral part of the construction of gender identity of girls/women.

WHERE:

Generally the statements are made in family settings: the family house/compound, including when visiting relatives in the rural areas. Schools and playgrounds where girls, adolescents and young girls meet provide a typical arena for peers to discuss issues linked to sexuality, boyfriends, marriage, therefore also FGM/C.

Step 3: 30 minutes

Plenary

Read through the different statements and ask participants to answer the following questions:

- Is this statement based on real facts?
- What arguments can be opposed to this statement?
- Ask one volunteer to come to the flipchart and write down the answers concerning each statement.

If needed to animate the discussion, and if time allows it, ask one of the group to take the position of a specific stakeholder in society - such as an old woman, an old man, or a young man/husband, and invite him/her to challenge the arguments from the point of view of this stakeholder, inviting everybody to consider the position of "others" when planning activities.

Note to facilitation

Real facts quoted by participants might include the following:

on identity… Gender identity is the result of socio-cultural construction that has no need for physical alteration. Culture is continuously changing and adapting over time, so that also the sense of identity, including ethnic identity, adapts to new conditions.
on sexuality… FGM/C is generally perceived and practiced to control women's sexuality. Nevertheless, sexual intercourse before marriage is common, in particular it is viewed positively for young men, as a proof of their "malehood". Stigma continues to apply only and foremost on girls.
on marriage… Families are abandoning the practice and marriages are not always organised in the traditional way, allowing for uncircumcised women to marry as well. nevertheless, bride price is still common, and the perception that FGM/C increases the bride price is widespread. Its effects go beyond FGM/C and should be addressed in an overall empowerment perspective of women.
on health… As the recent WHO study has shown, FGM/C has evident consequences on health, in particular on sexual and reproductive health, including difficulties in sexual intercourse and in delivery. Not cut women do not lead men to premature ejaculation. Glandular secretion of the vagina is natural to keep tissues smooth. If healthy there are no bad odours.
on beauty… Beauty is a matter of taste. In places where FGM/C has never been practiced other beauty criteria prevail.
on FGM/C as a rite of passage and other taboos associated with FGM/C… In rural areas FGM/C might still be considered as a rite of passage, although this is changing as more contacts are built with non practicing communities. In urban settings and where education is accessible for girls, the need for a rite of passage to adulthood is not perceived so strongly.
on religion… There is no mention of circumcising women in the Qu'ran, nor in other religious texts, although Islamic religious leader often promote clitoridectomy with or without excision of *labia minora* and oppose the activists who advocate for the total abandonment of the practice.
Traditional animistic religion often foresees FGM/C as well, and remains in the background promoting the practice despite people might have adopted another religion over time.

Note to facilitator

Note that the discussion will depend on the statements made by participants.
Explain that understanding the belief system which lies behind any society is essential in designing interventions aimed at changing beha-

viours. For this to happen, learning from and with local people and striving to appreciate their knowledge, instead of teaching them or imposing your knowledge or ideas, might be the most effective strategy.
In the most cases it will become clear that FGM/C is not necessary to preserve the cultural values and practices that it is linked to.

Step 4: 15 minutes

Individual reading, last round of comments

Distribute Handout 4 on "The realities of myths and beliefs regarding FGM/C" to participants at the end of the discussion: ask them to read it and make a last round of comments.

To finish propose the following definition of culture by sociologist Ulf Hannerz to the group:

"When you see a river from afar, it may look like a blue (or green, or brown) across a landscape; something of awesome permanence. But at the same time, "you cannot step into the same river twice", for it is always moving, and only in this way does it achieve its durability. The same way with culture – even if you perceive a structure, it is entirely depending on an ongoing process".

Source: Ulf Hannerz, *Cultural Complexity. Studies in the social organization of meaning,* Columbia University Press, 1992.

Materials:

- Flipchart paper
- Felt-tip pens
- Copies of handout for each person
- Overhead

Handouts:

- Handout 1: Form
- Handout 2: "Statements around FGM/C"
- Handout 3: "Myths and beliefs to justify the practice of FGM/C"
- Handout 4: "The reality of myths and beliefs behind the practice of FGM/C".

Readings:

- Carla Paquinelli, *Anthropology of Female Genital Mutilation*, AIDOS, 2000.
- Shell-Duncan B. and Y. Hernlund (ed.), *Female "circumcision" in Africa. Culture, controversy and change,* Boulder, London, 2000.

Handout 1

Activity 1

What …is said	Who	Why	Where	When

STATEMENTS ABOUT FGM/C

Every human being is born with a double identity: excision is used as an instrument to define femininity, cutting off the male part.

If not cut, a woman will not get married.

Excised women are always in good health and rarely fall ill.

The clitoris and the *labia minora* are removed for aesthetic reasons.

The clitoris will continue to grow and hang in an embarrassing way against the thighs, like the penis.

It confirms ethnic identity: women who are not cut will feel alienated from their communities.

People in the community and family will not eat the food prepared by uncircumcised women.

It is a rite of passage to adulthood, to womanhood.

It increases the bride price.

It preserves virginity until marriage and chastity during marriage.

The clitoris increases male excitement, leading to premature ejaculation.

The vulva opening is reduced to increase male pleasure

It is done to prevent *lawa lawa* (Tanzania), a disease that gives vaginal discharge.

The cut part of the external genital are used for Hamulets and rituals for the miners in order to get more tanzanite (Tanzania).

It is a tradition, and we have to respect it.

It is requested by the traditional African religion.

If she is not circumcised, she will not be able to attend the animals, open the door for the cattle, or serve food to her family members.

MYTHS AND BELIEFS TO JUSTIFY THE PRACTICE OF FGM/C

1 FGM/C contributes to gender identity

It is suggested through the myth of "twin birth" (duality of the soul) that every human being has a double identity, and that FGM/C is used as an instrument that affirms femininity or masculinity. Thus, the clitoris would be a male organ in a girl and the female organ in a man is the prepuce covering the penis. Moreover, the clitoris is perceived as an organ where evil forces may cause problems with the psyche or make a girl vulnerable to evil spirits. Because of all these magical powers attributed to the clitoris, FGM/C is conceived as a preliminary to marriage in those areas, believing that this protects the husband and progeny from the misfortune that can "assault" a non-excised woman.

2 FGM/C contributes to women's health

It is believed that women that have been submitted to FGM/C are always in good health and rarely fall ill; it is also believed that FGM/C has healing powers. It has, people say, healed women suffering from depression, melancholy, nymphomania, hysteria, madness, epilepsy and has the ability to stop women with kleptomania tendencies. Some supporters of FGM/C believe that the secretions produced by the *labia* and the clitoris gland (Skene and Bartholin), produce bad odors, compromise hygiene and keep women from caring for their bodies. In those communities where washing the vulvar region with soap and water is common after relieving oneself, it is believed that the hand that washes is contaminated by the secretions and that the contamination is extended to food, water, clothes, etc. It is therefore deemed necessary that the glands and organs responsible for these secretions be eliminated to avoid contamination and safeguard individual cleanliness.

3 FGM/C beautifies the sexual organs of women

It is said that prepuce of the penis is removed essentially for aesthetic reasons, and that the clitoris — homologous to the penis — is removed for the same reason. In addition, in some cultures, the theory prevails that female genital organs have the capacity to develop, as with those of a man as the body grows and that if the clitoris becomes longer it can hang in an embarrassing way against the thighs, like the penis. Even when there is a more rational concept of the size of a clitoris, a large number of ethnic groups consider this organ ugly to look at and indecent to touch. In their opinion a smoother female genital organ, with protuberances removed, is much more palatable.

4 It is a rite of passage for girls

FGM/C practiced in puberty in groups and with a period of reclusion for the excised girls used to be, and is still in some rural areas, an important rite of initiation for girls. The decision for FGM/C is made by the extended family (family chiefs, aunts, grandmothers or in-laws) or by local authorities (traditional chiefs, councils of elders and diviners). Girls' initiation was a socialization of their roles as wives and mothers, and an apprenticeship of the secret rites and codes of behavior of adult females. It sometimes included a transfer of occult knowledge or professional training. Girls in puberty submitted courageously to the torments of FGM/C and the

entire collectivity rejoiced in what was known as the girls' "blessed day" and their preparation for life. It was the allowed framework to discuss and learn the details of sexuality, and the chance to create group solidarity. The greatest recompense for excised girls was acquisition of the status of adulthood and the rights that came with it with the chance to be given in marriage, while in general boys who underwent circumcision were then allowed access to the highest spheres of power and sacred knowledge.

5 Excisors play an important role in the community

Traditionally, the practice was an occupation given to specific women (*excisors)* exclusively by the community, as a sort of heritage (from mother to daughter), and by their membership in a determinant social group (for example, blacksmiths in most countries in West Africa). The prestige and social acceptance were their main reward since they worked mainly in agriculture or trade. In most cases, payment in kind and in money were symbols of a job well done and not a strategy for survival.

6 FGM/C preserves virginity before marriage and ensures fidelity during marriage

Remaining a virgin until marriage is strongly encouraged in most African societies. So much so that virginity confers a high level of prestige and, even more than the morality of the girl herself, it symbolizes the morality of her family. In the communities that practice FGM/C, people are convinced that it is very difficult for a non-excised girl to remain a virgin until marriage given the hyper-sexuality of the exterior organs of the female genital apparatus. So FGM/C, infibulation in particular, is supposed to guarantee girls' chastity. Excised girls are more capable of controlling their sexual desire, of more easily dominating themselves, and will be more inclined to remain faithful during their marriages.

7 FGM/C contributes to increase male's pleasure

According to certain social groups the clitoris is analogous to the penis and increases male excitement, leading to premature ejaculation. In these societies, when the sexual act is completed too rapidly (even though it escapes the man's control) it is considered an insult and creates resentment and conflict within the marriage. It is also felt that the man should be able to control all aspects of sexual relations, from initial excitement to orgasm and ejaculation. In those types of FGM/C that call for cutting of the *labia minora* and *majora* and suture of the vulva, one of the aims is to convert the organ into a tight orifice whose size is calculated to increase male sexual pleasure.

8 FGM/C is recommended by religion, in particular Islam

There is an ambiguous relationship between affiliation to Islam and the justification of FGM/C in Africa. Some Muslims make reference to a dialogue that the Prophet Mohammed apparently had with a traditional practitioner during his lifetime to say that by excising their daughters, they are only following the Hadiths that are important elements in their religions. Indeed, in most of these countries, most of the women who practice FGM/C are Muslim, which some consider a *de facto* confirmation of the relationship between Islam and FGM/C, supported by the fact that the practice is almost universal in Islamic countries such as Somalia or Egypt. Nevertheless, the contradiction is that in the countries where this is practiced by a minority (e.g. Senegal, Mauritania and Niger), most of the Muslim population does

not follow this practice. Moreover, the most fundamentalist subgroups of some countries (for example, in Mali and Senegal) do not practice FGM/C while some of their countrywomen submit to it, convinced that all good Muslim women must have their daughters undergo FGM/C.
Some Christians claim that they practice FGM/C while keeping with Christian tradition. They explain FGM/C with their affiliation to given ethnic groups. In contrast, the symbols and initiations that accompany FGM/C adapt easily with animist beliefs and the tradition of blood sacrifice to gods or fetishes.

9 FGM/C is an essential practice for preserving ethnic identity

It is alleged that membership to an ethnic group and identification with that group requires that certain obligations be met to achieve full admission. Those adhering to the group must conform to the group's rules and regulations and defend its cultural base. The chiefs of certain ethnic groups firmly believe that non-compliance with these obligations takes away any right for members to claim the privileges and advantages they would normally be due. Most African families who want their children to be accepted by their societies and to make full use of the social rights, hold that it is very important to identify with the culture or group of their lineage. They attribute a very high value to membership in the group and the creation of ties with other children without fear of exclusion. In some communities, FGM/C is the rite that gives women this acceptability and social integration. Otherwise, they risk being separated from the group and losing their right to contribute to and participate in community life. Loss of these rights and privileges could even be extended to the head of a family where women and girls have not undergone FGM/C.

Source: AIDOS, IAC, ILO, *MGF. Une question de relations entre hommes et femmes, droits humains et santé.*

THE REALITY OF MYTHS AND BELIEFS BEHIND THE PRACTICE OF FGM/C:

None of the reasons advanced to justify excision have any scientific justification. From a medical point of view, modernization of the procedure (which means turning to specialized health care personnel to avoid possible infection and pain) is against medical ethics.

1 Preserving hygiene

The normal secretion of the vulvar glands are practically imperceptible—just enough to moisten the vulva area.

The expectation is at the moment of sexual arousal when secretion of the vagina increases enough to lubricate the zone and ease penetration. In addition, normal vaginal secretion is only seen in a vagina at rest (i.e. not sexually aroused) for a few days during the menstrual cycle. A "humid" period is a sign of ovulation and lubricates so that spermatozoids can swim the length of the vagina. Otherwise, the vulva is "dry". Under normal conditions, in a healthy, clean female, these secretion are colorless and their odor is not disagreeable. Thick, colored, bad-smelling, continuous vaginal secretions are signs of an infection and should be treated immediately. In areas where the women are required to wash the vulva after urinating, washing one's hands with a sponge and soap is sufficient if there is fear of contamination. It has been noticed that washing the anal area takes place in the same way but that no one every proposed excision of the anus. In addition, excision can close the vulva (by scarring or infibulation) and keep the urine and menstrual flow from running down the usual channels. This can provoke acute retention of urine and menstrual blood, and lead to a state known as haematocolpos which can seriously compromise the health of the girl or woman concerned and create much worse odors than those from normal hormonal secretions.

2 Aesthetic aspects

The configuration, structure and function of most of the organs of the human body are genetically and hormonally determined. The body's sexual hormones determine the distinctive characteristics of each sex. The male hormone stimulated grown and the function of all those organs that (like the penis) play a role in the male, just as it stops the growth of all those organs that the two sexes have in common (the breast, for example). In the same way, the female hormone stimulates development of the mammary glands (for the production of milk). A clitoris that grows abnormally in a female or breast that enlarges anomalously in a male are outward signs of an internal disorder that should be dealt with immediately. Just as no one would every dream of excising the breast of a young man (to avoid their developing one later), a girl's clitoris should never be touched since it cannot grow beyond a certain size. In addition, it is surprising that reasons of aesthetics and hygiene are invoked to justify excision. The hardened scar and the stump that normally replaces the clitoris, or the skin pulled to cover a long scar in the case of an infibulated vulva does not look normal.

3 Safeguarding health

The belief that an excised woman has a better chance to stay in good health is clearly not valid. In traditional communities, women rarely complain. There are numerous

examples in literature of excised women suffering from a multiple of ills caused by their operation. Their societies have taught them that this suffering is part of their condition as women. Generally speaking, in communities that pratice excision, certain organs and certain bodily functions are never mentioned and women are therefore required to ignore and bear any of the harmful consequences of excision as well as possible. We should also point out that it is often difficult for excised women to see the connection between infirmities or illnesses that they develop as adults and the FGM/C to which they were subjected during childhood and considered an isolated, far off episode.

4 Protection of fertility

The reasoning by which excision reinforces fertility and fecundity is absolutely groundless. Actually, the opposite is true. Excision is one of the causes of sterility, particularly among girls who develop pelvic infections after excision. The secretions believed to have a toxic effect on sperm are actually innocuous and are a lubricating mucus, eliminating the friction between the extremely sensitive walls of genital organs.

5 Prevention of stillbirths

There is no scientific basis to the idea that contact of the infant's head with the clitoris during labor can cause death. Actually, the large number of normal healthy children born to non-excised women is proof that the argument is groundless. To the contrary, there is a much higher percentage of stillbirths due to prolonged labor in excised women.

6 Improvement of male sexual performance

The reasoning that excision increases male sexual performance is only valid where tradition induces men to believe that sexual pleasure and performance can be obtained in excised women who passively support the sexual act. The truth is that men only rarely claim that female passivity contributes to sexual pleasure. Men interviewed on a random basis in some African countries have admitted that sexual relations with non-excised women were much more satisfying than with excised women. Many women have equally stated to family planning agents working in urban areas their belief that their husbands prefer rivals who are not excised. This is due to the fact that penetration in a well lubricated vulva of an excited woman is even more gratifying for a man than a woman.

7 Preserving virginity

From a material point of view, the "*virgo intacta*" is a girl whose hymen is still intact. From a psychological point of view, a virgin is a young woman who has never had sexual relations, i.e. whose vagina has never been penetrated by a penis. Presumably, at the moment of excision, since the walls of the vagina are scraped, the hymen can be torn and the girl could lose her virginity. At the same time, a girl can be a virgin in the literal meaning of the word and find herself pregnant as a result of heavy petting (if the sperm is ejaculated near the vagina).

8 Prevention of promiscuity

Every community has the right to take steps to oppose behavior that risks breaking the daily balance of community life. However, promiscuity is a form of conduct that arises from a complex combination of social conditions on which maintaining or elimi-

nating sensitive sexual organs have no direct influence.

A study conducted in Sudan has demonstrated that excision is not a way of stopping prostitution, here seen as a sign of promiscuity. Prostitution aside, some excised women believe that they are prevented from reaching certain levels of pleasure. After interviews with 50 urban women in Sierra Leone who had sexual experiences before excision, the researchers observed that none of these women ever reached the level of satisfaction they had before excision—and that before the interview, they had no idea that this lack was the result of excision. Some of the women interviewed admitted that their stubborn search for an ideal partner had cost them their husbands and their homes. Thus, an operation aimed at eliminating promiscuity risks achieving the opposite effect.

9 Promotion of social cohesion

The belief that excision assures social integration is a real problem, since the right of membership in a community and to be accepted as a full member should not be obtained at the price of human suffering and death. It should be possible to formulate other rules and conditions of acceptability that do not compromise the health of women and girls while preserving the social values and positive rules inherent in rites of passage. Practices that are dangerous to health (like excision) should be eliminated. Actually, the societies that are responsible for organizing rites of passage often pose laudable goals. In order to achieve these goals, initiation rites need to be altered and there must be teachings to prepare girls for their new status of womanhood (without excision). That kind of change does not necessarily mean, as is believed, dissolution of feminine society. It should be understood as a way of transformation or orientation towards a better life for everyone.

10 A religious practice

It is truly astonishing to see the extension of the practice of excision in the name of religion when neither the Qur'an nor the Bible mention it. Reviewing the writings of Muslim exegetes, no mention of excision is found in the Qur'an. According to the Qur'an, God created human beings in the best possible form, so why deform the work of God? Islam prohibits the practice of all that is harmful and, as a result, prohibits excision because it is physically and psychologically injurious. Islam respects women and guarantees them all rights to live a satisfying, normal life. Excision is not practiced in any of its various form in Islamic states such as Saudi Arabia, Iraq, Iran, Jordan or Libya. Actually, some of the most prestigious religious leaders and theologists completely disapprove of the practice. It is sometimes sad to note that there is absolutely no consensus within Islam in favor of the elimination of excision. While most exegesists state that citations of the Hadiths have been changed, others have a different point of view on this subject.

Activity 2

IS FGM/C A WOMEN'S AFFAIR?

Time: 1 hour

Why do this activity?

Why do African women, often also the well-educated, defend the practice?

In literature on FGM/C, both in the mainstream media as well as in specialised publications, it is often repeated that FGM/C is "a women's affair". Women are those subjected to the practice. Mothers, grandmothers, aunts are those requesting the practice to be performed on girls. Women are, in the majority, the traditional practitioners themselves. Mothers and other female relatives or neighbours are those who hold the girl down and still, while the knife cuts.
So often the question is raised: why do women in Africa insist on circumcising their girls and why even the educated ones still defend the practice?
This activity is meant to familiarize planners with the role women play in FGM/C and with its complex outcomes for women's lives and empowerment in rural and in urban settings, in more "traditional" as well as in more "modern" contexts.
As abandoning the practice implies a fundamental change in behaviour, the hidden meanings and dynamics of its performance also need to be understood and considered by program officers before planning activities. This concerns the “ritual” itself with its progressive and apparently irreversible disappearance in many settings/countries; how FGM/C is increasingly performed on very young girls (up to babies of a few months); how non-traditional practitioners leave girls deprived of the emotional and cultural surroundings that help take care of the pain endured and transform it into pride, dignity and force and how the values attached to the practice today are condensed in a simple word justifying the continuity of the performance: “tradition”.
The disappearance of traditional rituals leads the way to women's empowerment without cutting.

Objectives

- To understand the complexity of FGM/C and why women continue the practice, notwithstanding the harmful consequences.

How to do the activity

Step 1: 30 minutes

Small group discussion

Handout

This is a small group activity. It is based on the analysis of anthropologists and experts with the aim of challenging the "women's affairs" stereotype and looking deeper into it.
Each group is given one of the handouts with different case studies, as well as the handout with “Questions for guiding the discussion”. Ask the group to read it carefully and then discuss it.
Participants should confront the content of the handout with the myths and realities already discussed in the first activity.

Ask each group to choose a rapporteur to present considerations of the group to the plenary. Walk around and listen to the groups. If they are battling, then help them along offering alternative perspectives to look at the issue. Always try to move the discussion between the "violation" vs. the "empowerment" approaches to FGM/C.

Step 2: 30 minutes

Plenary discussion

Bring the group together. Ask each rapporteur to present the result of the discussion in small group, including a brief summary of the handout. Ask participants to comment. Keep the set of questions that have guided the discussion in mind, and try to let the double side of the practice emerge:

Note to facilitator

- on one side FGM/C is a practice that oppresses women, violates their bodily integrity and human rights, reduces and subjects their natural sexuality;

- on the other side, it grants women freedom of movement, dignity, respect and social recognition, access to resources, decision-making within community, adult female identity.

Guide the conclusion of the discussion towards the question:

Can FGM/C be abandoned / replaced without worsening the condition of women?

For example, is there a connection between the transformation of the practice in Somalia, with number of families seeking less severe forms of FGM/C instead of infibulation, and increasing women's segregation, rigid dress codes and imposition of the Islamic veil?

The question above does not need to find a definitive answer at the end of the discussion. It can be left to the group to think about it, as it will be raised again within the section dedicated to programming activities.

Materials:

- Copies of handouts for each group.
- Flipchart paper
- Felt-tip pens.

Handouts:

- Handout 1: “Questions for guiding the discussion”
- Handout 2: “Not born as a woman, but created as a woman by culture”
- Handout 3: “Sierra Leone: women's secret societies and FGM/C”
- Handout 4: “Why is FGM/C such a strongly upheld ‘traditional practice’ and is it ‘harmful’ or useful to women?”

Reading:

- Bettina Shell-Duncan and Ylva Hernlund (ed.), *Female 'Circumcision' in Africa: Culture, Controversy, and Change*, Lynne Rienner Publishers, Inc., 2000

- Carla Pasquinelli, *"Anthropology of Female Genital Mutilation"*, in *Stop FGM. Legal tools for the prevention of FGM, Proceedings from the Expert Consultation, Cairo 21-23 June 2003*, published by AIDOS and NPWJ, Rome, 2003.

- Nahid Toubia, *"Legislation as a tool for Behavioural and Social Change"*, in *Stop FGM. Legal tools for the prevention of FGM, Proceedings from the Expert Consultation, Cairo 21-23 June 2003*, published by AIDOS and NPWJ, Rome, 2003.

- Hanny Lightfoot-Klein, *Prisoners of ritual. An Odyssey into Female Circumcision in Africa*, Harrington Park Press, New York, 1989.

QUESTIONS TO GUIDE THE CASE STUDY ANALYSIS AND PRESENTATION

1. Give a brief presentation of the case study
2. What is the attitude of women in the case study towards the practice?
3. Does the practice contribute to women's empowerment?
4. If yes, how?
5. Are eventual negative consequences of the practice recognized?
6. Is there conflict between traditional and modern ways of socialization of women?
7. Which changes in the socialization of women already affect the practice in your environment?

CASE STUDY 1

NOT BORN AS A WOMAN, BUT CREATED AS A WOMAN BY CULTURE*

Female genital mutilation is a fundamental component of the initiation rites performed in a traditional society to become a "woman". One is not born a woman, in the sense that the biological connotation is not in and of itself a sufficient factor of identification. For that, rites are needed to transform membership in an ascribed sex to an acquired status, freeing biological destiny of sex and allowing it to become a "social essence": a woman. It is the rites that decide a person's identity, starting with ascribed belongings such as sex and age. By separating it from biology, rites inform a person of his/her identity, indicating what s/he is and should be.

Of course, this does not happen only in Africa. With differing emphasis, every society transforms biological sexuality into a cultural construction, differentiating between male and female to decide gender membership. For the most part, they are implicit models in their ways of acting, projecting the difference between the sexes on the cultural level, redeeming them from pure biological belonging. The state of gender in complex societies is subject to continuous negotiation, in the sense that none of the distinctions between men and women is destined to remain the same for long. As such, these distinctions cannot be taken for granted. In traditional societies, on the other hand, gender is better established and, at present, seems fairly unchangeable.

In African societies, the creation of gender identity is first of all physical manipulation of the body. With respect to the ceremonial aspects of the rites of initiation, which take care of the symbolic control of the passage of status, female genital mutilation does something more: it carves the woman's gender identity onto her body. And it does so in two ways, first, by changing the morphology of her body and then by shaping its expressiveness.
Along with manipulation of the woman's body, mutilation forms the physical appearance, proportion and harmony among the various parts, the exis (final outcome), posture and bearing, giving a woman's body what anthropologist Marcel Mauss calls "techniques", those automatic body gestures and movements that, in different ways, represent "femininity" in every culture. This is particularly visible in infibulated women whose lithe, slow gait is a result of the operation that makes a series of movements very difficult. The operation brings the legs closer together, restricting the intermediate space and keeping women from separating their thighs too much. This forces the woman's body into a carriage and stride that we could define as centripetal. After they are infibulated, the girls are re-educated to use their bodies, choosing certain movements and postures that are compatible with the changes brought by the operation, abandoning others that might compromise its results and reopen the freshly sutured wound. "Careful, don't run, don't play ball, you'll tear," admonish their mothers. The latter take it on themselves to teach their daughters to discipline their bodies according to rules and models of behaviour

inspired by the women's subordinate role in society and characterized by rigid differentiation and separation of male and female. The operation also ends any form of promiscuity between boys and girls who stop playing with each other, not only because the operation makes any type of activity we associate with masculinity, like running, playing with balls, jumping, and so forth difficult, but also because the new status of woman forbids it.

The natural body is impure because it is open and violable, exposed to a promiscuity that can contaminate not only the individual woman but her entire family group which would be discredited and shamed. In this scenario, female genital mutilation is the only way of protecting women from the male desire that is always lurking and especially from herself. That helpless body is defended by a cultural construction of bodies that deprives them of all tumescence and excess, making them smooth and innocent after stealing their naturalness and pleasure.

* Excerpts from: Carla Pasquinelli, *"Anthropology of Female Genital Mutilation",* in *Stop FGM. Legal tools for the prevention of FGM, Proceedings from the Expert Consultation, Cairo 21-23 June 2003,* published by AIDOS and NPWJ, Rome, 2003.

CASE STUDY 2

SIERRA LEONE: WOMEN'S SECRET SOCIETIES AND FGM/C

The two [most salient social organizations, who care for initiation and circumcisions among the Kono, a Mande speaking group of Sierra Leone] are *Bundu*, female "secret societies" and *Poro*, their male counterpart.

Most important, the *Soko* [leader of the *Bundu*] has the socio-religious authority to create "woman" - that most productive and reproductive asset as far as patriarchy, that is, male-headed families, compounds, villages, and lineages, is concerned. She gives religious, social, and cultural sanction to women's reproductive and productive roles: an initiated or well "trained" woman will fulfill her social responsibilities as mother and as farm laborer. Given the traditional socio-economic primacy of marriage and motherhood among the Kono, as in most African cultures, and *Bundu's* paramount historical function of producing marriageable women committed to accomplishing their productive and reproductive roles, the *Soko* is charged with the most credited task in society.

However, the role of *Bundu* and its leaders in this regard has engendered some controversy among scholars [who] have criticized female ritual officials as colluding with patriarchy in order to maintain the subordination of women in society. This position, however, misses the point that female subordination is much more complex and situational than Western analysis permits.

What *Bundu* teaches first and foremost is the subordination of young girls and women to female elders: their mothers, future mothers-in-law, grandmothers, older women within the community, and, of course, female ritual leaders.

Secondly, novices are taught the art of subservience to some categories of men, that is, their future husbands and other male representatives of those lineages. In the first instance, vis-à-vis female elders - that is, within their own sex group - initiates and younger women are inferior. […] But ritual leaders do not only teach subservience. They themselves are examples of ultimate female authority: wise, unyielding, and unsentimental. It is the *Soko's* responsibility to see to it that novices are inculcated with the ideals of femininity as laid down by previous ancestresses: stoicism, which must be displayed during excision; tenacity and endurance, which are achieved through the many other ordeals a novice must undergo; and, most important, "dry-eye" that is, daring, bravery, fearlessness, and audacity, qualities that will enable young women to stand their ground as adults in their households and within the greater community. Thus, the *Soko* has a paradoxical responsibility of "creating" dual-natured "woman": a community-oriented and subservient person to be exchanged in marriage, as well as a defiant individual who capitalizes on the bolder qualities ingrained in her feminine identity in defending her own goals, priorities, and stakes within society.

Female elders flank the upper echelons of *Bundu*. The next and most important category of women as far as the continuation of initiation and excision is concerned are the middle-aged grandmothers, whose critical job it is to put pressure on their daughters, who may be wary young mothers. These eminent elders have significant

moral and emotional control over their married daughters. New mothers often spend a great deal of time in their natal villages under the supervision of their own mothers, particularly after the birth of and throughout the weaning period of their children. This group of older women are well aware of their importance when it comes to initiation and are often the ones spearheading the organization and orchestration of their granddaughter's ceremonies. It is incumbent on mothers to initiate their daughters properly, according to ancestral customs, in order for the latter to become legally recognized as persons with rights and responsibilities in society. Thus, there is enormous cultural demand for mothers to conform to the tradition of initiation, no matter how far they travel, the length of their absence from their local communities, and for those who are abroad in Europe or the United States, the intensity of their "Westernization."

For Kono women living in the diaspora, there is not much difference because many remain very close to their mothers. Although older women and female ritual officials put tremendous social pressure on mothers to "circumcise" their daughters, this pressure does not sufficiently explain why most women adhere to the tradition. […] The reluctance of women to disengage from female "circumcision" could well be a result of gauging what other women will do - that is, some women may not actually support the continuation of the practice, but they do not want their daughters to be the odd ones out.

Kono women living in the diaspora explain that they want their daughters to enjoy the same legal rights as other women, and even more, they want them to "fit" into Kono society and be respected among their peers and the entire community of women. My own personal experience, which is hardly unusual, is a case in point. I am often reminded by Kono relations that had I not undergone initiation, I would not be able to be involved in meetings concerning "women's business," that I would not be able even to speak as a "woman" or on behalf of any women. Moreover, no initiated Kono woman would dare to talk to me about *Bundu*.

Societal coercion and pressure to conform, however, do not explain the eagerness and excitement felt by vast numbers of participants (residents in Kono as well as outside) in initiation ceremonies, including mothers of initiates, even if these same mothers also experience anxiety over the safety of their daughters. It is difficult for me - considering the number of these ceremonies I have observed, including my own - to accept that what appear to be expressions of joy and ecstatic celebrations of womanhood in actuality disguise hidden experiences of coercion and subjugation. Instead, I offer that most Kono women who uphold these rituals do so because they want to, they relish the supernatural powers of their ritual leaders over/against men in society, and they embrace the legitimacy of female authority and, particularly, the authority of their mothers and grandmothers. Also, they maintain their cultural superiority over uninitiated/uncircumcised women.

* Fuambai Ahmadu, *"Rites and Wrongs: An Insider/Ousider Reflects on Power and Excision",* in Shell-Duncan, B. and Y. Hernlund*, Female "circumcision" in Africa. Culture, controversy and change,* Lynne Rienner Publisher, 2000.

CASE STUDY 3

WHY IS FGM/C SUCH A STRONGLY UPHELD "TRADITIONAL PRACTICE" AND IS IT "HARMFUL" OR USEFUL TO WOMEN?*

As an African feminist and physician I have, in the past, been plagued and irritated by the nagging question: why do women in Africa insist on circumcising their girls and why even the educated ones still defend the practice? Studies show that women medical doctors refuse to condemn the practice in a society where infibulation is the norm. It may be easy to lay the burden of the demand for FGM/C on the shoulders of men or, more accurately, on patriarchal society including the women within it. While such analysis still holds, there is still the unresolved issue of why women defend the practice even when men in their family or their community want to abandon it.

The answer to this question revealed itself while we were conducting an analytical reviewing of major approaches taken against FGM/C in the past twenty years, which we undertook between 2001-2002. In extracting the elements of what worked and what didn't in persuading people to abandon the practice, we found that projects which focused on changing women's consciousness and, in some cases, their material conditions had a significant effect on accelerating the rate of abandonment. We also found that for the change in women's attitude and behaviour towards FGM/C to take root and be sustained it must gather sufficient support from power holders in the community such as husbands, health professionals, religious leaders and policy makers.

This finding made us look more carefully at our perceived notion that FGM/C is harmful to women. On the basis of objective logic and scientific criteria FGM/C is undoubtedly harmful to girls as it deprives them of vital sexual organs necessary for their health and holistic development.

The fact that the cutting happens to minors who have no true powers of consent is a violation of their human rights under the Convention of the Rights of the Child. But these are 'our' logical and rational reasons for condemning the practice which we attempt to transplant onto the women who want to preserve the practice. Women living in circumcising communities have 'their' own logic and rational reasons for not readily adopting our logic.

For them, living under a strong patriarchal social and economic regime with very few option for choices in livelihood, the room for negotiating a limited amount of power is extremely small. Circumcising your daughter and complying with other certain social norms, particularly around sexuality and its link to the economics of reproduction, is an essential requirement to these silent power negotiations. Women instinctively know this. We may scare them with all the possible risks of FGM/C to health. We may bring religious leaders to persuade them that the practice is not a

requirement. We can try to bring the wrath of the law to bear upon them. But in their desperate hold on the little negotiated power they have known for centuries, they are not willing to let go unless they see a benefit that is equal to or more than what they already have.

* Excerpts from: Nahid Toubia, *"Legislation as a tool for Behavioural and Social Change",* in *Stop FGM. Legal tools for the prevention of FGM, Proceedings from the Expert Consultation, Cairo 21-23 June 2003,* published by AIDOS and NPWJ, Rome, 2003.

Activity 3

IS FGM/C A RELIGIOUS PRACTICE?

Time: 1 hour and 55 minutes

Why do this activity?

FGM/C is a native practice, deeply rooted in local society. It existed in sub-Saharan and Central-Eastern Africa before the introduction of Islam in 1050, after the religion had established itself in Mediterranean Africa over earlier centuries, eliminating the ancient Christian Churches.

The fact that the origin of FGM/C in Africa is frequently attributed to Islam is probably due to the ease with which it adapted to indigenous traditions and conformed to local life. The penetration of Islam was possible due to the presence of certain elements in African culture, such as the patrilinear social structure and the concept of a strong sense of dependency on God. These elements fostered its acceptance, allowing Islam to take root in the traditional fabric of society much more deeply that the various Christian churches that started evangelizing the African continent several centuries later. This “Africanization of Islam”, also expressed in the adoption of the local name for God as translation of the name Allah, made it much more tolerant of female genital mutilation/cutting.

With time, identification of Islam with the native tradition became so complete that it subsequently became the main agent for the diffusion of FGM/C outside of Africa, exporting it to Indonesia and Malaysia, for exmple.

Addressing the issue of Islam and its connection to FGM/C, in the light also of the conversion to Islam by increasing populations in Africa, is of particular importance for designing campaigns that do not clash with recognized religious authorities/values and might therefore be rejected by the target population itself as disrespectful of spirituality.

Objectives

- To confront different positions and arguments concerning religion, in particular Islam and FGM/C.
- To become aware of the significance attributed to FGM/C by African women of Islamic faith.
- To understand its role in propagating the practice, as well as its potential in contributing to its abandonment.

How to do the activity

Step 1: 15 minutes

Plenary

Introduce the topic underlining that no known monotheistic religion in Africa is exempt of connections with FGM/C:

Note to facilitator

it can take the shape of early open opposition as with Christian missionaries spreading of the region in past centuries, and ending up with a sort of silent, not expressed tolerance of the practice, in order to facilitate evangelisation;

the same kind of tolerance can be found among Coptic religious authorities, as well as Jewish ones (as in Ethiopia);

in recent times leaders of all religions started to speak out against the practice, sometimes within their communities, sometimes in public gatherings (such as the Banjul Symposium for Medical Personnel and Religious Leaders organised by IAC, the Inter African Committee, in 1998).

Distribute Handout 1 “FGM/C prevalence rates and religious conposition of population”. The table shows that FGM/C practice is higher in countries where Islam is the prevailing religion, although it is very widespread also in countries with other religious compositions, such as Ethiopia (mainly Coptic Orthodox).

Step 2: 50 minutes

Small group activity

Divide participants in 4 small groups. Each one will work with the text presented in one of the Handouts. Also distribute the Handout with the “Question to guide case study analysis and presentation”. Ask the group to choose one person to read the question,

1.Give a brief presentation of the case study

2.How religion, particularly Islam, is used to justify the practice of FGM/C?

3.How does religion and cultural identity, including traditions, customs etc., intersect and overlap?

Note to facilitator

4.How do religious institutions perpetuate the status quo and/or control changes in the area of FGM/C?

5.Can you think of other development areas where religion/religious institutions play a role?

and then invite each group to analyse the following:

Elements that may come up during discussion

- where the action takes place (urban/rural setting);
- the role played by different stakeholders (highlighting protagonists);
- direct and indirect development issues that interfere (such as education of women, direct access to sacred scriptures, migration);
- role eventually played by foreign actors;
- presentation of religious teachings;
- strong or weak messages;
- eventual reactions: positive? negative?

Plenary discussion

Ask each group to evaluate, according to selected point of analysis, if the facts presented in the Handout contribute to:

the continuation of the practice
the abandonment of the practice

and how.

Step 3: 50 minutes

Ask each reporter to summarize the content of the handout which their small group has been working on, then to present their list of considerations and evaluation about possible contributions to the continuation or to the abandonment of the practice. Invite other participants to comment on the cases presented. Try to understand the role religious leaders can play and possible ways of involving them.

Note to facilitator

Main points to bring out:

Across nations and cultures practicing some form of female genital mutilation/cutting, the perception that it is a religious obligation, or at least a religious virtue, is ubiquitous.

The belief that FGM/C is required by religion is “common.” Although it is not a practice of the majority of Muslims in the world, among those who do practice it, “female circumcision” is nonetheless often considered to be legitimated by religion.

A disingenuous refusal to see the connection between FGM/C and Islamic religion can serve the interests of Muslims who want to defend their religion and culture from Western criticism.

While it was not at the origin of the practice on the African continent, Islamic scriptures has been interpreted to suit the practicing community. Today, this close identification with traditional cultures is becoming a problem. Part of Islam, including the fundamentalist clergy trained in Saudi Arabia, is trying to distance itself from the most destructive forms such as excision and infibulation, sometimes only to propose the practice of *sunna* instead. However, in practice different types of FGM/C are understood under the name of *sunna* some of them only a little less intrusive and damaging than infibulation itself.

Arguments from religious texts can be useful for advocacy purposes, as well living examples of those religious leaders who have decided to spare their daughters from the knife, but it has to be remembered that the large majority of the population does not have direct access to religious texts.

Activists, including Western NGOs and International organizations should be careful in affirming adamantly that “no religion supports FGM/C” and need to look closely into real community life to understand the role religion plays, including Christian, Catholic, Coptic and Islamic religion, in perpetuating the practice.

Materials:

- Flipchart paper
- Felt-tip pens
- Paper and pens for participants to write notes
- Copies of handouts for each small group

Handouts:

- Handout 1: "Question to guide case study analysis and presentation"
- Handout 2: "Islam and Female Circumcision"
- Handout 3: "Becoming a Muslim: Female 'Circumcision' and Religious Identity Among the Mandinga"
- Handout 4: "*Sunna:* what form of FGM/C lies behind this name?"

Overheads:

- Overhead 1: FGM/C prevalence rates according to Demographic and Health Surveys (DHS)

Readings:

- Sara Johnsdotter, "Somali Women in Western Exile: Reassessing Female Circumcision in the Light of Islamic Teachings", in *Journal of Muslim Minority Affairs*, vol. 23, n. 2, October 2003.
- Dara Carr, *Findings from the Demographic and Health Surveys Program*, Macro International, USA, 1997.
- Shell-Duncan, B. and Y. Hernlund, *Female "circumcision" in Africa. Culture, controversy and change*, Lynne Rienner Publisher, 2000.
- Amna A.R. Hassan, *Female genital mutilation (FGM). Historical background, views in Islamic Shari'a, and recent findings on FGM*, SNCTP, Karthoum, www.scnctp.org.

FGM/C PREVALENCE RATES AND RELIGIOUS COMPOSITION OF THE POPULATION

Country	Survey type and date	National prevalence FGM/C %	Religious composition of population		
			Islam	Christ	Oth
Benin	DHS 2001	17	24	43	33
Burkina Faso	DHS 2003	77	50	10	40
Central African Republic	MICS 2000	36	15	50	35
Chad (provisional)	DHS 2004	45	53	34	13
Ivory Coast	DHS 1998-9	45	40	35	25
Egypt*	DHS 2003	97	90	10	-
Eritrea	DHS 2002	89	-	-	-
Ethiopia	DHS 2000	80	33	61	6
Ghana**	DHS 2003	5	16	69	15
Guinea	DHS 1999	99	85	8	7
Kenya	DHS 2003	32	10	78	12
Mali	DHS 2001	92	90	1	9
Mauritania	DHS 2000-1	71	100	-	-
Niger	DHS 1998	5	80	20	-
Nigeria	DHS 2003	19	50	40	10
Sudan* +	MICS 2000	90	70	5	25
Tanzania	DHS 1996	18	35	30	35
Yemen***	DHS 1997	23	-	-	-

* Sample consisted of ever-married women

** According to the 2000 Census, 6,1 per cent of the population does not have any religion.

*** No exact data are available. According to *The world Factbook*, population is "Muslim, small numbers of Jewish, Christian, and Hindu".

+ Surveys were conducted in northern Sudan

Adaptated from the Innocent Digest "Changing A Harmful Social Convention: Female Genital Mutilation/Cutting" by UNICEF, 2005 and "The World Factbook", CIA, 2007.

QUESTIONS TO GUIDE CASE STUDY ANALYSIS AND PRESENTATION

1. Give a brief presentation of the case study
2. How is religion, particularly Islam, used to justify the practice of FGM/C?
3. How does religion and cultural identity, including traditions, customs etc., intersect and overlap?
4. How do religious institutions perpetuate the status quo and/or control changes in the area of FGM/C?
5. Can you think of other development areas where religion/religious institutions play a role?

CASE STUDY 1

ISLAM AND FEMALE CIRCUMCISION

Even if female circumcision is practiced by people with a variety of religious orientations, there is a general tendency to associate female circumcision with Islam. Here I shall briefly discuss some of the possible positions from a Muslim perspective. As my Somali informants refer to the Qur'an and the Hadith when they explain their dissociation of any harsher forms of female circumcision, the discussion here will focus on these sources. This is interesting, considering that the Somalis belong to the Shafi'i school of *fiqh*, which is one of the two Islamic law schools that interpret female circumcision as required. The form recommended is a mild type. It is a paradox, however, that in many parts of the Muslim world where the Shafi'i school dominates, the practice is nonexistent.

Muslim researchers and activists have engaged in the debate over whether female circumcision is an Islamic practice or not. There is no way to state a "true" Islamic position, as all of those involved argue from their own interpretations of the written sources. This section will work as a background to the statements made by many of the Somalis in this study, who claim that further reflection upon Islamic teachings made them reassess the practice of female circumcision.

Female circumcision is not practised in an overwhelming majority of Muslim societies in the world. Indeed in 80% of the Islamic world, the practice is unknown. The practice was firmly rooted in parts of Arabia and Africa thousands of years before these areas were Christianized or Islamized. After the coming of Christianity and Islam, the customs were integrated into the religious belief systems. Female circumcision is not mentioned in the Qur'an. The religious sources at hand, then, are the Hadith. The most frequently quoted Hadith, both in the literature and among Somalis I talk to, is the one about how Prophet Muhammad talks to a circumciser on her way to perform the procedure. Prophet Muhammad then says, in one of many possible translations into English: 'Do not overdo it, because it [the clitoris] is a good fortune for the spouse and a delight to her'. There is a weakness in the chain of transmission of this Hadith, which cause some scholars to claim that there is no *Sunna* to comply with in the matter of female circumcision.

Strong or weak, it is still not clear how to interpret it. Some Muslims claim that Prophet Muhammad advocates a mild type of female circumcision, a symbolic operation where nothing at all or only a tiny part of the clitoris is removed. Most Muslim scholars believe that Prophet Muhammad would have condemned what is today known as infibulation. "Circumcision not carried out according to the *Sunna* [of Prophet Muhammad] is forbidden by all religious circles", says Sami Abu-Sahlieh. Yet other scholars understand the Hadith as a way for Prophet Muhammad to condemn the tradition of female circumcision altogether, and claim that his utterances show that he, in time, had the purpose of being more outspoken about his opposition. In the same way as Prophet Muhammad step by step dissociated himself from the use of alcohol, Muslim intellectuals in Sophie Roald's study argue that it is possible to believe that he had the intention to counteract the harmful practice of female circumcision. There is no evidence that Prophet Muhammad had his own daughters circumcised; a fact that has been used as an argument against female circumcision by those opposing the practice.

Another Hadith, among the few mentioning female circumcision, includes this instruction: 'If the two circumcised parts have been in touch with each other, ritual purification [*ghusl*] is necessary'. Ritual purification of the whole body, *ghusl*, should be undertaken when a man and a woman have had sexual intercourse. Are these words to be understood as if Prophet Muhammad supported circumcision of women? […] The statement may be seen as a comment upon the fact that there were circumcised women in the area where Prophet Muhammad lived at this point in history, and does not have to be interpreted as an approval of the tradition per se.

Finally, another weak Hadith, awakening controversy among scholars: "Circumcision is a way for men, but is merely ennobling for women". The most frequent interpretation of this Hadith seems to be that circumcision is a religious duty for men, while it is an honourable act for a woman - "there is no harm if a woman is circumcised whereas for a man circumcision is unavoidable", as a scholar from the tenth century put it.

Muslim scholars propagating for the abandonment of female circumcision find some support in the Qur'an. The passages "Verily, we create man in the best conformation" (95:4), "Let there be no alteration in Allah's creation" (30:30) and "He perfected everything he created" (32:7) are often adduced to lay down the fact that genital operations in women strongly conflict with fundamental values in Islam. These Muslim scholars' attitude is paradoxical, as they at the same time accept male circumcision; such a procedure also changes God's creation. Claims that Egyptian Islamists have an indifferent attitude to the practice or favour it, living in a society where it is widely practised, whereas "Islamists from other Arabic-speaking countries tend to have a strong emotional reaction against it" (Roald), the strongest being an opposition to female circumcision. According to Giladi and Abu-Sahlieh, the position of the *ulama* today urges the faithful practising female circumcision to adopt the most moderate form of circumcision.

Despite this fact, many lay Muslims understand clitoridectomy and infibulation to be religious duties. This makes sense, if one considers the fact that to the great majority of people who practice female circumcision, the religious texts are out of reach. Reflection upon Islamic sources is an activity restricted to the educated and the religious elite, and the discussion does not reach ordinary people. Religious texts do not necessarily guide people's practices in everyday life. Indeed there is reason to believe that legitimating infibulation by means of religious arguments would be trickier if people had access to the religious sources.

* Excerpts from: Johnsdotter, S., *"Somali Women in Western Exile: Reassessing Female Circumcision in the Light of Islamic Teachings",* in Journal of Muslim Minority Affairs, vol. 23, n. 2, October 2003

CASE STUDY 2

BECOMING A MUSLIM: FEMALE "CIRCUMCISION" AND RELIGIOUS IDENTITY AMONG THE MANDINGA*

When asked to explain the reasons behind clitoridectomy, Mandinga informants assert that it is a cleansing rite that defines a woman as a Muslim and enables her to pray in the proper fashion, both of which are defining features of Mandinga identity.

This need for cleansing or purification fits with Muslim ideas concerning gender and the life cycle. As women progress through the life cycle, changes in the body affect changes in purity and hence in religious participation. Often, changing bodily states have contradictory effects on women's public and private religious lives. Physical maturation can have a positive effect on religious practice and identity. As Susan Rasmussen notes for the Tuareg of Niger (1997), women begin to take part in religious observances such as obligatory prayer and fasting upon their first menstruation. At the same time, however, as women mature physically they come into contact with polluting substances such as menstrual blood, the blood of childbirth, and bodily emissions of young children, all of which limit women's involvement in religious activities such as prayer and going to the mosque. Among the Mandinga, clitoridectomy is considered to be at least a partial solution to the problem of compromised purity associated with physical maturation.

Recent campaigns to alter or eradicate excision practices in Guinea Bissau that have been led by foreign aid organizations, local and foreign healthcare workers, and government agencies have responded to this explicit link between female "circumcision" and religious identity as perceived by many in Guinea Bissau. Focusing on educating women about the negative health consequences associated with the practice, these activists started by trying to convince women that Islam does not advocate female "circumcision," nor does the Qu'ran prescribe it. In my research with Mandinga men and women however, I discovered that the relationship between female "circumcision" and Islam extends beyond what is explicitly stated (or not stated) in Islamic texts. Whether others claim that Islam does not advocate the practice for women is not the issue, since many Mandinga with whom I spoke are fully convinced that it does.

When I asked how female "circumcision" began and why the Mandinga first started practicing it, several women (and some men as well) told me the following story, which they claimed comes from the Qu'ran. The version that I cite here was taken from a recorded interview I conducted with an elder Mandinga woman who lives in Bissau and whose grandmother was a *ngamano* (traditional circumciser). She explained: "It was from the side of Mohammed that we took this thing [female "circumcision"]. Mohammed took a wife who was very old - so old that she couldn't have a child. They wanted to have children so they looked for a way around this problem. Mohammed adopted a young girl who would become his second wife and who would give them a child. Now, as time went on, his first wife began to realize that Mohammed was growing to like the young girl more than his first wife. She

quickly became jealous of the young girl, who soon became pregnant. When Mohammed went on a trip - and he travelled a lot in those days - the old woman took the young girl into the courtyard and slit [pierced] her earlobes. Because in those days only slaves [war captives] had their earlobes pierced, the old woman hoped that Mohammed, upon his return, would reject the young girl. When he arrived and saw what had happened, he said nothing. Mohammed was a powerful man and had many intermediaries who helped and advised him. Many of these men received direct messages from God. One of them heard about the incident and came to Mohammed. He said that God had spoken to him, telling him that Mohammed should not be angry, that soon all women would begin to slit [pierce] their earlobes just like his young wife. Mohammed bought some gold pieces and put them in his young wife's earlobes. She looked more beautiful than ever. All of the women in the village came to see just how beautiful she was. They all went home to slit [pierce] their own ears and collect gold pieces to put in them. Mohammed's first wife did the same. Mohammed left for another trip, and this time he was away for three months. Again, he left his first wife in charge of the house. Since the old wife was still full of jealousy and spite for the young girl, one day in the early morning she took her into the courtyard and cut her little thing [clitoris]. When Mohammed returned from his trip and wanted to sleep with her, the young girl was afraid and refused him. Mohammed asked her: "What is it?" The young girl explained that she hurt down there. A friend came to him and told him that he had received a message from God that Mohammed should not be angry. He said: "That little thing - now removed - will make your young wife even more beautiful and pure".

Excerpts from: Michelle C. Johnson*, "Becoming a Muslim, Becoming a Person: Female "Circumcision", Religious Identity, and Personhood in Guinea Bissau",* in Shell-Duncan, B. and Y. Hernlund, *Female "circumcision" in Africa. Culture, controversy and change,* Lynne Rienner Publisher, 2000.

CASE STUDY 3

SUNNA AS A FEMALE GENITAL MUTILATION/CUTTING

In Islam as practiced in everyday life, the association of religious ideas with female circumcision is evident in the colloquial terms used to describe the custom. The use of the term "*sunna*" (meaning to follow the tradition of the Prophet), implies that the custom is prescribe by religion. Similarly, although the classical Arabic term for female circumcision is "*khifad*" (literally "reduction"), in colloquial Arabic it is popularly called "*tahara*", referring to a ritual state of purity that is required for Islamic prayer. In the bipolar opposition implied by the term "*tahara*", genitals in their natural state are ritually impure. In fact, in Egypt to ask if a woman is circumcised one asks "Intii mutahara?" "Are you purified?"

Among Somali women, *Sunna* has been found to have at least four different meanings:

1. *Sunna*, as a descriptive term for different types of circumcision; practically all forms of female circumcision except what is labelled pharaonic.

2. *Sunna*, as a normative term for the only form of female circumcision said to be accepted by Islam: a ritual and symbolic operation where no genital parts are removed.

3. *Sunna*, as a descriptive religious term (noun) denoting Prophet Muhammad's sayings and doings, the tradition as it is described in the Hadith.

4. *Sunna*, as a normative religious term (adjective) when classifying some actions to be recommended, within the framework of the Islamic normative system where actions are divided into categories depending on how desirable they are in a religious perspective.

An experience of *Sunna* from the field

Hello,
I found your e-mail address through a conversation in the Foko network of Scandinavian countries on the proposal by a Somali doctor on performing "*Sunna*" as a symbolic cut in hospitals in Italy. I just felt it timely to inform you about my experience from a three weeks study tour together with a Somali colleague in Somali areas in Kenya, Somalia and Somaliland, and the conversations we had with many persons who work in the field. What we saw in all organisations at grass-root level was a resistance to infibulation and support of "*Sunna*" in all posters and information materials.
"*Sunna*" was promoted in at least three types:

1) Infibulation was called "*sunna*" when the technique of fixing the *labia majora* was changed from sewing with thread and thorns, to the use of herbs (*mal mal*) and tying the legs together. Thus FGM was infibulation, but renamed "Sunna" and as such supported by religious leaders and even posters and information materials of international NGOs.
2) "*Sunna*" in the form of excision with sewing or sticking of *labia minora*, thus closing the vulva.
3) "*Sunna*" in the sense of removing part of the clitoris, that we never saw or heard of in practice, just in theory.
We also saw an increasing tendency of medicalisation and new groups, such as trained TBAs and paramedical staff, take up the practice.
Thus I am very sceptical that any medicalisation of a "minor" cut would actually be a minor cut, in addition to the other problems already mentioned. I have also heard that a project called "Water for life" supported "symbolic circumcision" in Somalia. In reality it also performed fully-fledged infibulation.
Having also talked to Somali doctors and gynaecologists working with international NGOs against FGM and feeling even doubtful to what extent they are really against all types of FGM, makes me additionally worried. Many still expressed fear that uncircumcised girls would "run after boys" and could be rejected on the wedding day if she was still "open".
Thus I believe that it is very dangerous to support "*sunna*" that in reality it is much more invasive than a "symbolic cut". It must be stopped!

Source: E-mail received by AIDOS from Elise B. Johansen, project leader of OK and Ph.D. Student in medical anthropology, 10 February 2004.

CASE STUDY 4

EGYPT. THE MINISTER FOR HEALTH, ISLAM AND CNN*

In Egypt, where the proportion of genitally altered women is among the highest in the world, there was a growing sentiment against the practice beginning in the 1930s and peaking in the late 1950s with a 1959 decree by the Ministry of Health prohibiting female alteration in public hospitals. (From the fact that Egypt has a prevalence rate of around 97%, one can infer that this prohibition merely insured that girls were subjected to this practice outside public hospitals.) During that period, female genital alterations (FGA) rose and fell on the agendas of various health and women's organizations, and was "initially of little importance to the Islamist movement."

This decree remained in place until 1994. That was the year when, at the International Conference on Population and Development in Cairo, women from all over the world took activist positions on the connections between women's health, family planning, and human rights. During the Conference, a CNN film was shown that depicted the circumcision of a little girl, in its most horrific form. The film galvanized international opposition to the practice, often in terms that even Muslim opponents of FGA found insulting and racist. "In the few-minutes-long segment a small part of Egyptian culture was displayed that seriously angered and 'shamed' Egypt before the international community."

Immediately after the film was aired, Egypt's Population Minister and members of parliament spoke publicly about the need to pass legislation criminalizing FGA. However, this was met with swift opposition from the Grand Shaikh of Al Azhar, one of the country's prominent Islamic leaders, who issued a fatwa (religious opinion) that "female circumcision is 'an Islamic duty to which all Muslim women should adhere.'" "[C]ivic, religious, and state entities and groups began to use the issue as a way to define their position on the Egyptian political and ideological map." The Minister of Health and the Minister of Population each made a promise to the international community to strengthen the 1959 decree and to work harder to eradicate the practice.

On its side, Al Azhar and traditionalist organizations launched a public campaign claiming that circumcision kept women free and independent and promoted female equality by preserving their virtue. Furthermore the campaign depicted female circumcision as an integral component of Egyptian national identity. Faced with growing political/religious furor, the Health Minister announced that he would defer any action until after the upcoming parliamentary elections. He then formed an advisory committee, whose advice he proceeded to reject. The committee had advised against legalizing FGA, and the Grand Mufti (the official government interpreter of Islamic law) had declared that the practice is not strongly endorsed by Islam and that its legality should be decided by physicians; nonetheless the Minister issued a directive making FGA "a legitimate medical treatment."

In 1996, a new Health Minister again banned the practice, this time both in and out of hospitals. He was supported by a new head of Al Azhar, Sheik Mohammed

Tantawi, who found the Hadith concerning FGA "too vague to constitute a ruling."
The efficacy of the ban remains to be seen. In rural areas, where the prevalence of FGA is virtually total, it is unthinkable to most villagers that the practice not continue. Doctors themselves, typically extremely conservative, inattentive to women's concerns, and with economic incentives to continue the practice, have challenged the ban, citing reasons of religion, health, and law. "Dr. Gamal Gaith, who works at the Minya el Qamh Public Hospital, said the decree finally prompted him to turn families away. 'I used to do it,' he said, 'even though I knew it was harmful for the women, because of the money.' "

Excerpts from : Dena S. Davis, "Male and Female Genital Alterations: A Collision Course with the Law", in Health Matrix, vol. 11/487.

* In June 2007 Egypt strengthened its law against FGM/C through a ministerial decree banning the practice also in case of medical reasons. The decree was issued after a 12-year-old died with an anesthesia overdose while undergoing circumcision. FGM was later put under the spotlight with the death of 13-year-old undergoing the same operation shortly after.

Activity 4

FGM/C, POWER AND EMPOWERMENT

Time: 1 hour and 30 minutes

Why do this activity?

The term *empowerment* has been widely used within development literature mostly to refer to the end impact of development projects. Increasingly empowerment is recognized as an approach to development practice.

Perceiving empowerment as a process that denotes a change in the abilities and capacities of individuals and groups from one stage to another is a useful definition. This is especially true when discussing 'women's empowerment'. On the one hand, 'women' are not a homogenous undifferentiated category that are necessarily 'disempowered' and 'disadvantaged' merely by the fact that they are women. Moreover, women do not experience or negotiate situations of oppression or disadvantage in the same way. This is because they do not lead their everyday lives only as gendered subjects but also as individuals located in and belonging to different socio-economic and political hierarchies and power dynamics. The realization that women's identities are differentially and contextually structured and situated at the intersection of different (and sometimes conflicting) systems of stratification is particularly important in choosing the empowerment inputs in any projects as well as in analyzing and measuring its impact.

Organisations of women, or other popular organisations as well as local/national institutions which recognise the need to empower women, have to develop strategies to enable women to make decisions for themselves, and to take action for themselves. While NGOs, as intermediary organisations, can sometimes facilitate this role, it usually requires the existence of community based organisations - that is organisations at grassroots level - in order to achieve anything beyond some strengthened capacity at the individual level. Since women's empowerment requires changes in social values, it usually requires collective action. Empowerment is a process rather than only an end-point. Thus, well before changes in policy or programming have been achieved, women may have built their confidence in their right to demand change and to participate in processes of shaping the policy agenda.

During this session, we shall go through the different meanings of empowerment as used in development projects. We shall also discuss how FGM/C is used by women as well as other stakeholders as a power gaining tool.

Objectives

- To describe and assess different approaches to empowerment.
- To describe why empowerment is central to ending FGM/C

How to do the activity

Step 1: 20 minutes

Plenary

Ask each participant the following question:

Why do you personally oppose FGM/C / why are you involved in the struggle for the* abandonment *of FGM/C?

Note to facilitator

Participants might have a variety of reasons, but quite certainly some of them will come out with personal motivations that include:

- because the practice is undermining women's rights
- because I'm committed to human rights for all people, and FGM/C is a violation of women's human rights
- because it puts women's health in danger
- because I believe in freedom of choice, and women do not have any choice about FGM/C
- because it is based on erroneous ideas, on myths that are contradicted by reality
- because it is performed on girls who do not have the power to oppose it
- ….

In other words, many of the personal reasons whis participants have committed themselves to the abandonment of FGM/C have to do with the issue of power: the power to defend themselves from the practice, the power to decide about one's own life, the power to protect their own daughters from the practices, etc.

Moreover, it will become evident that many of the reason given imply women's empowerment, that is often also the objective of other development programs and projects, such as income generating activities, family planning and safe motherhood healthcare services, education for girls etc.

Step 2: 10 minutes

Plenary

Brainstorm around meanings and definitions of ***empowerment***. Ask participants to define empowerment. Use flipchart and ask one of the participants to note down participants' contributions.

Note to facilitator

Definitions might include:
- autonomy of women
- the improvement of their political, social, economic and health status
- equality with men in decision-making process

- full participation and partnership with men in development activities, including productive and reproductive life
- sharing responsibilities for the care and nurturing of children and maintenance of the household
- policy and program actions that seek to overcome gender inequality
- improving women's access to secure livelihoods and resources
- full expression of women's capacities and potential
- elimination of inequality through laws enacted by the government
- ….

Step 3: 30 minutes

Handout

Distribute Handout 1 "Definitions of power" and ask participants to read it first individually. Allow sufficient time to complete the reading.

This exercise is meant to understand how FGM/C is used to 'negotiate power', in particular how is it used by women as well as other stakeholders to achieve control of power

Definitions of power	**What it implies**
Power over…	Conflict and direct confrontation between powerful and powerless groups
Power to…	Capacity building, supporting leadership skills and decision making abilities.
Power with…	Social mobilisation, building alliances and coalitions
Power within…	Consciousness raising, enhanced decision making abilities, increased self esteem and awareness

Small group activity

Divide participants into 3 groups. Assign a specific stakeholder to each small group:

– women
– grandmothers/elders
– fathers/husbands

Distribute Handout 2 to each group and ask them to brainstorm and answer the questions in the Handout.

Step 4: 30 minutes

Plenary

Reconvene the plenary.

On the flipchart draw a table with the 4 definitions of power in order to list the answers by the groups.

How ... use FGM/C to get…	Power over?	Power to?	Power with?	Power within?
Group 1				
Group 2				
Group 3				

Ask each group to present the conclusions of their brainstorming in 5 minutes.

Fill in the table together with participants.

Invite participants to consider the following:

Power is not unidirectional, nor is it quantitative.
It is multi-directional, complex and qualitative.
This is to say that people (including women) attain different 'kinds' of power, using different negotiating mechanisms. FGM/C is a powerful power gaining tool as well as a 'negotiating tool' for women.
Women are the main sufferers from FGM/C. They are also its main beneficiaries. This is why in so many contexts women are its main perpetrators. It is only through the understanding of this contradictory and conflicting role of women in sustaining the practice that we can begin to address appropriate interventions to end it.
Thus, women stand to gain the most by perpetuating it and lose the most by abandoning it. Until women can achieve the same gains through other channels rather those traditionally acquired through FGM/C they will be resistant to abandoning FGM/C.
In order to design appropriate and effective women's empowerment inputs that would lead to the abandonment of FGM/C, we need to know what are the perceived 'gains' of FGM/C to the women in **the specific context** where the project/program will be implemented, looking at the broader development agenda.

Note to facilitator

To conclude distribute Handout 3 "Empowerment and the status of women", which presents definitions of empowerment and actions needed to reach it from the International Conference on Population and Development Program of Action (1994), the Millennium Development Goals (2000) and the Additional Protocol on Women's Rights to the African Charter of Human and Peoples' Rights (2003).

Handout

Materials:

- Flipchart
- Copies of handouts for participants

Handouts:

- Handout 1: “Definitions of power”
- Handout 2: “Exercise”
- Handout 3: “Empowerment and the status of women”

DEFINITIONS OF POWER

In order to fully understand the issue of "empowerment" within the context of FGM/C and its relation to designing effective programming frameworks, we need to look at its root concept: that of "power".

Power over:

It concerns the decisions/decision-making process over which there is an evident conflict. It describes the ability to take the decisions that one wishes. It understands power as the capacity to make decisions, acquire new skills and solve problems. It underpins most "women in development" projects and policies and is built on the assumption that women will have a greater decision-making power/will be empowered where/when they have more access to/control over resources, in particular economic resources, hence the focus on income-generating activities and the like.

Power to:

A broad view of power that captures not only the enactment of decisions, but moves to include areas that are not customarily thought of as "decisionable" i.e.: what lies outside the area of direct observable decision-making process. Thus it focuses on the less visible institutionalised forms of advantage and disadvantage that actually empower particular individuals/groups and impose their views of reality on others. Gender roles can be considered one of these forms of power to do/be.

Both these points about the understanding of power involve a dichotomy of domination/subordination where one side holds absolute power over a completely disadvantaged partner. This understanding of power has informed many social science theories and development practices.

Power with:

This refers to the collective efforts of communities to achieve common goals. In particular it concerns the ability to negotiate with wider social actors as well as the ability and capacity to mobilize and seek support from wider social, political and economic actors.

Power within:

This is perhaps a more holistic understanding of power. It involves increasing self awareness, confidence and consciousness. It refers to the ability to understand the complex operations of power in the everyday life on the individual as well as the institutional level, and to the ability to effect change. It questions the assumption that power and conflict are necessarily linked i.e.: where there is no direct, observable conflict, consensus prevails. In fact, interests might be unarticulated or unobservable and, above all, people might be mistaken about or unaware of their own interests.

EXERCISE

Question	**Power over**	**Power to**	**Power with**	**Power within**
How **women** use FGM/C to get…				
How **grandmothers/elders** use FGM/C to get…				
How **fathers/husbands** use FGM/C to get…				

EMPOWERMENT AND THE STATUS OF WOMEN

From the International Conference on Population and Development (ICPD) Programme of Action:

"The empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself. In addition, it is essential for the achievement of sustainable development. The full participation and partnership of both women and men is required in productive and reproductive life, including shared responsibilities for the care and nurturing of children and maintenance of the household.
In all parts of the world, women are facing threats to their lives, health and well-being as a result of being overburdened with work and their lack of power and influence. The power relations that impede women's attainment of healthy and fulfilling lives operate at many levels of society, from the most personal to the highly public political. Achieving change requires policy and programme actions that will improve women's access to secure livelihoods and economic resources, alleviate the extreme responsibilities with regard to the household, remove legal impediments to their participation in public life, and raise society's awareness through effective programmes of education and mass communication. In addition, improving the status of women also enhances their decision-making capacity at all levels, in all spheres of life, especially in the area of sexuality and reproduction"

"All countries should make greater efforts to promulgate, implement and enforce national laws and international conventions to which they are party, such as the Convention on the Elimination of All Forms of Discrimination against Women and to implement fully the Declaration on the Elimination of Violence Against Women. Countries are urged to sign, ratify and implement all existing agreements that promote women's rights."

"Countries should act to empower women and should take steps to eliminate inequalities between men and women as soon as possible by:
a) Establishing mechanisms for women's equal participation and equitable representation at all levels of the political process and public life in each community and society and enabling women to articulate their concerns and needs; b) promoting the fulfilment of women's potential through education, skills development and employment, giving paramount importance to the elimination of poverty, illiteracy and ill health among women; c) eliminating all practices that discriminate against women; assisting women to establish and realize their rights, including those that relate to reproductive and sexual health; d) adopting appropriate measures to improve women's ability to earn income beyond traditional occupations, achieve economic self-reliance, and ensure women's equal access to the labour market and social security systems; e) eliminating violence against women; f) eliminating discriminatory practices by employers against women, such as those based on proof of contraceptive use or pregnancy status; g)

making it possible, through laws, regulations and other appropriate measures, for women to combine the roles of child-rearing, breast-feeding and child-rearing with participation in the work-force".

From the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, article 2 "Elimination of Discrimination Against Women"

1. States Parties shall combat all forms of discrimination against women through appropriate legislative, institutional and other measures. In this regard they shall:

a) include in their national constitutions and other legislative instruments, if not already done, the principle of equality between women and men and ensure its effective application;

b) enact and effectively implement appropriate legislative or regulatory measures, including those prohibiting and curbing all forms of discrimination particularly those harmful practices which endanger the health and general well-being of women;

c) integrate a gender perspective in their policy decisions, legislation, development plans, programmes and activities and in all other spheres of life;

d) take corrective and positive action in those areas where discrimination against women in law in fact continues to exist;

e) support the local, national, regional and continental initiatives directed at eradicating all forms of discrimination against women.

2. States Parties shall commit themselves to modify the social and cultural patterns of conduct of women and men through public education, information, education and communication strategies, with a view to achieving the elimination of harmful cultural and traditional practices and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes, or on stereotyped roles for women and men.

The Millenium Development Goals:

The Millennium Development Goals and targets come from the Millennium Declaration, signed by 189 countries, including 147 heads of State and Government, in September 2000 (http://www.un.org/millennium/declaration/ares552e.htm).

Gender equality is not only a goal in its own right, but an essential ingredient for achieving all the MDGs, be it poverty eradication, protecting the environment, or access to healthcare. Attempting to meet the MDGs without incorporating gender perspective will both increase the costs and minimize success. Because the MDGs are mutually reinforcing, success in meeting the goals will have positive impacts on gender equality.

The abandonment of FGM/C can be obtained also through the achievement of the MDGs, especially Goal 2, 3 and 5.

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	**Indicators for monitoring progress**
Goal 2: Achieve universal primary education	
Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	6. Net enrolment ratio in primary education* 7. Proportion of pupils starting grade 1 who reach grade 5 8. Literacy rate of 15-24 year olds
Goal 3: Promote gender equality and empower women	
Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	9. Ratios of girls to boys in primary, secondary and tertiary education 10. Ratio of literate women to men, 15-24 years old 11. Share of women in wage employment in the non-agricultural sector 12. Proportion of seats held by women in national parliament
Goal 5: Improve maternal health	
Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel (new) Adolescent birth rate (new) Antenatal care coverage (new) Unmet need for family planning (new) Contraceptive prevalence rate

* An alternative indicator under development is “primary completion rate”.

MODULE 4

MAINSTREAMING FGM/C PREVENTION IN DEVELOPMENT PROGRAMS AND PROJECTS

Module objective

- To have an overview of the different approaches to programmes for the prevention and abandonment of FGM/C
- To understand positive and negative effects of different types of intervention for different target groups
- To suggest ways of mainstreaming FGM/C prevention actions into more general development projects and programmes.

Why this module?

First attempts to stop the practice

The first documented Western attempts to end FGM/C can be traced back to colonial administrations and missionaries of the early 20th century. Early century colonialists adopted a cultural absolutist approach, opposing FGM/C practices on moral grounds. Local leaders passed laws and church rules in an attempt to curb the practice. These efforts had limited success, primarily confined to communities where Christianity had taken hold. However, most communities reacted in anger to foreign intervention into their customs. In Kenya, attempts to end FGM/C practices led to violent confrontations and fed into a larger nationalist resistance movement. In Sudan, attempts by the British colonial government to enforce a ban on infibulation resulted in rioting and destruction of a prison holding women arrested for violating the new law.
Throughout the middle of the century, the international community shifted to a cultural relativist approach, declining to pass judgment on the traditional practices of other cultures. In 1950, WHO declined to take a stand on FGM/C because the practice involved "operations based on social and cultural backgrounds" that should not be disturbed.

International attention and FGM/C

WHO was the first international organization to take a public position against FGM/C, and by the 1970s, it was actively working to gather health-related information surrounding the practice. The 1979 Meeting on Traditional Practices Affecting the Health of Women and Children - held in Khartoum, Sudan - was the first international conference that specifically

addressed FGM/C. For the first time at an international forum, delegates voted to support efforts leading to the end of all forms of the practice. Hailed as a watershed event, this conference greatly influenced further discussions about FGM/C practices and brought the international community together to develop ways to end FGM/C.
GAMS, Groupe de femmes pour l'Abolition des Mutilations Sexuelles (Women's group for the Abolition of Sexual Mutilations), in France, was the first organisation officially dedicated to preventing FGM/C, founded in 1982. It was followed by the IAC, Inter African Committee on Traditional Practices affecting the Health of Women and Children, composed originally of 6 national committees and created during a conference in Senegal in 1984. Meanwhile, an increasing number of African women started to raise their voice against the practice.

International conferences in the 1990s

By the early 1990s, activists were working to move FGM/C from a public health issue into the larger women's rights movement. In 1993 at the UN World Conference on Human Rights, the international community declared FGM/C a human rights violation. In 1994 at the UN International Conference on Population and Development in Cairo, Egypt, the Programme of Action urged governments to prohibit FGM/C wherever it is practiced and to actively support anti-FGM/C campaigns conducted within their own countries. And in 1995, the World Conference on Women, held in Beijing, China, declared FGM/C a form of violence against women.

A critical analysis

Over the last twenty years, projects and programmes of FGM/C prevention have spread to almost all the African countries where it is present. The results of the Demographic and Health Surveys (DHS), and the high rate of prevalence recorded and often reconfirmed in the second survey (such as in Egypt, Burkina Faso, Mali, Eritrea) have inspired a more critical look at these interventions, not only by international bodies such as WHO but also national development cooperation bodies and private institutions/donors. In 1999, WHO published the results of a vast study carried out by the NGO PATH (Program for Appropriate Technology in Health) with the aim of documenting the “status and trends in programming FGM/C prevention, and to identify crucial elements for establishing priorities in assigning future resources.” This analysis was meant as an “instrument of planning or a basis of comparison for monitoring evolution of efforts to eradicate FGM/C” for governments, non-governmental organizations and donors.

Using Senegal as a case study

Meanwhile a programme started in Senegal by the NGO TOSTAN has succeeded in obtaining 1,300 villages to affirm through a Public Declaration, their official decision to abandon FGM/C and early marriage. The “snow ball” effect, from the first few villages to up to 300 villages collectively declaring during the same ceremony, their decision to abandon the practice, is a phenomenon that deserves better attention in order to understand if this action can, in the long run, bring a definitive abandonment of the practice and if this model of intervention can be repeated elsewhere, where the structures of society and culture are different.

This module aims to offer planners a closer and critical look at interventions taken so far, confronting them with the multidimensional nature of FGM/C, understanding the importance of appropriate research, monitoring and evaluation mechanisms, and to promote creative programming in connection with the broader local and national development agendas.

Activities

Activity 1: Gender planning
Activity 2: Review of past approaches
Activity 3: Behavioural and social change models
Activity 4: Interaction between women and community: the WECC
Activity 5: Programming framework

Total time: 4 hours

Activity 1

BEHAVIOURAL AND SOCIAL CHANGE MODELS

Time: 1 hour and 30 minutes

Why do this activity?

Over the past years, 'behaviour change' has entered development jargon. The 'behavioural' aspect of practising FGM/C is increasingly recognised. However, effective interventions for ending FGM/C do not only involve influencing personal behaviour; they also involve influencing social norms, values and customs as well as what we can term the 'behaviour of societies'. This is what we call 'social change'.
We believe that the processes of behavioural and social change are continual, non-linear, porous and overlapping. And although we may discuss them separately as theoretical constructs, in reality, we need to recognise how they trigger, influence and are influenced by each other.

Objectives

- To introduce the concepts of behavioural and social change.
- To identify the relevance of behavioural and social change concepts to the practice of FGM/C.
- To identify ways of using these concepts to design and monitor projects to end FGM/C.

How to do the activity

Step 1: 1 hour

Presentation in plenary

The facilitator takes the participants through the Power Point presentation on "FGM/C, behavioural and social change". The presentation attempts to define behavioural and social change. It also shows how these models of change are linked to FGM/C and more importantly how they can impact:

a) Our understanding of FGM/C as a practice that has individual and social manifestations.

b) How can we use these models of change in efforts to end FGM/C.
c) How to use these models to develop specific project inputs

FGM/C, behavioral and social change

Behavioral Change & FGM/C

Attempts to outline:
- The stages of behavioral change.
- The process of behavioral change.
- Interventions necessary to sustain a new behavior.

Note to facilitator

Behavioral Change & FGM/C

- **Why is understanding behavioral change important**?
- Presents a useful framework for designing interventions to end FGM/C
- Presents a useful framework for evaluating/ measuring change.

Behavioral Change & FGM/C

Characteristics of behavioral change related to FGM/C.
- Target groups for behavioral change are not those directly affected by the practice.
- Decision to perform FGM/C is a complex process of group decision & power negotiation

Behavioral Change & FGM/C

Stages of behavioral change:
- Pre-contemplation.
- Contemplation.
- Preparation
- Action
- Maintenance

Stages of Behavioral Change

Pre-contemplation
The individual has not considered not circumcising the child.

Contemplation:
The individual starts to question the practice. This can be triggered by various factors: accident, increased knowledge, change in circumstances.

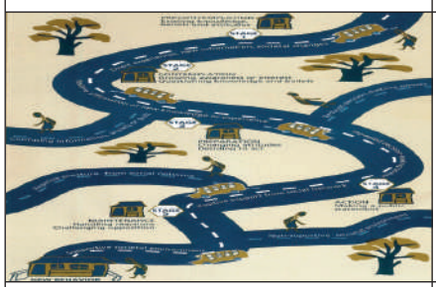
Stages of Behavioral Change

- ***Preparation:***
  Individual recognises FGM/C as a problem, and intends to make a decision not to circumcise the daughter.
  Starts preparing the scene to mitigate any real or perceived negative consequences. (Bargaining)

Stages of Behavioral Change

Action:
The declaration of the decision not to circumcise the daughter.

Maintenance
Sustained new behaviour:
Managing opposition, pressure or resistance.



Social Change

- ***Social change happens constantly.***
- ***Social change is non-linear.***
- ***Changes in individuals may not lead to social change.***
- ***Changes in individual behaviour/ interpersonal relationships may/ may not reflect in social institutions & systems. (lag period)***

Adopters of innovation.

Adopters of innovation generally fall into 5 categories:
Innovators
Early Adopters
Early Majority
Late Majority
Late Adopters

- ***Innovators:***

Venturesome, risk-takers, eager to try new ideas.
Tend to lead a lifestyle that enables mobility & communication with exposure to outside ideas.
Require a shorter adoption period.

- ***Early Adopters***:

More integrated within the social system.
Have a great degree of leadership/opinion-forming within a community.
Respected & looked up to by other members of society.
Are in close contact with innovators.
Reduce uncertainty of an innovation by adopting it.

- ***Early Majority:***

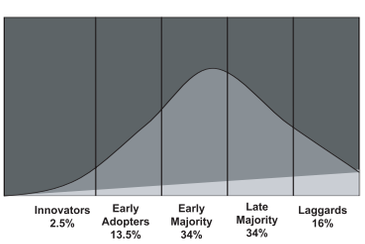
Adopt an innovation before the average member of a community.
Follow in the footsteps of early adopters
Interact with peers but seldom hold leadership positions/status.
Deliberate for longer before adopting an innovation.

- ***Late Majority***:

The average member of the community.
Adopt innovation after 'testing' it on the early majority.
Skeptic & cautious about new ideas.
Almost all uncertainty about an innovation must be removed before they adopt it.

- ***Late adopters/ Resistors:***

The last in the social system to adopt an innovation.
Openly suspicious of new ideas.
Self-proclaimed upholders of the 'status quo'.



Please Note:

- **These categories are not static.**
- **They are permeable.**
- **Do not assume that innovators in one idea are necessarily so with another innovation.**
- **WIFM**

Strategies to move the adoption process:

Attention:
Use of media.

Interest:
Emphasise the relative advantage of the new idea.

Trial:
Present innovation in a simple, accessible to try way.

Adoption:
Modify the idea to individuals' needs

Confirmation:
Emphasise the positive results of the new idea.

How to use behavioural & social change models to end FGM/C?	*How to use behavioural & social change models to end FGM/C?*	*How to use behavioural & social change models to end FGM/C?*
Deciding on the Target Group: Through situation analysis, we can identify and map out the target community using the 5 categories for adopting change. Draw a bell chart of our target community	• Identify where the community is at present & where does the project want to take it to? • Identify key project allies. • Identify key project obstacles/ hindrances.	• Identify the approaches to be used to reach each segment. • Develop project inputs accordingly.

Approaches for project inputs

The segment	The approach to reach the segment
Innovators lead the way for others. They have already personally adopted the new behaviour.	•Media sources. •Directly involve innovators in the design of the programme through Participatory Planning. •Recruit and train the innovators as the peer educators (promoters.)
Early Adopters are open to new ideas that provide personal benefit. They are fashion setters, may have big egos and need a lot of personal support.	•Inter-personal contact •Addressing concerns. •Step by step guidance to experiment with the idea. •Strong face to face support with a limited number of early adapters to try out the practice. •Reward the participants ego through media coverage. •Maintain strong relationship with this group through regular feedback.

Approaches for project inputs

Early majority will only act when they get adequate proof of benefits. They are pragmatists, will accept simple, proven new ideas. They will adopt when there is minimum discontinuity with the lifestyle they are used to.	•Media stories featuring endorsements from credible individuals, opinion makers. •Provide one to one support discussing concerns, and consequences.
Late Majority do not like taking risks, or new ideas, but also do not want to be left behind, hence will follow the mainstream and the established standard. They can also be influenced by the sceptics	•Refine your new idea to increase convenience and reduce untoward consequences. •Respond to the criticism from sceptics.
Laggards/ Late Adopters will block progressive change. Take their arguments seriously, as they often identify real problems that need to be solved before the majority segment can accept the innovation	•Actively enforce regulations •Publicise prosecutions

If time and attention by the plenary allow it the “Approaches to reach different segments” can also be discussed. Otherwise live them out.

Step 2: 30 minutes

Exercise in plenary

The exercise will lead to drawing a representation of the group in terms of behavioural and social change in the shape of a bell chart.

A) Choose an innovation in consultation with the group. This may be an ‘innovation’ that is not necessarily related to social change. In fact this is preferable (such as the introduction of mobile phones, but it can also be concerning abandonment of FGM/C…).

B) Choose a facilitator from within the group to reflect the segmentation on the flip chart. The facilitator asks each participant, one by one, which is his/her position towards the innovation:
   1. has she/he ever considered adopting the new behaviour?
   2. has she/he adopted the innovation immediately?
   3. has she/he waited to adopt it until a significant number of other persons around him/her have done the same?
   4. was she/he among the last ones to adopt the new behaviour among his/her community?
   5. is she/he resisting the adoption of the new behaviour?

Calculate percentage of the group in the different positions from the answers received:

1. …% of innovators
2. …% of early adopters
3. …% of early majority
4….% of late majority
5….% of laggards (resistors)

Using a flip chart, the facilitator develops a graph of the 5 segments of society derived from the group input. Put on the abscissas the qualitative data: innovators, early adopters, early majority, late majority, laggards; and add the percentage of groups: 2.5% for innovators; 13.5% for early adopters; 34% for early majority; 34% for late majority; 16% for laggards.
Link the dots on the graph to arrive at the bell figure representing the group.

Handout

Invite people to consider this particular exercise while looking at a community where they foresee introducing FGM/C prevention activities. Distribute the following haudout for participants to read and keep as a reference for the programming exercise.

Handout 1: “FGM/C, behavioural and social change - Power Point presentation”
Handout 2: “Understanding behavioural change”
Handout 3: “Understanding social change”
Handout 4: “Adoption of social change”
Handout 5: “Changing the social convention: towards the abandonment of FGM/C”
Handout 6: “Road to individual behavioural change”
Handout 7: “Stages in behaviour adoption”
Handout 8: “The six stages of innovation, or adoption process, applied to FGM/C”

Materials:

Power Point presentation
LCD projector
Laptop computer
Handouts for each participant
Flip chart
Marker pen

Handouts:

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Handout 1

Activity 1

FGM/C, behavioral and social change

Behavioral Change & FGM/C

Attempts to outline:

- The stages of behavioral change.
- The process of behavioral change.
- Interventions necessary to sustain a new behavior.

Behavioral Change & FGM/C

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- Action
- Maintenance

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Sustained new behaviour:
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Activity 1 Handout 1

4

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Handout 1

Activity 1

Strategies to move the adoption process: ***Attention***: Use of media. ***Interest***: Emphasise the relative advantage of the new idea.	***Trial***: Present innovation in a simple, accessible to try way. ***Adoption***: Modify the idea to individuals' needs ***Confirmation***: Emphasise the positive results of the new idea.	*How to use behavioural & social change models to end FGM/C?* Deciding on the Target Group: Through situation analysis, we can identify and map out the target community using the 5 categories for adopting change. Draw a bell chart of our target community
How to use behavioural & social change models to end FGM/C? • Identify where the community is at present & where does the project want to take it to? • Identify key project allies. • Identify key project obstacles/ hindrances.	*How to use behavioural & social change models to end FGM/C?* • Identify the approaches to be used to reach each segment. • Develop project inputs accordingly.	

UNDERSTANDING BEHAVIOURAL CHANGE

Research into changing behaviour regarding FGM/C is still a relatively new concept. There are many theories and models of behavioral change from the fields of psychology, health education and communication, which contain elements relevant to the field of FGM/C. For an effective FGM/C intervention we strongly recommend using the trans-theoretical or "Stages of Change" model which presents a framework for integrating several key concepts and theories about human behaviour to explain how and why change occurs. It is also more suitable to measure behaviour change in a community and to evaluate the effect of an intervention in that community.

The stages of change model was originally applied in a study of smoking cessation by Prochaska and Diclementine (1983), but it has been used to study other areas including alcohol abuse, contraceptive use and psychological distress. It was first applied to the field of FGM/C by Izzett and Toubia (1999). It is based on a comparative analysis of major systems of therapy and includes three dimensions: change processes – activities that are used to modify behaviour, levels of change – the types of problems to be changed and stages of change – the phases people move through in changing their behaviour.

Behavioural change is very complex; a person may go through many different stages before reaching a sustainable new behaviour. Behaviour change can be an *individual* and/or a *group* process and is part of the larger process of social change. Other theories of health behaviour have also been used in health promotion. These include the health belief model; theory of reasoned action; social cognitive theory; diffusion of innovations and others.

Two **important characteristics** that distinguish the field of FGM/C to other frequently studied social behaviours are that: those whose behaviour is to change are not the individuals who are affected by the practice (i.e.: the young girls) and that the decision to perform FGM/C is either a group decision or the outcome of the balance of power among a group of individuals related to the child.

Information on the process that leads to a decision not to circumcise a girl and the actions needed to follow through are essential to design and formulate effective strategies to stop FGM/C. The five stages outlined in the Stages of Change Model – **pre-contemplation, contemplation, preparation, action and maintenance** – present a useful framework to study a person's journey towards FGM/C abandonment. They also provide a way to monitor progress towards change.

Pre-contemplation: would represent a state where the individual had not even considered the possibility of not circumcising the daughter.

Contemplation: would be reached if something caused the individual (she or he) to question the practice. This might be through new knowledge gained as the result of an intervention or hearing about serious complications or death of a relative or neighbour's daughter due to FGM/C. It is important to remember that for women who themselves are circumcised the contemplation or questioning phase will evoke memories and feelings towards their own circumcision experience. This may propel them forward towards stronger conviction to stop the practice or, alternatively, prove too painful to handle with a renewed state of denial setting in. As women's personal experience of emotional and physical pain during the circumcision indelibly marks their mental map of their bodies (Johansen 2001) it may prove to be a determining factor in how women go through behavioural change towards the practice in

ways that are very different from men. We propose that for women the interplay between the intellectual and emotional in processing new information about the negative effects of FGM/C (cognitive dissonance) is greater than men (Toubia et al, 2002).

Preparation: would be reached when the mother (or any other influential member of the family) has considered all her thoughts and feelings and decides she does not want her daughter circumcised.

Action: the decision made must be stated or declared, for example, when relatives start talking about preparations for circumcising the child or during any other occasion. The declaration may be a **public declaration** of not circumcising the girl or **intent** not to circumcise the girl.

Maintenance: Opposition of the decision made would need to be managed, particularly from individuals with more social power in order to sustain "maintenance". The maintenance stage is often very prolonged until the daughter is past the risk of circumcision which might not necessarily be age dependant. The most common marker of the end of the risk of circumcision is marriage but, for an emerging minority of modern women, it is employment and economic and social independence. However, at any time the decision that has been made might be over-ridden by a more powerful family member, often a grandmother, and the daughter is circumcised.

It is also crucial to identify accurately the individual's stage of change so that an intervention based on stage specific processes of change can be applied. The stages of change model proposes that efforts to bring FGM/C abandonment that assess and take into account the stage at which the individual is in before the intervention, will be much more effective and efficient than an intervention which does not take this into account.

The journey towards change can be a "long and winding road". As we travel along the road there are often new items of information, personal experiences, peer approval and societal influences, which can move progress either forwards or backwards.

In adapting this model to the study of behaviour change for FGM/C, programme staff conducting the intervention need to learn what will **encourage** people to move forwards along the road, and what the potential **barriers** may be. While it may not be possible to explain behaviour completely, studying the different influences on the journeys that individuals make in coming to a decision to stop circumcising girls would be of great importance in identifying commonalities and differences across societies and cultures and hence facilitate comparative studies, research and interventions.

UNDERSTANDING SOCIAL CHANGE

Perhaps the first point that we need to recognize about social change is that it is a cumulative, complex ***process*** that happens **all** the time and can be, more often than not, imperceptible.

"The term social change could apply to modifications in social cultural relationships. All societies are involved in a process of social change; however, this change may be so slight that the members of the society might hardly be aware of it". (Christine Preston, 2000).
"Social change is a complex phenomenon which is non-linear and encompassed in various levels of social life; it is because the whole of social life is continually changing. What differs is the rate of change." (Lauer R., 1976).
As an example, in a community an individual's behaviour with regards to FGM/C might change more or less quickly than in the relevant social institution. That discrepancy will measure the differing rate at a given point of time and not that there has been a change or not."
From much of the literature on social change it is not easy to extract a clear definition of the concept. *Social change* is explained much more extensively in both the sciences of sociology and psychology. Most definitions available for social change define it in very broad terms. But for our purpose, what do we mean by *social change*?
Social change is both normal and continual. The important questions to ask relate to the direction and rate of change at various levels of social life. Some disputes about change occur because people forget about the various levels and the differing rates. For some, there is no change, or at least no significant change, until the institution itself has changed. For others, even changes in attitudes and behaviour reflect significant alterations in social life.
It is important to remember that behavioural change may or may not lead to or reflect changes in interpersonal relationships, organisations, or institutions. Or there may be a time lag involved, with changes at one level occurring more slowly than changes at another.

1. Diffusion of Innovations Theory

The theoretical framework described here, on how a new idea spreads through society, comes from the work of Everett Rogers and co-workers over the past thirty years.
Diffusion is the process by which an **innovation**/**idea** is **communicated** through certain **channels** over **time** among the members of a **social system.** The Diffusion of Innovations Model treats change like a wave passing through society. It looks at the way innovations are taken up by a population.
The Innovations Diffusion framework provides a description of the different audience segments that help to establish specific strategies to meet their needs for information and skills.

1.1. Defining the Four Main Elements in the Diffusion of Innovations Model:

Innovation: An idea or a new practice that is perceived as new by its audience.
Communication channels: The means by which messages get from one individual to another
Time: Rate of adoption of the innovation
Social System: A set of interrelated units engaged in joint problem solving to accomplish a common goal

1.2. The six stages (individual or group) of Innovation Diffusion, or Adoption Process:

Given that decisions are not authoritative or collective, each member of the social system faces his/her own innovation-decision that follows a six step process.

1. ***Attention*** (awareness) - exposure to its existence
2. ***Interest*** development, persuasion - forming of a favourable attitude towards it
3. ***Evaluation*** – the pros and cons of the idea are compared
4. ***Trial*** - made to adopt or reject the idea, *commitment* to its use
5. ***Adoption*** - putting it to use
6. ***Confirmation - reinforcement*** based on positive outcomes from it.

1.3. Strategies to move the Adoption Process Forward

At each of these steps of the 'Life Cycle' there are strategies that can be used to push the process along. The strategies are most successful when they address these elements of the new idea introduced:

1. ***Attention***: Use of mass media advantage(s)
2. ***Interest***: Emphasise the relative advantage of the innovation
3. ***Evaluation***: Show compatibility with existing values, needs and past experience
4. ***Trial***: Present 'innovation' in a simple way, understandable, and easy to try
5. ***Adoption***: Modify the 'idea' to individuals' needs
6. ***Confirmation***: Emphasise and show the positive results of the innovation

1.4. Adopter categories on the basis of Innovativeness

Not all individuals in society adopt an innovation at the same time. Diffusion researchers tell us that for any given behaviour, individuals adopt in a time sequence which can be broken down into 5 segments, based on their propensity to accept the new idea or behaviour.
While an individual might be an early adopter with respect to one idea, he could be a late adopter with respect to another. Therefore, people can be categorised as a type but only with reference to a particular idea.
Adoption begins with visionary, imaginative *innovators*, which later attract the experimental *early adopters*, and eventually sweep in the *majority* audiences with the *sceptics/laggards* who are holding out to the bitter end and see no urgent reason to change.

Usually, the early adopters are characterised as opinion leaders, respected by the community and ones who watch and analyse things, but this is not always necessarily the case. See Table 1 for an example of some of the characteristics.

Table 1: Examples of Key Characteristics of Adopters

Segment	Key characteristics
Innovators	• venturesome, risk takers • eager to try new ideas • are mobile, and communicate outside local peer networks • have ability to grasp abstract ideas • easily reached by communication networks • can cope with the uncertainty associated with an innovation • require a shorter adoption period.
Early adopters	• are a more integrated part of the local social system • have the greatest degree of opinion or social leadership with a group • respected by society and thought by others to be successful • potential adopters look to early adopters for advice and information • serve as a role model for many other members of the social system • they reduce uncertainty about a new idea by adopting it

Segment	Key characteristics
Early Majority	• they adopt ideas just before the average member of the social system • get their information from early adopters • often interact with peers, but seldom hold leadership positions • are an important link in the adoption process • usually deliberate before adopting a new idea
Late Majority	• adopt new ideas just after the average member of a social system • adoption usually in response to increasing peer pressure • approach to new ideas is sceptical and cautious • worry about how the new idea will affect them • almost all uncertainty about a new idea must be removed before they feel it is safe to adopt
Late adopters	• are the last in the social system to adopt an innovation, therefore are isolated • tend to be frankly suspicious of innovations and new ideas • their adoption lags far behind awareness of a new idea

2. Approaches to reach different segments of population on the basis of innovativeness

Always remember, these characteristics are not fixed and people can move across categories.

2.1. Role of media and communication: It used to be assumed that the mass media had direct, immediate, and powerful effects on the mass audience. But the diffusion theory argues that a powerful way to affect the diffusion of an innovation is to affect opinion leaders' attitudes, through one-to-one support. Mass media is important however:

a. When there is a need to spread knowledge of an innovation to a large audience
b. To change weakly held attitudes

2.2. Support early adopters: Contacting early adopters is often easy as they will come looking for you. But the challenge is to provide the one-to-one support that early adopters expect and the recognition they need.

2.3. Win mainstream credibility: most projects fail to make the leap from experimental (pilot) to mainstream. Reasons for this are:

a. Mainstream audiences do not like risks
b. require endorsement from conservative leaders
c. require positive results
d. depend on word-of-mouth promotion

For an example of how to reach some of the categorised segments of a society see table 2 below:

Table 2: Approaches to Reach Different Segments

The segment	The approach to reach the segment
Innovators lead the way for others. They have already personally adopted the new behaviour.	• Media sources. • Directly involve innovators in the design of the programme through Participatory Planning. • Recruit and train the innovators as the peer educators (promoters.)

The segment	The approach to reach the segment
Early Adopters are open to new ideas that provide personal benefit. They are fashion setters, may have big egos and need a lot of personal support.	• Inter-personal contact • Addressing concerns. • Step-by-step guidance to experiment with the idea. • Strong face-to-face support with a limited number of early adapters to try out the practice. • Reward the participants ego through media coverage. • Maintain strong relationship with this group through regular feedback.
Early majority will only act when they get adequate proof of benefits. They are pragmatists, will accept simple, proven new ideas. They will adopt when there is minimum discontinuity with the lifestyle they are used to.	• Media stories featuring endorsements from credible individuals, opinion makers. • Provide one-to-one support discussing concerns, and consequences.
Late Majority do not like taking risks, or new ideas, but also do not want to be left behind, hence will follow the mainstream and the established standard. They can also be influenced by the sceptics.	• Refine your new idea to increase convenience and reduce untoward consequences. • Respond to the criticism from sceptics.
Laggards/ Late Adopters will block progressive change. Take their arguments seriously, as they often identify real problems that need to be solved before the majority segment can accept the innovation.	• Actively enforce regulations • Publicise prosecutions

ADOPTION OF SOCIAL CHANGE

The Rate of Adoption is influenced by the degree to which the new idea is perceived as offering an advantage over the presently held idea and the degree to which the new idea is compatible with individual's present beliefs.

The average rate of adoption varies greatly according to the '*innovation'* and the *individuals* concerned.

New ideas (innovations): that are relatively simple in nature, easy to try, and compatible with previous experience are usually adopted more quickly than innovations that lack these characteristics.

Therefore the innovation-decision is made through a cost-benefit analysis, where the major obstacle is uncertainty. People will adopt an innovation if they believe that it will enhance their utility. Analysis would depend on the degree to which the innovation would disrupt the functioning of their daily life.

Individuals: early adopters have a shorter adoption/decision period than late adopters. Thus the first individuals to adopt a new concept or idea, do so not only because they become aware of the innovation somewhat sooner than their peers, but also because they require less time to move from knowledge to decision.

A striking feature is that for most members of the social system, the innovation-decision depends heavily on the innovation-decisions of the other members of the system.

Once an innovation is adopted by 20% of the population, it is virtually unstoppable and a relatively rapid adoption will occur by the remaining members.

Past research has shown that the adoption of an innovation follows a bell shaped curve, when plotted against time. The curve of adoption rises slowly first when there are few adopters. It then accelerates to a maximum until half of the individuals in the society have adopted. It then increases at a slower rate as the remaining individuals finally adopt (See figure 1 below)

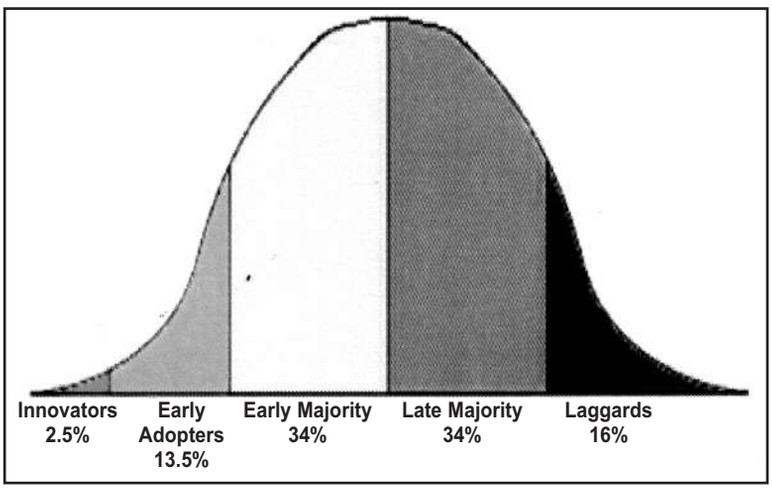


Figure 1: The Adoption Curve

According to Rogers, word of mouth is the most important method for adopting new ideas. Innovators get their information from media sources. Starting with early adopters, word of mouth takes on more significance.

Designing successful interventions

Knowing the mechanisms of diffusion gives us a basis for considering what efforts are most successful in encouraging the spread of an innovation.

Why do certain innovations spread more quickly than others? Why do others fail altogether?

The rate of adoption of an innovation depends on the **characteristics of the innovation** (as perceived by the audience)

a. Relative advantage
b. Compatibility with existing values and practices
c. Simplicity and ease of use
d. Whether it has been tried previously by others
e. Observable results

CHANGING THE SOCIAL CONVENTION: TOWARDS THE ABANDONMENT OF FGM/C

As with any self-enforcing social convention, the choice of an individual – in the case of FGM/C, a single family's choice of whether or not to cut their daughter or daughters – is conditioned by the choice of others. This social pressure tends to perpetuate the practice. It can also be the key to promote rapid collective abandonment. The practice of footbinding in China, for example, which lasted some 1000 years, was abandoned in little more than a generation. To understand how a social convention might be transformed, it is helpful to use a simple metaphor. A group has a convention whereby audiences (at the cinema, at plays, at recitals) stand up rather than sit down. An outsider comes along and explains that elsewhere audiences sit. After the shock of surprise wears off, some people begin to think that sitting might be better. If only one person sits, that person can't see anything on the stage. However, if a critical mass of people in the audience can be organized to sit, even a group of people who are less than the majority, they realize that they can sit comfortably and have a clear view of the stage. Similarly, in communities where cutting is a prerequisite for marriage, if only one family abandons FGM/C, the daughter doesn't get married. A critical mass is needed to bring about change. Once enough individuals are willing to abandon FGM/C, they will work to convince others to follow suit because this will reduce the social stigma associated with not cutting. The critical mass need not be a majority, but simply a sufficient number of individuals to demonstrate to others the relative benefits of *not* practicing FGM/C. Individuals within the group who have opted to abandon the practice will still face social pressure to cut their daughters, as illustrated by the challenges faced by a mother in Sudan. For this pressure to disappear, the number of people who have expressed their intention to abandon the practice must reach a "tipping point". At this point, those who still consider following the practice recognise that the status and honour it brings to a girl and her family no longer outweigh the risks involved. Once the new convention of valuing a girl's physical integrity is established, it becomes, like the old convention, self-enforcing. For those who have abandoned FGM/C, there is no incentive to revert to the practice, while the few individuals who continue to support FGM/C will face the disapproval of the community.

Abandoning FGM/C: six key elements for change

Concrete field experience, together with insights from academic theory and lessons learned from the experience of footbinding in China suggest that six key elements can contribute to transforming the social convention of cutting girls and encourage the rapid and mass abandonment of the practice.

1. *A non-coercive and non-judgmental approach whose primary focus is the fulfilment of human rights and the empowerment of girls and women.* Communities tend to raise the issue of FGM/C when they increase their awareness and understanding of human rights and make progress toward the realisation of what they consider to be of immediate concern, such as health and education. Despite taboos regarding the discussion of FGM/C, the issue emerges because group members are aware that the practice causes harm. Community discussion and debate contribute to a new understanding that girls would be better off if everyone abandoned the practice.

2. *An awareness on the part of a community of the harm caused by the practice.* Through non-judgmental, non-directive public discussion and reflection, the costs of FGM/C tend to become more evident as women – and men – share their experiences and those of their daughters.

3. *The decision to abandon the practice as a collective choice of a group that intra-marries or is closely connected in other ways.* FGM/C is a community practice and, consequently, is most effectively given up by the community acting together rather than by individuals acting on their own. Successful transformation of the social convention ultimately rests with the ability of members of the group to organize and take collective action.

4. *An explicit, public affirmation on the part of communities of their collective commitment to abandon FGM/C.* It is necessary, but not sufficient, that most members of a community favour abandonment. A successful shift requires that they manifest – as a community – the will to abandon. This may take various forms, including a joint public declaration in a large public gathering or an authoritative written statement of the collective commitment to abandon.

5. *A process of organized diffusion to ensure that the decision to abandon FGM/C spreads rapidly from one community to another and is sustained.* Communities must engage neighbouring villages so that the decision to abandon FGM/C can be spread and sustained. It is particularly important to engage those communities that exercise a strong influence. When the decision to abandon becomes sufficiently diffused, the social dynamics that originally perpetuated the practice can serve to accelerate and sustain its abandonment. Where previously there was social pressure to perform FGM/C, there will be social pressure to abandon the practice. When the process of abandonment reaches this point, the social convention of not cutting becomes self-enforcing and abandonment continues swiftly and spontaneously.

6. *An environment that enables and supports change.* Success in promoting the abandonment of FGM/C also depends on the commitment of government, at all levels, to introduce appropriate social measures and legislation, complemented by effective advocacy and awareness efforts. Civil society forms an integral part of this enabling environment. In particular, the media have a key role in facilitating the diffusion process.

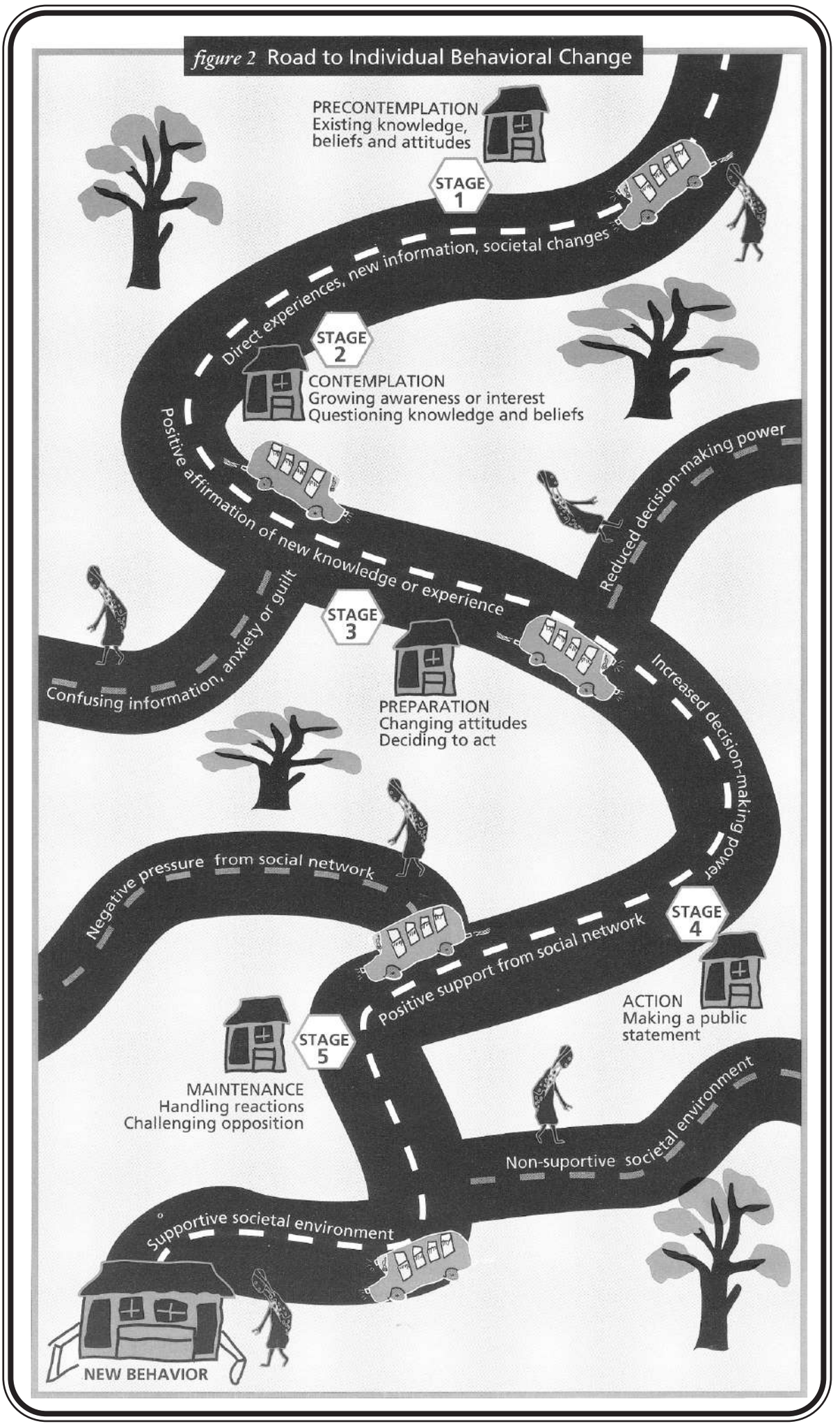


figure 2 Road to Individual Behavioral Change

Handout 7

Activity 1

STAGES OF BEHAVIOUR ADOPTION

Source: WHO-PATH, *Female genital mutilation: Programs to Date: what works, what doesn't,* WHO-PATH, Geneva, 1999

Activity 1 Handout 8 4

The six stages of Innovation Diffusion among individuals or group, or Adoption Process, applied to FGM/C

Stage	What happens at this stage	Strategies to move the adoption process forward
Attention	Awareness, exposure to the 'innovation': the possibility of abandoning FGM/C.	Use of mass media to channel the idea that abandoning FGM/C is possible
Interest	Development, persuasion - forming a favourable attitude towards the abandonment of FGM/C.	Emphasise the relative advantages of the abandonment of FGM/C
Evaluation	The pros and cons of the idea are compared.	Show compatibility of abandonment of FGM/C with existing values, needs and past experience
Trial	Made to adopt or reject the idea, leading possibly to a ***commitment*** to its implementation.	Present this 'innovation' in a simple way, understandable, and easy to try
Adoption	The new behaviour is adopted.	Modify the 'idea' to individuals' needs
Confirmation - reinforcement	...based on positive outcomes from it.	Emphasise and show the positive results of the innovation.

Activity 2

FGM/C PREVENTION: REVIEW OF PAST APPROACHES

Time: 1 hour and 30 minutes

Why do this activity?

Since international involvement in the campaign against FGM/C started over 20 years ago, marked by the World Health Organization sponsored conference in Khartoum in 1979, interest in this issue has increased progressively. Policies were announced and projects were funded to target the practice, but little investment was made to guide these policies and projects with evidence-based information. The involvement of different actors in different countries with varying assumptions and values resulted in the development of a variety of approaches for the abandonment of the practice. Only recently these approaches and their outcomes have been objectively evaluated.
This process started after results of the first Demographic and Health Surveys (DHS) including data on FGM/C were published, showing impressive high rates of prevalence also in countries where FGM/C prevention activities had been carried out over a long period of time (such as Mali). In 1999 WHO published the results of a vast study carried out by PATH, Program for Appropriate Technology in Health, with the aim of documenting the “status and trends in programming FGM prevention, and identifying crucial elements for establishing priorities in assigning future resources”. The fundamental question was: Can such an old and deeply entrenched cultural practice be stopped? Many scholars and activists answer this question by “an unequivocal yes”; FGM/C is no longer a taboo issue, there is evidence of decrease in support as well as of prevalence, with local quality research sometimes offering more encouraging results than the large scale DHS.
But it is evident that some approaches work, or at least have worked in the past, and some others do not.
This activity is aimed at learning about the different approaches to FGM/C prevention activities, in order to choose the most appropriate for designing interventions in different settings.

Objectives

- To obtain an overview of the different approaches for prevention of FGM/C
- To identify positive and negative aspects of different approaches
- To understand which approach is better suited for a specific target group, area of intervention, type of FGM/C.

4 How to do the activity

Step 1: 15 minutes

Put up the Overhead 1: “Why the practice of FGM/C continues: A Mental Map” and explain it.

This mental map has been developed by WHO and PATH for their first evaluation of projects and programs to prevent and stop FGM/C. This mental map synthesizes what has been learnt in the previous module about the multidimensional nature of FGM/C, involving a number of: “myths, convictions, values and codes of behavior [that] lead an entire community to see women’s outside genitals as potentially dangerous which, if not eliminated, have a negative effect on the woman who did not undergo the practice, her family and the entire community. In order to ensure that people respect the practice, the community has set a powerful system of persuasion in motion, including refusal of the non-excised/infibulated woman as a wife, the risk of immediate divorce of wives who prove to be intact, public derision and the threat of public excision at the moment of marriage, the instillation of ancestral fears of possible risk. While circumcised girls are given gifts, public recognition, the possibility to marry, respect and entrance into the community of adults”.

Explain that according to WHO and PATH, as well as a number of activists and researchers, the reason why the prevalence is still high, is that programmes implemented in the past have failed to efficiently address this “mental map”. Ask group for comments:

- Is the mental map complete?
- What should be added?
- Are there additional elements to consider? Which ones?
- Does the mental map reflect opinions by all actors involved in the decision-making process about subjecting a girl to FGM/C?

Note to facilitator

According to results of the discussion write any suggestions on the flip chart.

Step 2: 15 minutes

Put on Overhead 2 “Women and gatekeepers” and referring back to the “mental map”, analyse the drawing together with participants:

Plenary
Overhead

- At the centre of change concerning FGM/C there are women and girls, those who are submitted to and take the first decision in perpetuating the practice.

- Their freedom of movement within the community is regulated by the so called “gatekeepers” that use FGM/C as a key to open the doors. These are the men, the village leaders including the elders and the excisor/circumciser, the religious leaders, and the other women (relatives, elders, peers).

- Each of them uses a different “community enforcement mechanism” (refer to the Overhead “Why the Practice of FGM/C continues: A Mental

Note to facilitator

Map") to make sure that women adhere to the practice, offering in exchange the key to open the gate.

- Outside, women may find supporters, those starting a dialogue that might lead to threatening the "tradition" and trigger a process of behavioural change (or women's empowerment).

- Finally, at the outer lever, there is "society at large": those who build the environment allowing for a change in behaviour to take place, e.g.: by adopting laws and policies that empower women, or by promoting girls' enrolment in higher education, or by providing adequate reproductive health counselling services. This is a sort of "indirect" influence, or entry point, that might be very important in a programme addressing a sensitive and multifaceted issue like FGM/C.

Step 3: 30 minutes

Buzzing

Divide participants in groups of two or three and hand each goup one of the approaches previously cut up in Handout 1 "Approaches to FGM/C prevention". Note that there are 10 approaches in total, so you should have maximum 10 couples/groups to analyse them.

Also distribute Handout 2 "Questions to guide past approach analysis and presentation" and read them out to explain how to carry on the exercise:

Does the selected approach address…

1. …the **traditional arguments** given for perpetuating the practice, such as myths about being born with a male-female soul that has to be shaped in a precise gender identity, religion (needing to be pure to pray), rite of passage to adulthood

2. …the **psycho-social reasons**, including those linked to sexuality, such as maintaining virginity and chastity, getting married, diminishing women's sexual desire, increasing male sexual pleasure …

3. …the **community enforcement mechanisms**, such as refusal to marry uncircumcised women, peer pressure, calling of names and insults, taboos such as: food prepared by uncircumcised women will not be eaten, fear of rejection by community/ethnic group ...

4. ...and involve the **different key actors** participating in the decision-making process concerning performance of FGM/C on girls?

5. ...the **different stages of behavioural and social change** that key actors in the community are in?

6. ...and contribute to **building an environment** favouring the abandonment of FGM/C at individual and/or community level?

7. ...the **perceived empowerment** that women gain from FGM/C?

Step 4: 30 minutes

Invite each group to share their analysis and briefly explain which approach they have considered, then how they have responded to the questions. Invite others to share their views and comments.

Plenary discussion

To conclude

Distribute Handout 3 “Past approaches in synthesis”. Ask the groups anyone has been part of an activity including the presented approach, and likes to share his/her experience.

Handout

Does the experience confirm understanding by the group?

Materials:

- Overhead projector
- Copies of Handouts

Overheads:

- Overhead 1: Why the practice of FGM/C continues: A Mental Map
- Overhead 2: Women and gatekeepers

Handouts:

- Handout 1: “Approaches to FGM/C prevention”
- Handout 2: “Questions to guide past approach, analysis and presentation”
- Handout 3: “Past approaches in synthesis”

Reading:

• WHO, Female Genital Mutilation. Programmes to Date: What Works and What Doesn't. A Review, WHO, Geneva, 1999.

• GTZ, Addressing Female Genital Mutilation. Challenges and Perspectives for Health Programmes, Part I: Selected Approaches, GTZ, Eschborn (Germany), 2001

• GTZ, Promotion of Initiatives to End Female Genital Mutilation, fact sheets.

• Population Reference Bureau, Abandoning Female Genital Cutting. Prevalence, Attitudes and Efforts to End the Practice, PRB, Usa, 2001.

• Fotheringham Megan, Culture Clashes: Balancing Local and International Interests in Ending Female Genital Cutting Practices, in LBJ Journal Of Public Affairs, Vol XVI

• Toubia N. and Sharief E.H., Female genital mutilation: have we made progress?, in International Journal of Gynecology and Obstetrics, n. 82, 2003.

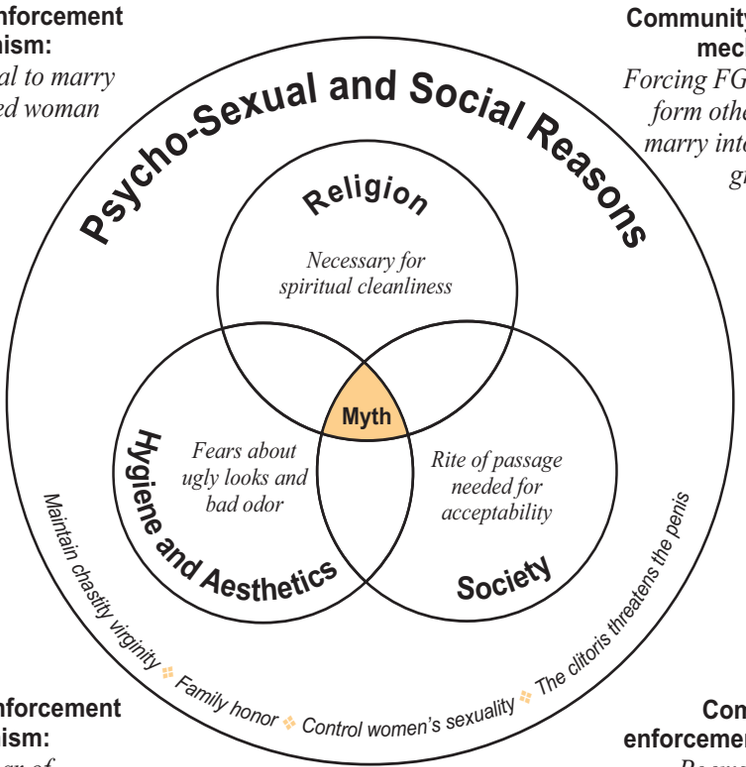
• PATH, Evaluating Efforts to Eliminate the Practice of Female Genital Mutilation. Raising Awareness and Changing Harmful Norms in Kenya, PATH, May 2002.

• Hanson Swanson J., The FGM/C Abandonment Project: Mobilizing Communities Through a Positive Deviancy Approach, unpublished paper presented to the 29th yearly conference of the Global Health Council, Washington D.C., May 29, 2002.

Why the Practice of FGC Continues: A Mental Map

Community enforcement mechanism:
Divorce, refusal to marry uncircumcised woman

Community enforcement mechanism:
Forcing FGM/C an women form other tribes who marry into circumcised groups



Community enforcement mechanism:
Using fear of punishment by God or supernatural forces

Community enforcement mechanism:
Poems, song that celebrate circumcision and deride uncircumcised girls

Source: Asha Mohamud, Nancy Ali, Nancy Yinger, World Health Organization and Program for Apropriate Technology in Health (WHO/PATH), *FGM Programs to date: What works and What Doesn't* (Geneva: WHO 1999); 7

Overhead 2

Activity 2

Adapted from : N. Toubia-RAINBO, *Community based Indicators assessing progress in stopping FGM/C*, PowerPoint presentation at the UNICEF Global Consultation on Indicators, 11-13 November 2003, New York

APPROACHES TO FGM/C PREVENTION

The Harmful Practice Approach. Involvement of medical and paramedical personnel (obstetricians, nurses, social workers and other local professionals) in providing information on the health risks connected to the practice, both immediate and long term ones. The idea is that this kind of information will automatically lead to abandonment of the practice, once the seriousness of short and long term health risks is fully understood. This approach was and is extensively used in awareness raising activities by agents of local NGOs and CBOs (community-based organizations) in villages, with groups including women, village leaders, youth.

Training of medical personnel as "promoters of change". This came out of the consideration of the multiple role played by medical personnel in developing countries with respect to the practice. If, on a personal level, every doctor is called on to resolve the conflict caused by membership in an ethnic group where FGM/C is practiced with respect to WHO prohibition, at the community level, the physician also plays other roles. It is the doctor to whom the family first turns in the case of complications from an excision or infibulation or the women/couple in the case of problems, especially in sexual relations frigidity/sterility, that might be the result of the practice. This is a very important, fertile moment of contact with the community. Having what is recognized as "superior" training, the physician ends up in the role of opinion leader, which puts him in the best possible position for promoting change of behaviors in his/her patients.

Alternative income-generating activities for traditional practitioners. After sensitization towards the dangerous consequences of the practice and related risks, the programmes aim to substitute the practice of FGM/C with other income-generating activities – agricultural production, food processing, crafts, trade. To this end they foresee appropriate professional training for the former traditional practitioners, as well as a credit scheme providing funds for the start up of the chosen activity. This approach was adopted in a number of countries, especially in Western Africa (Guinea, Ghana, Mali, Burkina Faso) and in Ethiopia.

Alternative rites of passage. This specific action has been designed and used in particular in Kenya by Maendeleo Ya Wanawake Organization (MYWO) as a key element of a community based-approach aimed to raise awareness of the human rights and health implications of FGM/C, and to involve peer educators, teachers, religious and community leaders in mobilizing for social change. The alternative rite of passage was built on an existing rite of passage that is common for girls in some ethnic groups in Kenya where circumcision is part of a process to mark girl's coming of age and prepare her for marriage. The alternative rite of passage promotes positive aspects of culture and passing on of traditional wisdom while educating girls about sexuality, HIV/AIDS, relationships and family life. It culminates in a celebration of the girl's altered social status as a young woman. For girls and their families who have decided against circumcision, the program provides social support to offset the stigmatization that commonly occurs to those who don't follow conventional norms.
A similar approach has been recently implemented by BAFROW in The Gambia, with a focus on women as central decision-makers for their daughters' circumcision. The alternative right of passage was organized at the end of a 2-year community based literacy course focusing in reproductive health and women's participation.

Awareness raising through use of IEC materials. IEC stands for Information, Education, Communication and is very common in first generation programs aimed at raising the veil that hides the practice, stimulating an open debate in society and promoting different behavior on the basis of new information made available. There are a number of studies comparing the production of posters, brochures, leaflets, stickers, and colored tables to arouse debate, anatomic models (this approach is adopted mainly by the IAC national committees) and analyzing the messages, graphic design and contents. On the basis of this analysis, WHO lists the most common messages, including the following:

- FGM/C has a negative affect on the health of women and girls
- FGM/C is a harmful practice
- use of the same knife can facilitate contagion with HIV/AIDS
- FGM/C violates the rights of women and girls
- FGM/C is not required by Islam
- a non-excised girl is a good wife
- FGM/C does not prevent sexual promiscuity
- FGM/C reduces female sexual pleasure
- FGM/C is contrary to Christian teaching
- Since the age when excision is practiced is constantly lowered, FGM/C can not longer be considered a rite of passage into adulthood
- FGM/C does not increase male sexual pleasure

Involvement of religious leaders. This is an essential element of local programmes, as the conviction that FGM/C is a religious obligation is widespread. It is therefore not enough to state that neither the Qu'ran nor the Bible require FGM/C. They have to be the first ones to abandon the practice (in the case of Imam or Protestant ministers with daughters) and must not tolerate further use among their congregations. For that reason they need the proper theological knowledge to motivate their own choices, answer questions and doubts, support individual decisions to abandon the practice made by isolated families and guide the entire community towards a future without FGM/C.

Positive deviance. This is the name given to an approach that underwent systematic experimentation in Egypt by the Center for Development and Population Activities (CEDPA) but is actually an integral part of all those programmes that intervene at the village level, first engaging a few individuals who, when conquered for the cause, promote a change of behavior within their communities, for whom they become a model of behavior. The experiment in Egypt was aimed first of all at identifying people who had already abandoned the practice, the "positive deviant". Their motivation, the process followed to reach the decision, the way they resisted community pressure and stuck to the choices made were then the subject of an in-depth qualitative study that revealed the strategies for abandonment developed within the cultural context. Later awareness raising activities within the community were developed in accordance with the study result. The second phase of the project identified girls at risk (at the age for FGM/C intervention). The positive deviants formed small groups and contacted the families of the girls at risk, gained their trust and gradually induced them to reconsider their decisions regarding FGM/C. The challenge is to preserve this status at least until the girl is married: if the husband does not insist that she be excised/infibulated before marriage, it is rare for the practice to be carried out afterwards.

Human rights approach. This is aimed at making people understand, even in practicing villages, the fundamental human rights of people, women and children in particular, the advantages derived from them and how FGM/C is a manifest violation of these rights. For this approach to be effective, it must mediate with the cultural values shared within the community and find the proper, respectful language of those values to transmit concepts that, at first glance, might seem abstract. The local community's involvement to draw up an effective communication strategy is therefore essential. This strategy also uses conventions and treaties (CEDAW and the Convention on the Rights of the Child, but also regional conventions, such as the African Charter on Human and Peoples' Rights and the recent Protocol to the Charter on Women's Rights) to put pressure on government so that they intervene more effectively in the prevention of female genital mutilation, thus protecting and realizing women's human rights, including sexual and reproductive right as set forth in the 1994 Action Program of the Cairo Conference on Population and Development.

The legal approach. this approach is aimed at obtaining laws that forbid the practice. It is a highly controversial strategy: about twenty African countries now have a law against female genital mutilation. Most of them are penal laws which punish the practice bud do not contain preventive measures. Nor do they allocate funds for realization of preventive action. Moreover, the laws are not well enforced, in part because the judicial class is often in favor of the practice, or because the law criminalizes only the traditional practitioner, i.e. once again the supply, without attempting to effect the demand.

The comprehensive social development approach. In order to overcome limits emerged by addressing exclusively the negative heath consequences of FGM/C and focusing merely on health personnel as well as circumcises (the performers of the act), this approach calls for addressing all aspects of development, including gender issues as well as social, political, legal, health and economic development of a community. FGM/C is not the main focus of meetings and training activities carried out in the community, and its possible negative health effects are understood as part of a more comprehensive sexual and reproductive health program. It uses an integraed and participatory learning method, and can lead – as in the case of the NGO Tostan in Senegal – to a whole community or group of intramarring villages deciding to publicly declare their intention to abandon FGM/C and early marriages or, as in the case od MYWO in Kenya and BAFROW in The Gambia, in the organization of an alternative rite of passage for the girls.

QUESTIONS TO GUIDE PAST APPROACH ANALYSIS AND PRESENTATION

Does the selected approach address…

1. …the **traditional arguments** given for perpetuating the practice, such as myths about being born with a male-female soul that has to be shaped in a precise gender identity, religion (needing to be pure to pray), rite of passage to adulthood
If yes, how.....
.....
.....

2. …the **psycho-social reasons**, including those linked to sexuality, such as maintaining virginity and chastity, getting married, diminishing women's sexual desire, increasing male sexual pleasure …
If yes, how.....
.....
.....

3. …the **community enforcement mechanisms**, such as refusal to marry uncircumcised women, peer pressure, calling of names and insults, taboos such as: food prepared by in circumcised women will not be eaten, fear of rejection by community/ethnic group ...
If yes, how.....
.....
.....

4. ...and involve the **different key actors** participating in the decision-making process concerning performance of FGM/C on girls?
If yes, how.....
.....
.....

5. ...and the **different stages of behavioural and social change** that key actors in the community are in?
If yes, how.....
.....
.....

6. ...and contribute to **building an environment** favouring the abandonment of FGM/C at individual and/or community level?
If yes, how.....
.....
.....

7. ...the **perceived empowerment** that women gain from FGM/C?
If yes, how.....
.....
.....

FGM/C PREVENTION
PAST APPROACHES IN SYNTHESIS

1. The harmful traditional practice: providing information on the health risks connected to the practice, both immediate and long term with the idea that this kind of information will automatically lead to abandonment of the practice, once the seriousness of short and long term health risks is fully understood.

2. Training of medical personnel as promoters of change, as they may use the particular moment of medical consultation to persuade their patients about the need and importance of abandoning the practice, given the authority these professionals have in the community generally.

3. Alternative income generating activities for traditional practitioners: train excisors in other income generating activities and offer them economic support to start their new businesses, in order to substitute the income they earned through FGM/C performance and encourage them to lay down their knives.

4. Alternative rites of passage, also defined as initiation without cutting, foresees a preparation period during which "good" aspects of culture and tradition are taught to the girls, culminating whit a public ceremony/ritual with planting trees or other symbolic acts, instead of cutting.

5. IEC materials to raise awareness: Information, Education and Communication materials were widely used in both rural and urban settings to stimulate a debate about the need to abandon the practice, with the idea that the awareness raised would lead to this result.

6. Involvement of religious leaders to confirm that FGM/C is not a practice required by Islam or any Christian religion, and to counter the widespread belief that it is necessary to be pure to pray etc.

7. Positive deviance: this initially engages a few individuals who, once conquered for the cause, promote a change of behavior within their communities, for whom they become a role model for having dared to deviate from tradition to promote what is defined as a more positive future for their daughters.

8. Human rights approach: this is aimed at making people understand, even in practicing villages, the fundamental human rights of people, women and children in particular, the advantages derived from them and how FGM/C is a manifest violation of these rights.

9. The legal approach aims at obtaining laws that prohibit or otherwise prevent the practice. It also foresees advocacy for their implementation, where appropriate.

10. The comprehensive social development approach: to overcome the limits which emerged by exclusively addressing the negative heath consequences of FGM/C and focusing solely on health personnel, as well as circumcisers (the performers of the act), this approach calls for addressing all aspects of development, including gender issues as well as the social, political, legal, health and economic development of a community.

Activity 3

PROGRAMMING TOOLS TO MAINSTREAM FGM/C PREVENTION IN DEVELOPMENT PROGRAMS AND PROJECTS

Time: 1 hour

Why do this activity?

This activity builds on two methods for programming, in particular:

a) gender planning

b) the WECC (Women's Empowerment Community Consensus) model

to learn how to best mainstream FGM/C prevention into development programmes.

The analysis carried out during the previous modules has shown how FGM/C will come to an end when women themselves feel that they can abandon the practice without losing what the practice guarantees them: survival and security through marriage, child-bearing and social recognition for their children, dignity and an accepted social role, including freedom of movement and some decision-making.
The "gender spectacles" that we have put on during this training course will allow us to recognize the "practical gender needs" as well as the "strategic gender needs" that crosscut with FGM/C. This in turn will permit the identification of target groups, objectives, appropriate messages, and how to follow them through the different "stages of behavioural change", and understanding which are the necessary interventions. As well how to resist adverse pressure and arrive to the point where the whole community has reached a consensus on the abandonment of FGM/C, and makes it public through some sort of "Declaration", as the methodology used by the Senegalese NGO TOSTAN shows.
The programme should be designed to build the supportive social and cultural environment necessary for women and families to adopt a different behaviour. Ingredients for this environment include information through the media, as well as policy and laws. Moreover, the proposed method will help to identify activities to be implemented to uphold the decision to abandon the practice, and to allow a smooth transition to a new collective behaviour.

Objectives

- To understand how to use the learned skills for effective programming, including “gender planning”, “stages of behavioural and social change” and the “WECC model”.
- To identify the links between women’s empowerment programmes and FGM/C prevention programmes
- To define concrete steps to mainstream FGM/C prevention activities into different development programmes in order to bring about long lasting behavioural change.

How to do the activity

Step 1: 1 hour

The facilitator leads the group through the Power Point presentation on “Programming tools to mainstream the abandonment of FGM/C into development programs and projects”.

Read Handout 2 “A closer Eye on Gender Planning” to prepare presentation.

Power Point presentation in plenary

Programming tools to mainstream the abandonment of FGM/C into development programs and projects	What have we discovered? • women work more hours then men • women’s work is largely not paid (valued) • women work to reproduce life, through childbearing and household chores • women do not have leisure time • women do not control resources, although they might have access to them • women are meant to satisfy men’s sexual desire • women gain dignity, social recognition, freedom only through marriage, facilitated by FGM/C	Which role does FGM/C play? • empowers women, giving them access to marriage leading to social mobility • gives men greater control over women, through the denial of women’ sexuality • reinforces existing community power institutions (elders, circumcisors) • plays an economic role, as it promotes exchange of wealth (payment to circumcisers/elders, gifts and presents, future bride price) • gives women access to resources (water, earnings through work on husband’s fields…) • is an identity marker
Which are the development priorities for women/communities? • poverty / economic security: earning more, access to and property of land, paid job • education • children’s wellbeing (present and future) • family planning (birth spacing) • prevention of HIV/AIDS • healthcare (general) • mobility • water and sanitation …	Priorities = Needs from a gender perspective: • Practical gender needs (PGN) *the needs women identify in their socially accepted roles in society (as wives and mothers: water, better education for their children…)* • Strategic gender needs (SGN) *the needs women identify because of their subordinate position to men in society (…leading to unequal workload, domestic violence…)*	Strategic gender needs: • challenge existing social structure/functioning • challenge existing gender roles • challenge current socialization of girls/women • interact with existing power dynamics • demand women’s empowerment • foresee a change in behaviour • lead to fulfilment of practical gender needs • cannot be fulfilled without the active involvement of the other social actors that influence women’s decision making power and position in society • *ultimately they* question the need for FGM/C as a power gaining tool
Programming tool: the steps 1. conduct a gender / situational analysis 2. prioritisation of development problems 3. identify working objectives: women’s empowerment 4. identify the entry strategy / access the community 5. expand the room for manoeuvre / choose project inputs (WECC: Women’s Empowerment and Community Consensus) 6. conduct progressive monitoring to adjust project to changes and avoid resistances	1. gender / situational analysis ***includes the following:*** • disaggregate target groups within the community (women, husbands, elders, girls…) • look at household structure (family…extended) • look at roles played by women and men, both in the household and in the community • look at access/control over resources (including economic, time, education, internal, information, political…)	1. gender / situational analysis cont. • identify stages of behavioural and social change • identify gatekeepers • collect data/quality information on FGM/C *ultimately the gender/situational analysis will lead to* • **identify PGN and SGN of women** • **identify development needs of the community**

Data/information on FGM/C here and now:

- FGM/C prevalence in women and girls?
- What type of FGM/C is performed?
- Who performs the practice?
- Which is the age at FGM/C?
- What are the main reasons given by women / community for supporting FGM/C?
- Attitudes towards possibility of abandoning FGM/C?
- What people know about FGM/C?
- Were there previous campaigns / interventions?
- Is FGM/C a power gaining tool for women?

2. Prioritisation of development problems in a gender perspective

- To understand the inter-relationship between the different problems, what is causing subordination of women, and which are the barriers preventing its elimination
- build a **cause and effect** hierarchy of problems
- *which is* a **hierarchy of unmet practical and strategic gender needs**

asking the questions:

- **WHY is the problem (unmet PGN/SGN) there?**
- **what role does FGM/C play in it?**

3. Identify working objectives for women's empowerment

Working objectives are those that address SGN

- by addressing SGN, also PGN will be addressed
- FGM/C is a tool to achieve SGN in absence of women's empowerment mechanisms
- working objectives pursue women's empowerment and might include:
  - changing land property / inheritance laws
  - implement compulsory education for boys/girls
  - quotas for women in community/national institutions
  - domestic violence prevention programs
  - raising the age of legal marriage
  - abolition of FGM/C…

How to identify working objectives?
Using gender consultation & community dialogue

GENDER CONSULTATION

- *use participatory approaches including women beside political / local leaders (authorities)*
- *listen to those working for the improvement of women's lives*
- *identify negotiation strategy and elements*

COMMUNITY DIALOGUE

- *use participatory approaches / listen*
- *give a voice to the voiceless (…women)*
- *facilitate identification of own needs by community*
- *give priority to areas where FGM/C plays a role*

results will …

Gender consultation and community dialogue will lead to…

- identify the **entry strategy** to meet SGN of women, thus bringing a change in traditional gender roles and gender socialization processes
- identify **stages of behavioural change** different social actors (target groups) are already in
- identify **assets = supporters** and **constraints = resistors** for building community consensus necessary to meet SGN
- build a baseline to **monitor** progress and redefine ongoing working objective, adapted to changing power dynamics

4. Identify entry strategy/access the community

Look at power dynamics and stages of behavioural change:

- what is possible to do?
- what is NOT possible to do? (…will elicit resistance/refusal by community and/or selected actors)
- who will contribute to / support women's empowerment?
- who will openly oppose it?
- how should the issue of FGM/C be addressed?

The answers define the room for manoeuvre

5. Expand room for manoeuvre / WECC

Women's Empowerment and Community Consensus

- choose development areas where gender equality / women's empowerment will benefit the whole community
- choose areas where FGM/C is perceived as a power gaining tool for women
- build supportive structures / institutions for women's empowerment including full participation of women …/…

5. Expand room for manoeuvre / WECC cond.

- choose appropriate message / WECC inputs
- work with supporters (assets) to move resistors (constraints) towards different stage
- move to collective decision making: public declared intent to change behaviour…public declaration to abandon FGM/C
- build a sustainable environment for change (where new gender roles and power dynamics, including abandonment of FGM/C, can be maintained)

6. Conduct progressive monitoring

- look at women's empowerment without FGM/C: do women gain power over/to/with/within in a different way?
- use quantity/quality data/information gathered through gender/situational analysis as a baseline: what changed in the community after intervention?
- look at social change: which changes in stages of behaviour of target groups happened?
- identify unexpected results: were there positive and/or negative unforeseen outcomes?
- define new working objectives/entry strategy
- define how to scale up activities

Note to facilitator on how to present

Please, note that the lists on **slide 1, 2 and 3** are purely indicative: it would be better to add comments from participants, before showing the content of the slide, asking the title questions and writing the answers on a flipchart. Some of the answers might coincide with the proposed answers on the slides, some will be different according to local situation. Each list will then be shown only as an indicative reference.

As many program officers might already be familiar with the **gender planning methodology**, when it comes to **slide 5**, ask participants first to define "practical gender needs" and "strategic gender needs". Then focus more in detail on the "strategic gender needs" with **slide 6**, eventually asking participants again to define them more in detail.

When it comes to **slide 11 on Prioritisation of development problems with a gender perspective,** invite participants to do the **prioritisation of problems** imagining a community that all are familiar with, shortly describing the condition of women there and then asking the questions:

- WHY is that particular problem there?
- what is its impact on women?
- which are its causes?
- does FGM/C play a role in it?
- if yes which one?

To conclude

At the end, explain that this programming tool is the result of the fusion of two different methodologies:
Gender Planning, a methodology developed at the Development Planning Unit of the University of London by Caroline Moser and her colleague and co-trainer Caren Levy. The whole methodology, which has been synthesised to its essential steps and applied to the specific field of FGM/C as a development issue, has been presented in Caroline Moser's book *Gender planning and development. Theory, practice & training*, first published by Routledge in 1993;
WECC, the Women's Empowerment and Community Consensus framework developed by RAINBO on the basis of behavioural and social change theories, after a two year long review of approaches used in preventing FGM/C throughout Africa.

Distribute the Handouts

Handout

Materials:

- Power Point presentation
- LCD project
- Laptop computer
- Handouts for all participants

Handouts:

- Handout 1: "Programming tools to mainstream the abandonment of FGM/C into development programs and projects – Power Point presentation"
- Handout 2: "A closer eye on gender planning"

Reading:

- Caroline Moser, "Gender planning and development. Theory, practice & training", Routledge, London & New York, 1993.

Programming tools to mainstream the abandonment of FGM/C into development programs and projects

What have we discovered?

- women work more hours then men
- women's work is largely not paid (valued)
- women work to reproduce life, through childbearing and household chores
- women do not have leisure time
- women do not control resources, although they might have access to them
- women are meant to satisfy men's sexual desire
- women gain dignity, social recognition, freedom only through marriage, facilitated by FGM/C

Which role does FGM/C play?

- empowers women, giving them access to marriage leading to social mobility
- gives men greater control over women, through the denial of women' sexuality
- reinforces existing community power institutions (elders, circumcisors)
- plays an economic role, as it promotes exchange of wealth (payment to circumcisers/elders, gifts and presents, future bride price)
- gives women access to resources (water, earnings through work on husband's fields…)
- is an identity marker

Which are the development priorities for women/communities?

- poverty / economic security: earning more, access to and property of land, paid job
- education
- children's wellbeing (present and future)
- family planning (birth spacing)
- prevention of HIV/AIDS
- healthcare (general)
- mobility
- water and sanitation …

Priorities = Needs from a gender perspective:

- Practical gender needs (PGN)
  the needs women identify in their socially accepted roles in society (as wives and mothers: water, better education for their children…)
- Strategic gender needs (SGN)
  the needs women identify because of their subordinate position to men in society (…leading to unequal workload, domestic violence…)

Strategic gender needs:

- challenge existing social structure/functioning
- challenge existing gender roles
- challenge current socialization of girls/women
- interact with existing power dynamics
- demand women's empowerment
- foresee a change in behaviour
- lead to fulfilment of practical gender needs
- cannot be fulfilled without the active involvement of the other social actors that influence women's decision making power and position in society
- *ultimately they* question the need for FGM/C as a power gaining tool

Programming tool: the steps

1. conduct a gender / situational analysis
2. prioritisation of development problems
3. identify working objectives: women's empowerment
4. identify the entry strategy / access the community
5. expand the room for manoeuvre / choose project inputs (WECC: Women's Empowerment and Community Consensus)
6. conduct progressive monitoring to adjust project to changes and avoid resistances

1. gender / situational analysis

includes the following:

- disaggregate target groups within the community (women, husbands, elders, girls…)
- look at household structure (family…extended)
- look at roles played by women and men, both in the household and in the community
- look at access/control over resources (including economic, time, education, internal, information, political…)

1. gender / situational analysis cont.

- identify stages of behavioural and social change
- identify gatekeepers
- collect data/quality information on FGM/C

ultimately the gender/situational analysis will lead to

- **identify PGN and SGN of women**
- **identify development needs of the community**

Activity 3 Handout 1

4

Data/information on FGM/C here and now:

- FGM/C prevalence in women and girls?
- What type of FGM/C is performed?
- Who performs the practice?
- Which is the age at FGM/C?
- What are the main reasons given by women / community for supporting FGM/C?
- Attitudes towards possibility of abandoning FGM/C?
- What people know about FGM/C?
- Were there previous campaigns / interventions?
- Is FGM/C a power gaining tool for women?

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- To understand the inter-relationship between the different problems, what is causing subordination of women, and which are the barriers preventing its elimination
- build a **cause and effect** hierarchy of problems
- *which is* a **hierarchy of unmet practical and strategic gender needs**

asking the questions:

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How to identify working objectives?

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COMMUNITY DIALOGUE

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- *facilitate identification of own needs by community*
- *give priority to areas where FGM/C plays a role*

results will …

Gender consultation and community dialogue will lead to…

- identify the **entry strategy** to meet SGN of women, thus bringing a change in traditional gender roles and gender socialization processes
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- identify **assets = supporters** and **constraints = resistors** for building community consensus necessary to meet SGN
- build a baseline to **monitor** progress and redefine ongoing working objective, adapted to changing power dynamics

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Look at power dynamics and stages of behavioural change:

- what is possible to do?
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- choose appropriate message / WECC inputs
- work with supporters (assets) to move resistors (constraints) towards different stage
- move to collective decision making: public declared intent to change behaviour…public declaration to abandon FGM/C
- build a sustainable environment for change (where new gender roles and power dynamics, including abandonment of FGM/C, can be maintained)

6. Conduct progressive monitoring

- look at women's empowerment without FGM/C: do women gain power over/to/with/within in a different way?
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- look at social change: which changes in stages of behaviour of target groups happened?
- identify unexpected results: were there positive and/or negative unforeseen outcomes?
- define new working objectives/entry strategy
- define how to scale up activities

A CLOSER EYE ON GENDER PLANNING
(Power Point Commentary)

The previous activities we have been involved in are what we call an "initial gender analysis"; we have started looking to the different roles that men and women have in societies and their different access and control over resources.

Because men and women have different roles, they have different needs. These are called **gender needs**.
What do we mean by gender needs? Based on the work of the French sociologist, Maxine Molyneaux, and the economist from the London School of Economics, Caroline Moser, who make a point regarding the limitative use of women's needs. First of all, the concept of women's needs does not reflect women's social position vis-a-vis men. Second, women's needs vary depending on social class, ethnic group, etc. Therefore it is not helpful to think that all women have the same needs or that women are a homogeneous group.

That's why it is more useful to talk about "gender needs".
Gender needs are those needs that men and women may develop by virtue of their social position through gender attributes. Again Molineaux makes a perfect distinction of these needs.

They can be **Practical gender needs** (PGN) or **Strategic gender needs** (SGN).
PGN are the needs of men and women by virtue of their position within the gender division of labour in a given society. It is usually a response to an immediate need. For example in a rural society to have water near the household is a PGN for women, because it is part of their responsibility within the gender division of labour. If we look at health, having access to family planning is a PGN for women. PGNs are aimed at actions because if make the performance of existing gender roles more efficient.
SGN, on the contrary are derived by the subordinate position of women with respect to men. They reflect an alternative for a more equitable division of labour.
From a planning point of view, when we talk about meeting SGNs, we talk about actions which challenge existing gender roles. For instance giving women access to land is meeting a SGN, because it changes the relationship between men and women. By making the distinction between PGNs and SGNs, planners can distinguish projects that target PGNs and those that address SGNs.
SGNs are challenging in nature and threatening in character.
When we use this distinction we find that most policies, programmes and projects aim to meet PGNs, as they do not intend to change the roles of men and women.
Making the distinction between PGNs and SGNs helps us disentangle these interventions from one another. In this way we know that if we deal with SGNs, we are challenging existing gender roles.
We could then start a project which aims to meet PGNs and then develop it into tackling SGNs. For instance, if you give income opportunities to women, even if you are providing them with a traditional job that does not challenge the traditional labour divisions, by giving them access to income in their own right, this might challenge the gender division of labour and empower women.

Gender planning tools

Integrating gender into the planning cycle or into planning activities is not an easy task, because we try to integrate a non-linear relationship into a linear process. If we try to integrate gender in a very simple step-by-step fashion we are going to fail. It is not a step-by-step process.

The purpose of gender analysis is to understand the mechanisms underlying dominant development problems and policy, programmes and planning interventions in terms of their implications for women and men and the relationships between them.

We talk about the implications of gender relations because by definition a gender analysis cannot be carried out in a vacuum.

The tools to carry out **the first stage of the gender analysis** are the following: we have to disaggregate participants in a particular community, look at the household structure, and the different roles of men and women like who does what in a household and at community level. In this way we want to interpret the kind of gender needs that are being met or not being met.

But how do we go beyond the analysis to some kind of action?

In thinking about actions, the biggest problem that we often face is: where do we start?

The second important stage is the **prioritisation of the problems** that we have identified. We do not know where to start unless we understand the inter-relationships between the problems we face. What we need to do is to construct some kind of cause and effect hierarchy of problems. We have to start looking at the negative: which gender needs are not met because they are the very symptoms of the problem. And then we need to ask ourselves why are these gender needs not met?

We have to look at the backward and forward linkages of what lies behind these particular problems.

We have to try to identify where the problems are and how one problem causes another problem.

Gender analysis is an on-going process. It is not something that stops with the preparation and identification of a project. It is an on-going process because we need to constantly redefine problems in a changing context. We might need to ask different kinds of questions at different points of the cycle. Gender analysis might take a slightly different form in the way that we question but in essence what we look at each point of this process is trying to understand what is happening around the roles and needs.

We need to know: who defines gender needs?

Is it the professional, the politician on the community itself?

A complementary part of doing any gender analysis is **the process of gender consultation**, that means, especially in a community dominated by traditional structures, interrogating not only the political or community leaders, but also the women of the community, listening to those who are committed to gender issues in the country.

We need to be aware, we need to wear our “gender spectacles” when we are talking about a consultation because, if we do not, we will find ourselves only talking to certain actors and not others.

When we prioritize our problems we have a much better way of seeing where to start. It is very useful to start action by **identifying working objectives (WO)**. These should not be confused with the objectives of the programme/project. These are objectives used specifically to introduce gender issues into a particular programme or project. They are working objectives in the sense that they may be redefined and changed along the process.
We can tackle many more problems by identifying the correct point at which to enter into action.
This is a very specific way of understanding how to make the most of the resources; they have to touch as many problems as they can.
This is why it is important to try to understand the cause and effect hierarchy of problems and therefore see at what point we can introduce the issue of gender and where it is most appropriate.

And this is why **we need to identify an entry strategy (ES)**. An ES is a very simple, prioritised and tactical set of actions designed to expand the room for manoeuvre at a particular socio-economic junction or point, to overcome any constraints which may block or subvert our interventions or to utilise the assets which may provide a resource or an opportunity to promote our intervention.

Why do we need an entry strategy? Why can't we just go and do what we want to do? We should always keep in mind that because gender relations represent a set of "power relations", they often resist change. Because they have become like an institutionalised practice within society they are not easy to change: they resist change. This is the case with FGM/C.
Therefore bringing about change is not a straightforward process. We need to prepare the ground for change. And this is exactly what entry strategies are trying to do. They are trying to create conditions to move forward for change.

How do we think about trying to create those conditions? Well, at the heart of developing entry strategies, **we have to understand the room for manoeuvre**, that means identifying what is possible and what is not possible to do. Why should we go on doing something that we know is going to fail? Maybe we need to prepare some ground now and then we will be able to succeed later. If we try to do it too soon we may fail, and that will be a disaster. In other words, in every situation there is room for manoeuvre. What we need to do is to expand that room for manoeuvre… Rather than dealing with a situation where the room for manoeuvre is perhaps restricting what we are doing, we are trying to find a way to keep an opening so that we can act.

In order to identify the room for manoeuvre, first we have to understand **which constraints exist**. What stops us achieving our working objectives? We also need to understand **what are the assets** and by assets we do not mean just resources, but also opportunities for opening. If we can identify the constraints and assets that are acting on a particular WO, we may actually decide: hang on a second, it is not a good WO, it is too soon, let's try something new, something different. We may redefine our WO.

For instance we may decide that in order to do a proper programme/project preparation what we need is some kind of disaggregated statistics. This is even before we

design a programme/project. It may even affect how the project is identified. Our WO will be to prepare documentation and also prepare an entry strategy for how and who should do it with what kind of qualification, and, what kind of report we are trying to prepare. By doing that perhaps we just widen our room for manoeuvre because we have more information than we had before and then move onto the next step.

It is important that once we start talking about entry strategies, we also need to start talking about **monitoring**. Once we start, we have to follow up what is happening and we actually achieve what we want.
Ultimately we may be involved in some kind of impact assessment in the longer term. Keeping in mind that at various points we are going to find that we want to change our WOs, find new entry strategies, and then we have three or four WO operating at the same time, in order to keep expanding the room for manoeuvre.

We may also find that even before we implement any kind of project, what we need to do is to start a process of what is called **Organisational Development** (OD). It is very hard to introduce a programme or a project which has a completely new perspective into an organisation which is operating from an old perspective. For example, training may be an ES to develop the organisational capacity to cope with properly developing and implementing gender aware policies, programmes and projects.

Finally we might really the point where we can actually identify a number of policies, programmes and projects which are really gender conscious. But generally there are an awful lot of steps before we get to the point where we actually have gender aware policies, programmes and projects. These are on-going processes. They are not complete steps. If we want to impose upon the cycle of a particular organisation, we can probably do that, but need to be aware of the problems we could possibly face.

In other words, we might find that **during the identification stage we have to do both analysis and gender consultation**. We may find in the preparative stage that we have to talk about gender analysis. Maybe we also need to start developing organisationally to cope with appropriate preparation of policy, programmes and projects. We may need to put a number of ES into action to achieve this as well. The preparation stage may take a number of months and therefore may need a number of ES to push it along, in a particular way. So our process starts to take on all the different elements that may be necessary at different points of the project cycle.

MODULE 5

BUILDING BLOCKS FOR PROGRAMMING

Module objective

- To identify interventions or activities in development programs for the abandonment of the FGM/C
- To understand the importance of community participation in programs against FGM/C
- To identify tools to monitor and evaluate programs

Why this module?

Legislation can play an important role in the fight against FGM/C, but it is not the only one. The most important role and tool is program or/and projects which involve beneficiaries and targets groups in the whole process of intervention: from identification to all the implementation phases.
The NGO within the community has to establish dialogue with and among the various groups and identify their own local solutions. The importance of participation is to consider the community as a whole in which different groups, composed of different persons with different roles, live. In fact is very important not to forget that there is a wide range of actors and external contingency factors which play an important role in the decision making process in ending FGM/C.
This module puts in evidence the tools that can help to identity and elaborate useful project against the practice and the arrangement of a clear plan for assessing project impact.

Activities

Activity 1: Women's empowerment and community consensus inputs
Activity 2: Can the law be used to stop/prevent FGM/C?
Activity 3: Indicators for monitoring and evaluation
Activity 4: Mainstreaming FGM/C prevention: develop your program

Total time: 11 hours

Activity 1

WOMEN'S EMPOWERMENT AND COMMUNITY CONSENSUS INPUTS

Time: 2 hours

Why do this activity?

In the previous sections we have established the link between women's empowerment and development practice. We have also discussed the different meanings of the term empowerment and how these impacted on development thinking and practice. Increasingly, women's empowerment is perceived not only as a legitimate end result for development inputs, but also as the most effective way to achieve sustainable development.
At the same time, we have understood that FGM/C lays at the heart of the subordinate role of women, as women are perceived as not able to control themselves in particular in the area of sexuality and therefore do not respond to men's requests and gender role models, hence need "normalisation" that comes with the whole socialization process of girls and women, and goes as far as cutting off a part of their healthy body. Empowerment of women comes therefore with the abandonment of FGM/C, as much as the abandonment of FGM/C comes with the empowerment of women. For both to happen, the community around the target group needs to approve and consent to this major change in behaviour.
To facilitate this process, specific inputs need to be included in the development of programs and projects where FGM/C prevention will be mainstreamed. This activity is aimed at identifying specific women's empowerment activities to be included in development projects, as well as the activities that can be introduced to build the consensus of the community towards women's empowerment, thus renewing gender roles and power dynamics within the society, always bearing in mind that the specific local conditions will determine which ones are more appropriate and may lead to additional ones.

Objectives

· To identify interventions that organizations can include in either already existing development programs or in new ones to be designed.

How to do the activity

Step 1: 15 minutes

Plenary

Handout

Distribute Handout 1 “The relation between FGM/C, social change and women’s empowerment” and go through the four hypothesis with participants:

Hypothesis 1
- Women use FGM/C as a power-gaining tool.
- They forego their sexual organs in exchange for social acceptability, material survival (marriage) and other freedoms such as mobility, choice and education.
- Therefore women protect and practice FGM/C.

Hypothesis 2
- By changing women’s consciousness, material conditions and decision-making ability, we shift their power base away from the need for FGM/C.

Hypothesis 3
- Shifting women’s power base will be ineffective (and maybe detrimental) unless community support and consensus are built around them.

Hypothesis 4
- Behavioural and social change is a cumulative non-linear process.
- To catalyse and sustain it requires supportive inputs over the longer term (laws, policies, investment in education, etc).

Remind participants of the power dynamics that have been explored during previous activities, in particular of the fact that women in the majority of societies in the world do not have access to and control over the resources that lead to power, and very often other social actors take decisions for them, including their husbands, the elders in their families, ultimately the elders in the community, etc. If FGM/C facilitates their affiliation to those “power structures”, they can hardly abandon the practice without the feeling of putting their daughters at risk of not accessing any form of participation to power and decision-making.

Step 2: 45 minutes

Video screening

Invite participants to watch the video “**Fatoumata’s Story”**. Give a short introduction:

It is the story of a woman in an African country, who has undergone a painful FGM/C ceremony. Later on she learns that the problems she experienced in her reproductive life are caused by her circumcision, and wants to spare her daughter the same destiny. In front of the growing pressure the relatives put on her, she finds a way to bring this issue up within the community and an alternative solution.

After the video screening, refer back to the considerations about power and empowerment, and invite participants to share their opinions on

"Fatoumata's Story" according to the different power dynamics and in particular around the dichotomy

FGM/C as a power gaining tool vs. empowerment as a means to overcome FGM/C

using the following questions to guide a discussion:

Note to facilitator

Questions for discussion

1. Who really takes the decision around FGM/C in the end?

2. Which steps are needed to bring about a change?

3. Is individual consciousness about the harm of the practice enough for the abandonment of the practice?

4. Which forms of power were addressed in order to abandon FGM/C?

5. In which stage of behavioural change/social change were the different members of the community?

6. Which forms of empowerment need to be in place in order to abandon the practice?

7. How did Fatoumata build the consensus of the community around the abandonment of the practice?

Remind participants that the rate of adoption of an innovation depends on the **characteristics of the innovation**, as perceived by the audience:

- relative advantage (what is in it for me?)
- compatibility with existing values and practices (thus not disrupting social fabric)
- simplicity and ease of use (e.g.: mobile phones)
- whether it has been previously tried/adopted by others (innovators, early adopters)
- observable results (abandoning the practice to avoid damage to the family', girls', women's lives).

This is very important for development planners because it has direct consequences on how the abandonment of the practice is presented to communities.

Step 3: 30 minutes

Buzzing

Introduce the exercise with the following considerations:

Note to facilitator

Experience gained over the years has lead to the four hypothesis presented in the previous overhead: only by changing women's consciousness, material conditions (access and control over resources) and decision-making ability, we shift the power base and female social identity away from the need for FGM/C. But changing women's consciousness will prove ineffective, will only lead to frustration and may even be detrimental, eliciting violent reactions by partners/families/communities, unless there is community consensus and support for women's empowerment and the abandonment of FGM/C.

In order to involve the community, it is important to address its **priority development concerns**, as FGM/C abandonment is otherwise perceived as a treat to community cultural values and traditions, an un-requested interference with social mechanisms and family relationships, including economic exchanges such as the bride price, or at least as an irrelevant development issue, as it is considered a "women's issue" and women are given only very little value in society, and this value is linked to what FGM/C is there for, namely marriage and legal childbearing.

Divide participants in pairs, inviting each participant to work with his/her neighbour, and distribute a copy of Handout 2 with the "Instruction for the exercise" to each.

Distribute a set of paper sheets in 3 different colours:

Colour 1: activities addressing overall development issues/priorities of the community
Colour 2: activities addressing women's empowerment without FGM/C
Colour 3: activities to build community consensus around women's empowerment without FGM/C

Invite participants to:

a) choose a community where the intervention will take place

b) give a short description of the community and **identify one priority development issue** (such as sanitation, healthcare, subsistence agriculture, child labour, HIV/AIDS, maternal mortality etc.)

c) **select 3 priority target groups** to work with in that community in order to mainstream FGM/C abandonment in a development program/project that will address the priority development problem identified.
Choose and define each target group **according to their stage in behavioural change/characteristics as adopters** (are they innovators, early adopters… or resistors?), within the community as this is the basis for gender and situational analysis, which in turn offers the basis for defining which working objectives, room for manoeuvre, entry strategy and project inputs should be considered.

d) for each target group write at least three activities on the appropriate coloured sheet of paper, so that they can be identified as:

1. activities addressing the development problem in general,

2. activities aimed at women's empowerment and the abandonment of FGM/C

3. activities to build the consensus of the community towards this new behaviour: no FGM/C practice and women actively involved in decision-making and other public activities, including development activities.

Step 4: 30 minutes

Reconvene the plenary and invite each couple to share with the group:

- brief description of the community they will work in, including the development problem they have identified as a priority for the community
- the target groups they have selected to address this problem

while leading to women's empowerment and to the abandonment of FGM/C
- the three activities for each target group they have foreseen.

It will become evident that the same type of activities are needed to address different target groups, and different needs in the community, and also that women's empowerment inputs will address overall development issues, if they are meant to fulfil women's **strategic gender needs**.

White the paris present their activities, invite considerations from the rest of the group.

Note to facilitator

Examples of activities that participants may propose include:

- Income-generating activities.
- Sexual and reproductive health services.
- Sexual and reproductive health information.
- Basic health services.
- Irrigation systems.
- Food processing/preservation plants.
- Revolving funds.
- Increased entrepreneurial skills.
- Vocational training.
- Building women's groups/cooperatives.
- Access to education.
- Providing safe spaces and places for women.
- Counselling and advice.
- Sports (youths activities)
- Women's support groups.
- Advocacy.
- Meetings with community leaders/decision makers.

Give participants a few moments to go through the list, then start a plenary discussion reminding them of the "practical gender needs" and "strategic gender needs" concepts that they have been introduced to earlier.

Practical gender needs (PGN) are the needs of men and women by virtue of their position within the gender division of labour in a given society. It is usually a response to an immediate need. For example in a rural society to have water near the household is a PGN for women, which is part of their responsibility within the gender division of labour. If we look at health, having access to family planning is a PGN for women. PGNs are aimed at actions which make the performance of existing gender roles more efficient.

Strategic gender needs (SGN), on the contrary, are derived by the subordinate position of women with respect to men. They reflect an alternative for a more equitable division of labour.

Concluding remarks

Participants invariably see the link between the **practical gender needs** (needs of men and women by virtue of their position within the gender division of labour in a given society) and **strategic gender needs**, derived from the subordinate position of women with respect to men. They will be able to establish how responding to practical needs affect women's capacities and abilities to achieve their strategic needs and vice versa.

Activities suggested by participants to reach the community consensus might already have pointed out the importance of **community dialogue and participation**, a process that should be an intrinsic path towards the whole implementation of the program/project. To go over some possible mechanisms to access the community and promote its **participation and consensus** around project's activities, distribute Handout 4 and 5.

Materials:

- Flipchart
- Felt-tip pens
- Paper sheets in 3 different colours
- Overhead projector
- Overhead
- Video "Fatoumata Story"
- LCD project
- Laptop computer
- Handouts for all participants

Handouts:

- Handout 1: "The relation between FGM/C, social change and women's empowerment"
- Handout 2: "Instructions for exercise"
- Handout 3: "The relation between FGM/C, social change and women's empowerment"
- Handout 4: "Approaches to reach different segments"
- Handout 5: "Mechanisms to access community and promote participation"

THE RELATION BETWEEN FGM/C, SOCIAL CHANGE AND WOMEN'S EMPOWERMENT

Hypothesis 1

- Women use FGM/C as a power-gaining tool.
  They forego their sexual organs in exchange for social acceptability, material survival (marriage) and other freedoms such as mobility, choice and education.
- Therefore women protect and practice FGM/C.

Hypothesis 2

- By changing women's consciousness, material conditions and decision-making ability, we shift their power base away from the need for FGM/C.

Hypothesis 3

- Shifting women's power base will be ineffective (and maybe detrimental) unless community support and consensus is built around them.

Hypothesis 4

- Behavioural and social change is a cumulative non-linear process
- To catalyse and sustain it requires supportive inputs over the longer term (laws, policies, investment in education, etc).

Source: Toubia, Nahid, "Legislation as a tool for behavioural change", in *Stop FGM*, Proceedings of the Expert consultation on "Legal tools for the prevention of female genital mutilation", Cairo 21-23 June 2003, AIDOS-NPWJ, Rome, 2003.

INSTRUCTIONS FOR THE EXERCISE

a) Choose a community where the intervention will take place

b) Give a short description of the community and **identify one priority development issue** (such as sanitation, healthcare, subsistence agriculture, child labour, HIV/AIDS, maternal mortality etc.)

c) **Select 3 priority target groups** to work with in that community in order to mainstream FGM/C abandonment in a development program/project that will address the priority development problem identified.

Briefly describe the target groups **according to their stage in behavioural change/characteristics as adopters** (are they innovators, early adopters… or resistors?)

d) For each target group describe three project activities using the differently coloured sheets of paper as follows:

Colour 1: activities addressing overall development issues/priorities of the community

Colour 2: activities addressing women's empowerment without FGM/C

Colour 3: activities to build community consensus around women's empowerment without FGM/C

WHY EMPOWERMENT OF WOMEN MAY STOP FGM/C

- Women use FGM/C as a power gaining tool.
- By changing women's consciousness, material conditions and decision making ability, we shift their power base and female social identity away from the need for FGM/C
- Changing women's consciousness will prove ineffective, and may be even detrimental, unless there is community support and consensus.
- Behavioural and social change is a cumulative non-linear processes. To catalyse and sustain it requires supportive inputs at the institutional level of society (laws, policy, education etc).

Approaches to Reach Different Segments

The segment	The approach to reach the segment
Innovators lead the way for others. They have already personally adopted the new behaviour.	• Media sources. • Directly involve innovators in the design of the programme through Participatory Planning. • Recruit and train the innovators as peer educators (promoters.)
Early Adopters are open to new ideas that provide personal benefit. They are fashion setters, may have big egos and need a lot of personal support.	• Inter-personal contact. • Addressing concerns. • Step-by-step guidance to experiment with the idea. • Strong face-to-face support with a limited number of early adapters to try out the practice. • Reward the participants' ego through media coverage. • Maintain strong relationship with this group through regular feedback.
Early majority will only act when they get adequate proof of benefits. They are pragmatists, will accept simple, proven new ideas. They will adopt when there is minimum discontinuity with the lifestyle they are used to.	• Media stories featuring endorsements from credible individuals, opinion makers. • Provide one-to-one support discussing concerns, and consequences.
Late Majority do not like taking risks, or new ideas, but also do not want to be left behind, hence will follow the mainstream and the established standard. They can also be influenced by the sceptics.	• Refine your new idea to increase convenience and reduce untoward consequences. • Respond to the criticism from sceptics.
Laggards/ Late Adopters will block progressive change. Take their arguments seriously, as they often identify real problems that need to be solved before the majority segment can accept the innovation.	• Actively enforce regulations • Publicise prosecutions

MECHANISMS TO ACCESS COMMUNITY / PROMOTE PARTICIPATION

Participatory assessment: Experience from projects show that one of the best points into a community is during the assessment phase, whereby a joint assessment conducted by the community creates a sense of trust, and more opportunity for contact with its activities and staff.

Creating awareness of the issue through use of catalysts: A catalyst could be a person or group of people highly interested in the subject. Catalysts serve to alleviate suspicion and mistrust about the project, and through one-to-one contact answer questions.

Examples of catalysts:

Change Agents
• those who have experienced the effects of the problem and want to be involved in finding an appropriate solution
• those who have found their own way to deal with the practice: 'the positive deviants'

Mass Media
• mass rally
• a captivating radio programme
• theatre

Formal sessions at which people's views are sought: Once confidence and mutual trust have been established, a context specific trigger is usually needed to initiate community dialogue on the topic of discussion. A core group then maintains dialogue within the community.

***Identification and development of core groups*:** Once the topic is brought into the discussion agenda of the community, the project is ready to develop a 'core group'. A core group is a group of individuals who will lead the effort on behalf of the community and who are interested in participating in the programme. This encourages greater participation, as well as providing a good entry point into the community.

Power of a group
The Core group meets regularly to discuss the issue and thereby keeps the topic on the agenda.
Collective action builds the women and girls' confidence that they are not alone in resisting FGM/C.
Being part of a support group reduces stress and social ostracisation for those wanting to give up circumcision.
Working in a group strengthens the capacity to address or advocate change.
Provides sense of ownership.
Communication capacity is introduced and built, helping women to use their voices.

Activity 2

CAN THE LAW BE USED TO STOP/PREVENT FGM/C?

Time: 1 hour and 50 minutes

Why do this activity?

The work of NGOs is at the heart of social change and can support the adoption and enforcement of legal measures to prevent FGM/C.

Very often, national-level debates over the role of the law in stopping FGM/C focus on government powers to control the behaviour of people living within its jurisdiction. It is assumed that laws addressing FGM/C will be criminal laws, and that the actors charged with enforcing those laws will be police officers. It is this sort of assumption that often creates uncertainty about whether law is an appropriate response to a practice as deeply ingrained and socially accepted as FGM/C. Where FGM/C is practiced by a majority, it is feared that criminalization of FGM/C will simply drive the practice underground. Where it is primarily minority groups that practice FGM/C, there is concern that criminalizing the practice will only further marginalize a potentially vulnerable community.
While use of criminal law need not have either of these undesirable effects, it is important to remember that criminalization is only one tool that governments have at their disposal. A legal approach to FGM/C can potentially engage a variety of actors, who can play a role in preventing the practice and changing attitudes and behaviours. Many of those actors might not have considered how they are in a position to implement legal and policy measures to stop FGM/C. In fact, NGOs and different national and local institutions can play a key role.

Objectives

- To identify ways in which participants can play a role in implementing and enforcing legal measures to stop FGM/C.
- To understand that laws can do much more than punish: they can also empower women and prevent FGM/C.

How to do the activity

Step 1: 15 minutes

Introduce the legal framework of the Country that can be used to prevent FGM/C and distribute Handout 1 “Tasks for work in small groups on the use of law to prevent FGM/C”

Tasks for work in small groups on the use of law to prevent FGM/C

A) Answer the following questions to describe the national legal framework in which actions to promote the abandonment of FGM/C will eventually be situated:

1. Has Kenya ratified the….

CEDAW – Convention for the Elimination of Discrimination Against Women?	YES
CRC – Children’s Rights Convention?	YES
ICCPR – International Covenant on Civil and Political Rights?	YES
ICESCR – International Covenant on Economic, Social and Cultural Rights?	YES
African Charter on Human and Peoples Rights?	YES
African Charter on the Rights of the Child	YES
Maputo Protocol on the Rights of Women?	YES

2. Does Kenya have a constitutional provision ensuring women’s equal rights?
3. Does the constitution say anything more explicit about FGM/C?
4. Does a national reproductive health law condemn FGM/C?
5. Is there a criminal law (included in the Penal Code) prohibiting FGM/C?
6. If yes, has this law been enforced?
7. Is there a criminal law (or Penal Code) prohibiting assault or abuse of minors?
8. Is there a criminal law (or Penal Code) prohibiting violence against women?
9. Has any judge ever issued an order preventing a girl from undergoing FGM/C or requiring an FGM/C practitioner to pay compensation to a girl or woman upon whom FGM/C was performed?
10. Are medical providers prohibited from performing FGM/C by specific regulations?
11. Are there other child protection laws that allow the state authorities to intervene to prevent FGM/C?

B) Then, given the legal situation above, explain what kind of actions/programs/activities would you – as a development NGO aiming at the abandonment of FGM/C – design concerning legal measures.

Note to facilitator

Step 2: 45 minutes

Small group role play

Divide participants into small groups of up to 5 people. Each person in the group will have to play one of the following roles

1. Representative of the **legal community**: a judge, a lawyer, a public official responsible for law enforcement (police officer or other)
2. Representative of the **health care community**: a doctor, a nurse, a public health official
3. Representative of the **institutional/political community**: a public official working in an interested ministry (such as Ministry for Women, or Social Affairs, Health etc.), a member of parliament, a community leader
4. Representative of **civil society organizations**: women's empowerment advocate, NGO or CBO leader, village women's association representative
5. A **woman** or a **man** who wants to prevent FGM/C being performed on his/her daughter.

Distribute Handout 2 How to use the law to prevent FGM/C. Task for the working group discussion.

Each small group will act within the legal framework of the country as presented answering questions in step 1:

- there is / is not a constitutional provision ensuring women's equal rights or addressing FGM/C,
- there is / is not a reproductive health law condemning FGM/C,
- there is / is not a criminal law prohibiting FGM/C,
- there is / is not a criminal law prohibiting assault or abuse of minors,
- there is / is not a specific regulation prohibiting performance of FGM/C by healthcare professionals,
- are there other measures that can be used?

Each participant will
- put him/herself in the chosen role
- based upon the legal framework decided by the group, express how he/she would best use the existing measures to prevent FGM/C
- involve the other role players to design the most efficient strategy to use the existing legal framework to prevent FGM/C

Each group chooses a rapporteur to report back to the plenary.

Step 3: 45 minutes

Plenary

Reconvene the group. On a flip chart have columns for each category of professionals and have each group report briefly on the type of roles their members have played and would like to play in using the law to prevent FGM/C.
Invite participants to share their professional experiences with FGM/C and discuss questions they have had about the law, their legal obligations and the way they would like to use the law to prevent FGM/C.

Points that might come out in discussion

In Kenya the law prohibits FGM/C to be perfomed on girls below 18 year of age.

1. In this case

Category	How can its members use the law to prevent FGM/C
Legal community	**Judge**: apply the law, issue order for arrest, and prosecute. Lawyer: represent girls who want to escape the practice. Raise awareness. **Police**: law enforcement, but needs to be sensitized.
Health care community	**Health care providers** might establish a Code of Conduct and a Supervisory body for preventing members of the medical community from performing FGM/C. They might also raise questions about the duty to report cases of FGM/C. Sensitize patients about FGM/C and existing laws. Become role model. Keep records of FGM/C related medical consequences to be used as evidence for law enforcement.
Institutional/political community	**Government representatives** should spread information about existence and functioning of the law, train and sensitize local authorities, allocate budget for FGM/C prevention campaigns. **Parliamentarians** should ensure that resources are allocated to prevention campaigns. Become role model for the abandonment of FGM/C. Sensitize their constituencies. **Local/community leaders** should sensitize population about existence/use of the law.
Civil society organisations	Inform/sensitize communities about existence of the law. Train people in using the law. Support victims. Educate youth. **Women's rights organizations** might talk about informing women of their rights under the law and strengthen women's capacities to use the law. Work with the **media** to inform about the law.
Women/Men who want to prevent FGM/C on their daughter(s).	Seek help from lawyers. Seek assistance from NGOs or other organisations to support costs of legal action, as well as to sensitize their community about the law prohibiting FGM/C and thus facilitate their decision.

Note to facilitator

2. As FGM/C is only prohibited in Kenya before age 18 there is room for a broader legal protection	
Category	**What can its members do to expand legal protection against FGM/C**
Legal community	**Judge**: apply existing laws, issue arrest warrants and protect orders and prosecute to show how efficient the law is. **Lawyer**: represent girls who want to escape the practice. Raise awareness. **Police**: law enforcement, but needs to be sensitized.
Health care community	Also in absence of specific laws prohibiting FGM/C **health care providers** might establish a Code of Conduct and a Supervisory body for preventing members of the medical community from performing FGM/C. Sensitize patients about FGM/C and its consequences on health. Become role models. Keep records of FGM/C related medical consequences.
Institutional/political community	**Government representative**, in particular government officials from women's rights ministries, may lobby for a law extending prohibition of FGM/C after 18 years of age. Parliamentarians should draft and approve legal measures to prevent FGM/C. Become a champion for the abandonment of FGM/C. Sensitize their constituencies. **Local/community leaders** can advocate for the adoption of legal measures, inform population about FGM/C and raise awareness.
Civil society organisations	Discuss among **communities** about possible benefits of a law. Promote other actions to prevent FGM/C. Sensitize communities. Work with the **media** to advocate for adoption of a law. Lobby parliamentarians. Inform about human rights and other existing laws. Problem of funding needs to be addressed.
Women/Men who want to prevent FGM/C on their daughter(s).	Seek assistance from NGOs or other organisations already working for the prevention of FGM/C to sensitize their community about the practice, promoting change in behaviour. Seek help from health care providers.

Step 4: 5 minutes

Distribute Handout 2 “Cairo Declaration on legal tools for preventing FGM/C” as additional reading.

The representatives of twenty-eight African and Arab countries affected by the practice of Female Genital Mutilation, of international and non-governmental organisations, and experts on FGM, met in Cairo from the 21st to the 23rd of June 2003 for the Afro-Arab Expert Consultation on “Legal Tools for the Prevention of Female Genital Mutilation” on the invitation of AIDOS - Italian Association for Women in Development - No Peace Without Justice, the Egyptian National Council for Childhood and Motherhood, and the Egyptian Society for the Prevention of Harmful Practices to Woman and Child, under the Auspices of H.E. Mrs Suzanne Mubarak, First Lady of Egypt, organized within the framework of the “STOP FGM Campaign” supported by the European Commission.
The Declaration was the result of the different working groups speakers’ contributions and the most valuable technical contribution by CRR - Centre for Reproductive Rights - and RAINBO - Research, Action and Information for the Bodily Integrity of Women - which made the successful outcome of the Consultation possible.

Note to facilitator

Materials:

- Flip chart.
- Felt-tip pens.
- Handout for each working group.

Handouts:

- Handout 1: How to use the law to prevent FGM/C. Tasks for the working group discussion
- Handout 2: Cairo Declaration on Legal Tools for Preventing FGM/C

Reading:

- CRLP (Centre for Reproductive Law and Policy, now CRR, Centre for Reproductive Rights), *Women of the World: Laws and Policies Affecting Their Reproductive Lives*. Anglophone Africa, New York, 1997 and Francophone Africa, New York, 2000

TASKS FOR WORK IN SMALL GROUPS ON THE USE OF LAW TO PREVENT FGM/C

A) Answer the following questions to describe the national legal framework in which actions to promote the abandonment of FGM/C will eventually be situated:

1. Has Kenya ratified the….

CEDAW – Convention for the Elimination of Discrimination Against Women?	YES NO
CRC – Children's Rights Convention?	YES NO
ICCPR – International Covenant on Civil and Political Rights?	YES NO
ICESCR – International Covenant on Economic, Social and Cultural Rights?	YES NO
African Charter on Human and Peoples Rights?	YES NO
African Charter on the Rights of the Child	YES NO
Maputo Protocol on the Rights of Women?	YES NO

2. Does Kenya have a constitutional provision ensuring women's equal rights?

3. Does the constitution say anything more explicit about FGM/C?

4. Does a national reproductive health law condemn FGM/C?

5. Is there a criminal law (included in the Penal Code) prohibiting FGM/C?

6. If yes, has this law been enforced?

7. Is there a criminal law (or Penal Code) prohibiting assault or abuse of minors?

8. Is there a criminal law (or Penal Code) prohibiting violence against women?

9. Has any judge ever issued an order preventing a girl from undergoing FGM/C or requiring an FGM/C practitioner to pay compensation to a girl or woman upon whom FGM/C was performed?

10. Are medical providers prohibited from performing FGM/C by specific regulations?

11. Are there other child protection laws that allow the state authorities to intervene to prevent FGM/C?

B) Then, given the legal situation above, explain what kind of actions/programs/activities would you – as a development NGO aiming at the abandonment of FGM/C – design concerning legal measures.

HOW TO USE THE LAW TO PREVENT FGM/C

Tasks for working group discussion

Each participant chooses a role from the following five categories:

1. Representative of the **legal community**: a judge, a lawyer, a public official responsible for law enforcement (police officer or other)
2. Representative of the **health care community**: a doctor, a nurse, a public health official
3. Representative of the **institutional/political community**: a public official working in an interested ministry (such as Ministry for Women, or Social Affairs, Health etc.), a member of parliament, a community leader
4. Representative of **civil society organizations**: women's empowerment advocate, NGO or CBO leader, village women's association representative
5. A **woman or a man** who wants to prevent FGM/C to be performed on her/his daughter.

Each small group will act within the legal framework of the Country as presented answering questions in Step 1:

- there is / is not a constitutional provision ensuring women's equal rights or addressing FGM/C,
- there is / is not a reproductive health law condemning FGM/C,
- there is / is not a criminal law prohibiting FGM/C,
- there is / is not a criminal law prohibiting assault or abuse of minors,
- there is / is not a specific regulation prohibiting performance of FGM/C by health-care professionals,
- are there other measures that can be used?

Each participant will
- put him/herself in the chosen role
- based upon the legal framework decided by the group, express how he/she would best use the existing measures to prevent FGM/C
- involve the other role players to design the most efficient strategy to use the existing legal framework to prevent FGM/C

Each group chooses a rapporteur to report back to the plenary.

Afro-Arab Expert Consultation on
"Legal Tools for the Prevention of Female Genital Mutilation"
Cairo, 21-23 June 2003

CAIRO DECLARATION ON LEGAL TOOLS TO PREVENT FGM/C

WE, the participants in the Afro-Arab Expert Consultation on "Legal Tools for the Prevention of Female Genital Mutilation"

Call upon governments to promote, protect and ensure the human rights of women and children in accordance with the obligations undertaken by them as state parties or signatories to:

- the African Charter on the Rights and Welfare of the Child,
- the African Charter on Human and People's Rights;
- the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW);
- the Convention on the Rights of the Child;
- the Cairo Programme of Action agreed to at the International Conference on Population and Development; and
- the Beijing Declaration and Platform for Action agreed to at the Fourth World Conference on Women.

Believe that the prevention and the abandonment of FGM/C can be achieved only through a comprehensive approach promoting behaviour change, and using legislative measures as a pivotal tool;

Launch the Cairo Declaration, appealing to Heads of State, governments, parliaments and responsible authorities in concerned countries, as well as international organisations and non-governmental organisations, to endorse the following recommendations in their legislation, social and health policies, aid programmes, bilateral and multilateral cooperation initiatives.

WE, the participants in the Afro-Arab Expert Consultation on "Legal Tools for the Prevention of Female Genital Mutilation"

Recommend that:

1. Governments, in consultation with civil society, should adopt specific legislation addressing FGM/C in order to affirm their commitment to stopping the practice and to ensure women's and girl's human rights. Where politically feasible, a prohibition on FGM/C should be integrated into broader legislation addressing other issues, such as:

- gender equality;
- protection from all forms of violence against women and children;
- women's reproductive health and rights; and
- children's rights.

2. The use of law should be one component of a multi-disciplinary approach to stopping the practice of FGM/C. Depending on the national context, outreach efforts by civil society and governments aimed at changing perceptions and attitudes regarding FGM/C should precede or accompany legislation on FGM/C. These activities should reach as many members of the public as possible and should include the participation of both elected officials and other government actors and members of civil society, including advocates, religious leaders, traditional leaders, medical providers, teachers, youth, social workers, and the all forms of media including electronic media. In particular, men must be targets of outreach, as well as family members, including grandmothers, mothers-in-law, etc. Means of outreach should take as many forms as available in each country, including community gatherings, media (radio, theatre) and other creative means of communication.

3. The work of NGOs is at the heart of social change. NGOs and government should work together to support an ongoing process of social change leading to the adoption of legislation against FGM/C. A long-term, multi-strategy approach shaping attitudes and perceptions about women's status and human rights should lead in the long-run to the criminalization of FGM/C. Governments and international donors should provide financial resources to empower national NGOs in their struggle to stop FGM/C. In addition, governments must ensure that national NGOs are able to pursue their activities freely.

4. The legal definition of FGM/C, which should encompass all forms of FGM/C, should be formulated by national legislatures on the basis of the World Health Organization definition and in consultation with civil society, including the medical community. However, depending on the national context, it may be desirable to provide for a period of sensitization to precede enforcement of the prohibition as it applies to parents and family members.

5. Governments should formulate time-bound objectives, strategies, plans of action, and programmes, backed by adequate national resources, whereby FGM/C laws will be enforced, taking into account that legislation condemning FGM/C has a moral force and an educational impact that could dissuade many individuals from submitting girls to the practice.

6. If existing criminal sanctions are enforced in the absence of specific legislation on FGM/C, governments should work with civil society to undertake a major information campaign to ensure that all members of society, particularly those who practice FGM/C, are aware that the existing law will be enforced.

7. In adopting a law, religious leaders, civil society organizations, including women's and community-based organizations, and health care providers, among others, should be part of the consultative process. Efforts to end FGM/C must be focused on empowering women to make choices impacting their health and lives.

8. Religious leaders should be sensitized to the negative impact of FGM/C on women's reproductive and sexual health. Religious leaders who support ending FGM/C should be incorporated into outreach strategies.

9. Once legislation prohibiting FGM/C has been adopted, whoever performs FGM/C, including health professionals and traditional circumcisers, should be put on immediate notice that performing FGM/C gives rise to legal and professional sanctions.

10. Licensed medical practitioners should be subject to the maximum available criminal penalties. Professional associations should adopt clear standards condemning the practice of FGM/C and apply strict sanctions to practitioners who violate those standards. Practitioners may be suspended or lose their licenses to practice. In addition, they should face civil liability for malpractice or unauthorized practice of medicine. Appropriate ethical guidelines against FGM/C should be incorporated into medical education and training curricula.

11. Provided sufficient outreach and sensitization has taken place, members of the community with knowledge of cases of FGM/C should be held criminally liable for failure to report such cases. Special measures are needed to protect those who come forward to report a case. Governments should consider alternative methods of monitoring prevalence and effects of FGM/C, for example, through gathering statistics from health care centers. Law enforcement officials should be trained to respond to cases of FGM/C (including cases that may still be prevented) in a manner that meets the needs of girls and women affected by the practice.

12. Women and girls should be empowered to access legal remedies specified by law to prevent FGM/C. In particular, women and girls who are victims or potential victims of FGM/C have the right to bring a civil action to seek compensation from practitioners or to protect themselves from undergoing FGM/C. Resources, such as information on legal rights, legal assistance, and social services and support for girls who may face negative repercussions from their families and communities, should be provided to women and girls. Medical professionals should assist by providing evidence supporting the claim of the girl or woman who has undergone FGM/C. The deterrent effect on practitioners of possible civil actions against them involving monetary damages may be significant.

13. The age of a girl or woman or her consent to undergoing FGM/C should not, under any conditions, affect the criminality of the act.

14. During periods of armed conflict, both governments and international donors must sustain activities aimed at ending the practice of FGM/C and other forms of discrimination against women and girls.

15. As agreed at the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995, as well as their subsequent reviews, governments should ensure all women access to the full range of reproductive and sexual health services and information. In addition, reproductive and sexual health information and education, including informa-

tion on the harmful effects of FGM/C, should be incorporated, where appropriate, into school curricula and other community education programs. Women who have undergone FGM/C should have access to the information and special health care they need.

16. In countries where minorities, including migrants, are vulnerable, the adoption of laws against FGM/C should not be used by governments to undermine the full enjoyment of human rights by these minorities. In such contexts, it is particularly important that criminal legislation be part of a broader strategy to provide resources to support community needs and to promote the health and human rights of community members. Members of minority communities, particularly activists working to stop the practice, should be consulted and their views taken into account prior to adoption and enforcement of the law. In some cases, it may be appropriate for legislation targeting FGM/C to make reference to constitutional protections of minority rights.

17. Governments should implement the regional and international conventions that they have ratified protecting the rights of women and children, and comply with their obligations to take action to end practices that harm women and girls, including by adopting legislation prohibiting FGM/C. Implementation measures should include translation of these texts into national languages and outreach programs to ensure broad knowledge of the rights protected. Civil society could promote government accountability under these treaties by using UN treaty monitoring bodies. NGOs can use treaty bodies' Concluding Observations and Recommendations to push for additional government actions. For example, legal mechanisms to intervene on behalf of children who may be subject to FGM/C may currently be inadequate but could be developed.

WE, the participants in the Afro-Arab Expert Consultation on "Legal Tools for the Prevention of Female Genital Mutilation"

Further recommend that:

The Cairo Declaration will be officially presented to the Secretary-General of the United Nations and the presidents of the African Union and the European Union, as well as the Secretary-General of the League of Arab States and the Organisation of Islamic Countries;

Finally,

We agree to hold a follow-up meeting to be convened on the African continent in a year's time, to review progress achieved towards the implementation of the Cairo Declaration.

Cairo, 23rd June 2003

Activity 3

INDICATORS FOR MONITORING AND EVALUATION

Time: 1 hour and 30 minutes

Why do this activity?

Methodology for assessing impact of projects directed at social change is in its infancy. That is also true of projects to stop or abandon FGM/C as in the past little investment has been made in this area. Developing a clear plan for assessing project impact is an essential component of the project itself, as it will contribute to the improvement of the action. In the past the most widely used methodology for impact assessment was that of measuring the knowledge, attitude and practice (KAP) or behaviour (KAB), with the underlying assumption that by providing factual information, usually though Information, Education and Communication (IEC) campaigns, there is a change in the knowledge base that will lead to a change in attitude, that will then translate in a change in practice or behaviour.

KAP/KAB impact assessment relies too heavily on the assumption of exclusively rational basis for human behaviour, not taking into account the more complex psychological and social dynamics that underlay such behaviour. It also assumes that change in knowledge is an automatic guarantee for a change in attitude sufficient to take the risk of changing pratice or behaviour. It does not allow for the fact that change, in particular towards a behaviour or practice that is not yet perceived as a needed and beneficial modification, is not always progressive nor linear, and that other social, economic, cultural or psychological factors must be taken into consideration to facilitate a positive and irreversible change in behaviour.

Finally the KAP/KAB methodology only measures individual behaviour and group or social behaviour is inferred through simple statistical aggregates: it ignores the consensus building, “snow balling” and contagious elements of social change.

In the FGM/C field, evidence is gathering that many communities have acquired the knowledge of the harmful effects of the practice, but have failed to change attitudes and/or behaviours. Lessons learned from HIV research confirm this, in particular when it comes to adopting safe sexual behaviours. “Sexual interaction”, as W. Parker points out, “takes place in a wide range of contexts and along a continuum of consent that extends from willed or conscious engagement in sexual activity to unwilled non-consensual sex, that include the use of coercion and possibly physical violence”. Similarly, the decision-making process around FGM/C involves a wide range of actors and is influenced by a number of external contingency factors.

At the same time large surveys, such as the DHS, Demographic and Health Surveys, administered by Macro International and funded by USAID, and the MICS, Multiple Indicator Cluster Surveys, carried out by UNICEF, both using large samples of the population, have included a questionnaire on

FGM/C, with the aim of measuring, among other aspects, prevalence of FGM/C (the number of women aged 15-49 years who have been submitted to the practice, and the trend towards its possible abandonment (number of women aged 15 to 49 years that have at least one daughter circumcised). Today a comparable set of data is available for a large number of African practicing countries. For some of these, where DHS or MICS have been conducted twice with an average distance between the two surveys of about 5/6 years, it is also possible to understand changes happening over time. In almost all of these countries the opposition to the practice is increasing, in particular among the younger generations. For example, data show that higher educational attainment among women is closely associated in almost all countries with a significant increase in disapproval of the practice. This is particular relevant for programs and projects aimed at the abandonment of the practice, at is cast a light on their possible efficacy or failure.

Objectives

- To understand how to monitor and evaluate activities promoting the abandonment of FGM/C mainstreamed into development programs and projects.
- To identify a set of indicators to measure progress towards the abandonment of the practice.

How to do the activity

Step 1: 30 minutes

Small group discussion

Divide participants into small groups. Distribute Handout 1 with the description of the project “Integrated initiatives for the empowerment of women as a strategy for the abandonment of FGM/C: a community approach in Keiyo district, Kenya” and Handout 2 with the “Instructions of the exercise”

Handout

Ask each group to read the project carefully and then to define a set of indicators to monitor and evaluate the impact of the project. Indicators should be SMART (Specific; Measurable; Available; Relevant; Time-Bound). Indicators should measure:

1. changes in the community, compared on the initial gender/situational analysis
2. stages of behavioural/social change of community members (identify the stage of behaviour the different target groups are in, after project intervention)
3. empowerment of women
4. changes in decision-making power
5. consensus of the community towards abandonment of FGM/C
6. influence of external factors
7. impact of development activities
8. abandonment of FGM/C

Note to facilitator

Remind participants that the Stages of Change Model, with its five stages:

- pre-contemplation
- contemplation
- preparation
- action
- maintenance.

Note that this model illustrates how between the decision to act to stop circumcision and the sustained irreversible behaviour (i.e. circumcision averted) there is a stage of 'maintenance' whereby opposition to the new behaviour and the chance of the decision being over-ruled by others is managed. In other words the 'declaration' by an individual or a family not to circumcise is only the first step in a process that will hopefully lead to irreversible new behaviour. When a family commits to taking the action, further strategic efforts must be put in place to support the maintenance of their decision. The component of building community consensus is therefore as vital as focussing on changing the consciousness of the primary stakeholders, the women.

Step 2: 30 minutes

Plenary

Ask one person to come to the flipchart. Ask each group to share the indicators they have developed for each area, and why they have chosen a particular indicator. Have these listed as soon as contributions from all groups offer additional indicators and reasons.

Note to facilitator

Possible indicators for the proposed project might include:

- girls' school enrolment rates
- number of girls completing education
- number of girls not circumcised in the target area
- increase in marriage age of girls
- girls participating in alternative coming of age ceremony
- number of people participating in the community support group
- number and content of meetings and actions by community support group
- number of families upholding the decision to not circumcise their girls
- number of activities funded by the revolving fund
- number of young men stating to be ready to marry uncircumcised girls/women
- number of mothers changing attitude/opinion towards non circumcised daughters-in-law
- number of other girls/women who ask to be part of the program
- continuity over time of project activities without further economic support by the NGO

…

Then wrap up the discussion based on the following considerations:

The most crucial question in developing evaluation and monitoring indicators is how to define success. The only acceptable success or "outcome indicator" is the irrefutable proof of **irreversible abandonment of the practice in a family or a community, which can only be measured over time.**
Sustained change in behaviour is only seen as a lengthy process involving many individuals and numerous social dynamics following a variety of inputs at individual and community level. Such a process does not have a simple and clear-cut beginning or end, as the age of circumcision may shift, or an intervention may later be reversed.
Consider that decision to abandon FGM/C is not taken by one individual, as in the case with cigarette smoking: it is a decision taken on behalf of a minor that may involve several individuals including father, mother, grandmother, aunts, and potential in-laws.
Successful behavioural change will not result in averting circumcision of girls unless the individual taking this decision wields disproportionate amounts of power or others in the decision-making circle are also converted.

The **publicly declared intent** to abandon the practice is one of such indicators. This can take different shapes: from a public declaration of a whole community coming together, some times with a group of intra-marrying villages, as in Tostan programs implemented in Senegal and more recently in other countries such as Guinea, the Gambia, Burkina Faso, Sudan and Somalia; through an alternative rite of passage; through a public statement and active engagement in a prevention program as a "positive deviant", a.s.o.

In terms of the reliability of a public declaration as a diagnostic indicator of whether a circumcision will remain averted, it could be safely assumed that if a whole family or community announces the decision not to circumcise a daughter there is a higher chance that the decision will be sustained. Such arguments can be applied more strongly to larger social units. If a community is cohesive and makes a joint declaration to stop circumcision there would be wide support for lasting change.

It therefore seems that the validity of public declarations as an indicator of true abandonment of FGM/c and its reliability for projecting sustainable change increases with the size of the unit making the declaration (individual, family, a social group or a whole community). Obviously this will only apply where social units are cohesive enough to reach joint decisions and will only be convincing if there is evidence of genuine debate and discussion around the issue before the declaration is made. It is also likely to be more valid in settings where the social value of 'word of honour' is still upheld.

Step 3: 30 minutes

Lecture and discussion in plenary

In order to gather the information needed to monitor and evaluate project impact several methods are proposed. The facilitator introduces them to participants, soliciting their appreciation and critical views on the topic.

Note to facilitator

1. Community based monitoring and evaluation methodologies

As mentioned earlier the component of building community consensus and support forms a vital element within the WECC framework. Involving the community in monitoring allows for further sustainability of the project, creating a sense of ownership amongst community members. There are different approaches in how to involve the community in a participatory manner. Using participatory approaches and participatory monitoring & evaluation differs from the more conventional approaches to monitoring and evaluation in that it aims to engage key stakeholders more actively in reflecting and assessing the progress of their project and in particular the achievement of results. Over the past years, participatory approaches have gained an increased popularity in the field of development and are being adopted more in developmental programs.

Some Key Principals of Participatory Monitoring and Evaluation, *adapted from CIDA Result-based Participatory Monitoring and Evaluation, 2001,* **include:**

- *'**Participation**' - which means opening up the design of the process to include those most directly affected, and agreeing to analyse data together;*
- *The inclusiveness of PM&E requires '**negotiation**' to reach agreement about what will be monitored or evaluated, how and*

when data will be collected and analysed, what the data actually means, and how findings will be shared, and action taken;
- ***'learning**' which becomes the basis for subsequent improvement, change and action*
- *Since the number, role, and skills of stakeholders, the external environment, and other factors change over time, '**flexibility**' is essential.*
- *The importance of "handing over the stick" and creating the space for **respect** and **participation***
- *Living with the community and **integrating** oneself with the local customs*

There are a wide range of methods and tools that have been developed to carry out participatory monitoring and evaluation. They all seek to compare the situation before and after a particular intervention, or set of events. The following are a few examples:

Visualised analysis - Visualisation techniques provide opportunities for creative reflection because they enable people to represent their own ideas in a way which they can discuss modify and extend. Examples of some of these methods include: participatory mapping; photograph analysis; flow charts; Venn diagrams; daily and activity profiles; pie diagrams.
• **Interviewing and sampling methods** - Examples of such techniques include: semi-structured interviewing; direct observation; focus group discussions; key informants; social maps.
• **Group and team dynamics method** - Examples of such techniques include: team review sessions; interview guides; villager and shared presentations; process notes and diaries.

2. Community Based Monitoring and Evaluation for FGM/C
Using community based monitoring techniques for FGM/C is still at a rudimentary stage. Different Settings for Conducting the Monitoring could be at existing points of services such as:

- Health services (e.g.: women attending ante-natal clinics, family planning clinics or child immunization)
- Education services (e.g.: at primary or elementary schools through the teachers or nurses within the schools).

For all of the above, staff training may be required to notice changes amongst girls at risk, being able to identify and differentiate between the different types, etc and also understanding the social and cultural setting within which they are working. There are ethical and regulatory considerations that need to be clarified in monitoring with special attention to informed consent.

3. Examples of Different techniques for Community Based Monitoring of FGM/C

Following Methods are Issued
3.1. Voluntary Self reporting - Voluntary self reporting, such as parents reporting on the status of their daughters before & after the project intervention. Unfortunately self-reporting brings in issues of validity, reliability and in some cases deception, such as occurred in the longitudinal study of the reproductive health project in Navrongo, Ghana. In Egypt following the Egyptian Demographic and Health Survey in 1995, a comparison of self reporting with clinical findings was performed by the Egyptian Fertility Care Society in 1996, to allow for assessment of self reporting for a sample of 1339 women in eleven clinics, with clinical examinations undertaken by gynaecologists. The findings unveiled a 6% discrepancy between the self-reporting (97%) and the actual clinical findings (93%), which is within

the statistically acceptable variable. In this case self-reporting was closely compatible with clinical findings.

3.2. Observation of Cut status

Observation of cut-status after the project intervention provides an ultimate indicator of whether the girl is cut or not, but it is very hard to measure with there being ethical and rights considerations.
Observation of cut status can be done through routine pelvic examination of gynaecological patients and during ante-natal care and delivery. This method of data gathering is non-invasive but compromises on lack of full representation of the sample.

3.3. Follow up to the publicly declared intent to abandon FGM/C

Developing a monitoring system which will track record the status of families who have declared that they will not circumcise their girls through interviews, routine visits. Such a monitoring method undertaken by the community is currently the **Positive Deviants** approach, decribed below.

3.4. Community Based Monitoring through "CARE" Methodology

As seen above there are different issues which arise in how community based monitoring is conducted. Based on this, we recommend using a **C**reative, **A**ppropriate **R**eliable and **E**thical **(CARE)** method, which might assist in choosing which techniques and tools could be used in a particular setting. As the Publicly Declared Intent (PDI) to abandon the practice is currently the first recommended indicator for assessing impact, it can be integrated within the monitoring systems developed.

Families of girls at-risk tracking: *after 6 months, the focus shifts to the girls at-risk families. The local NGOs, with the Positive Deviant (PD), define the meaning of 'at-risk.' They decide the at-risk age, working on the specific community, and they also do mapping, trace and write-down all the families that have girls, then during the workshop they discuss with each other (local NGO's & PDs) and define & decide what the at-risk age is in the given community. Every positive deviant chooses families which they will be responsible for, for close monitoring. At this stage focus is on the family, there is a kind of* ***tailoring****, the intervention itself is not pre-made. The local team, the PD's, will keep on monitoring and tracking...an on-going interaction that supposedly will continue very closely. After speaking with each one of the family members, they decide how they can intervene, in order to reach that step of stopping FGM. How it is done is for the PD's to decide. Becoming a community ownership...not a project at this stage...PD's supposedly continue monitoring & tracking, which goes on until the girl is not longer at risk*."
Positive Deviants Methodology described by Sahar Mashhour, Grants Program Manager, CEDPA

Drop in Incidence and Prevalence

Drop in incidence rates can be measured through community monitoring. Drop in prevalence rates can be measured through repeat national surveys such as the DHS or through independent local pre- and post-intervention surveys or through case control studies.

To conclude

Distribute to participants handouts concerning the evaluation of the TOSTAN program carried out by Population Council, and invite participants to consider the positives impact of the program on a variety of conditions, including better sexual and reproductive health, school enrolment of girls etc.

Materials:

- Flipchart
- Felt-tip pens
- Handouts for the small groups

Handouts:

- Handout 1: “Integrated initiatives for the empowerment of women as a strategy for the abandonment of FGM/C: a community approach in Keiyo district, Kenya”
- Handout 2: “Project indicators”
- Handout 3: “Community based monitoring and evaluation methodologies”
- Handout 4: “Convention shift in Senegal”
- Handout 5: “The Community Based Education Program”
- Handout 6: “Final consideration on the TOSTAN program”
- Handout 7: “Evaluation of the TOSTAN program in Senegal by Population Council”

Reading:

- Parker, W., *Rethinking conceptual approaches to behaviour change: The importance of context*, Centre for AIDS Development, Research and Evaluations (CADRE), 2004.

PROJECT

Integrated initiatives for the empowerment of women as a strategy for the abandonment of FGM/C: a community approach in Keiyo district, Kenya (Excerpts presented by Tumndo Ne Leel Support Group – TNLSG to RAINBO)

1. Problem statement

Girls in Chemoibon location face school retention and completion problems due to FGM/C, teenage pregnancy, early marriage and poverty. As a result the community during the Situation Analysis identified education as a need to be addressed for girls to remain and complete their education which is crucial to their empowerment as women. They felt that young men would soon lack women to marry from the community because girls are not educated to the level of the men.

Women's participation in economic activities is restricted to tilling the land for subsistence production of crops and limited access to income generated from the produce. This leaves women with insufficient income to sustain their daughter's education.

Proponents of FGM/C have stated culture and tradition as reasons for the persistence of the practice which help reinforce the subordinate status of women in family and society. Women have been used by men and society to perpetuate FGM/C denying girls education which is key to women's empowerment.

1.1. The target area

The project area has been restricted to one location, namely Chemoibon. The estimated population is 5,750. The sex ratio of female to male in the district is 100:98. The female population numbers 2,904 whereas males count 2,846, with a population density of 58 persons per km^2. (CBS, 2001).

The major economic activities in Chemoibon are centred on livestock: native cow breeds, sheep, chicken, goats and donkeys for transport, bee-keeping, and cultivation of fruits, millet, green grains and groundnuts. These activities do not adequately sustain the livelihoods of the population due to the harsh climatic conditions resulting in high poverty levels manifested by low living standards, famine and hunger.

1.2. Incidence of FGM/C in the target area

The results of the situation analysis revealed that it was difficult to determine the prevalence of the FGM/C practice since it is carried out in secret on girls and on women through coercion, which make reporting difficult. Women are also subjected to the cut during delivery when they are helpless and not consulted. The community does not consider female circumcision a problem.

The age range for circumcision is 15 to 18 for girls, 20 years and above for school drop-outs, and for married women aged 30 and above. There are exceptional cases where women of over 40 years are circumcised to remove the taboo on the occasion of the circumcision and marriage rites of the male child.

2. Project's goal and objectives

2.1. Goal of the project
The goal of the project is abandonment of FGM/C.

2.2. Specific objectives of the project
1. To promote retention and completion of education cycle for girls for the advancement and career development through education forums, use of role models and adoption of initiation without circumcision.
2. To train women and girl drop-outs to acquire skills on small business enterprise for their empowerment.
3. To provide a revolving fund to train women and school drop-out girls for the establishment of income-generating activities.
4. To establish support groups of specific populations to promote and support the abandonment of FGM/C.

3. Target population groups
The primary targets are: Women (mothers-in-law), girls and selected men who support anti-FGM/C programs. Secondary targets are circumcisers, initiators and TBAs who have been carrying out the practice.

4. Proposed activities

4.1. Initiation of 50 girls from each of the three sub-locations of Chemoibon location using *Tumndo Ne Leel* curriculum, whose contents has education and career development, empowerment and effects of FGM/C among others.

The initiated girls form a critical mass of peer educators who influence, through interaction and behaviour change, the other girls and young men, to positively appreciate initiation without circumcision. They will be encouraged to establish clubs which will disseminate information on girl/women rights and effects of FGM/C on girls' reproductive health, education and empowerment, through debates and public forums (parents' day, public holiday, prize-giving days, among others). During these occasions girls will be able to openly discuss issues of sexuality considered taboo by society and be able to make informed decisions.
TNLSG will provide 6-day training course to the girls from 7 primary and 3 secondary schools on how to establish youth clubs and identify club leaders to lead members in anti-FGM/C efforts.
Established clubs will be involved in the writing of articles on issues of sexuality, career choice and education advancement through the support of TNLSG. The newsletter published quarterly by a TNLSG will be a media of communication on anti-FGM/C messages, about the experiences of initiated girls and to report incidences of sexually related cases from the community, by girls and women. It will also be used to inform boys of women's sexuality and their reproductive health and disease prevention. This will help both boys and girls understand their sexuality and make informed decisions on issues of sexuality hence reducing early pregnancy

which causes girls school drop out and sexually transmitted diseases, resulting from unprotected sex.
The Support Group (created under activity 5.5.) will be meeting with the 3 leaders from the ten schools at the end of each term, to review activities and impact of the club as well as plan for the following term's activities. Such meetings will ensure sustainability of clubs after the girls move to the next level of their education e.g., upon finishing class eight and fourth form because the club leaders will have been empowered with leadership and management skills that will see them give others opportunities.

4.2. Train initiators (*motirenik*) on TNL curriculum to prepare them on the initiation of girls. Education sessions will be integrated in the training sessions so as to increase retention and completion of education by girls.

Initiation of girls without circumcision gives the traditional circumcisers and initiators a new role in moulding the future of the girls hence abandoning FGM/C. During the training, *motirenik* will understand the effects of FGM/C on the lives of others and their own, and will embrace the new coming-of-age concept for their girls hence strengthen efforts towards abandonment of the practice.

4.3. Training of 9 women and 6 girls drop-outs on skills for initiating income generating activities in three sub-locations of Chemoibon location for two days.

Training curriculum will be borrowed from an organization which has been conducting training on micro-enterprise. The said organization through an agreement with TNLSG will also provide facilitators for two-day training at a central venue in Chemoibon location. Training contents will be: skills for starting small business enterprises, identification of small business enterprises, management of enterprise (basic book-keeping skills), production/sourcing of raw materials, credit acquisition and management, and marketing of products among other skills which include leadership and group dynamics. The trainees, besides carrying out their business enterprises, will campaign for the abandonment of FGM/C and will serve as facilitators during initiation of girls.

4.4. Establish a revolving fund to benefit the trained women and school girl drop-outs to enable them to establish and manage small business enterprises for income generation.

The executive committee is responsible for the management of the fund through the Programme Co-ordinator who will be answerable to the committee. They are also responsible for development of funding criteria for implementation by the Programme Co-ordinator. Women and girls identified for training will form a group of five (three women and two girls) and guarantee each other. In default cases, the remaining members will be held responsible. Amounts loaned will be increased progressively depending on the performance of the business, until the project term is ended.

4.5. Identify support groups comprising of TBAs, traditional initiators and circumcisers - women and few men, decorators (men) and young men (who are future husbands and "consumers" of uncircumcised girls) to support efforts for the abandonment of FGM/C.

The two support groups will be identified and trained, after which they can meet regularly to discuss strategies and plans to strengthen their capacity and advocate for change in the community. They will enhance the efforts of the project on the abandonment of FGM/C.

The men's support will influence young men to marry uncircumcised women, the married men to retain their uncircumcised wives, and complement the work of the women's support group. The women's support group will participate in the initiation of girls without circumcision and will not participate in the circumcision of girls and young women. These are people who have taken a stand against FGM/C and will act as allies and monitors of FGM/C incidences in the community and promoters for FGM/C abandonment. They will complement the efforts of TNLSG hence will not cause conflict.

Support groups, beside participating in the initiation without circumcision, improve communication and leadership skills and enable women and youth to use their voices hence promoting anti-FGM/C efforts e.g.: support the youth in promoting anti-FGM/C in public forums and liaising with school management on behalf of TNLSG with regard to establishment of anti-FGM/C clubs. Through these they will build confidence of women, girls and youth in general.

5. Expected project outcomes

a) Empowerment of women and retention and completion of education circle by girls. Empowered women and educated girls will be able to make informed decisions in life and specifically with regard to FGM/C. The women are able to make decisions and manage their initiatives in the community. Educated girls will prioritize their goals in life, including advancement in education and career development as opposed to early marriage.

b) Increased community consensus for abandonment of FGM/C. The community at large will appreciate the value of education and anti-FGM/C project; hence provide support for abandonment of FGM/C. Parents will be committed towards retention and completion of education by their daughters (girls) resulting in empowerment of women. Men's support group will have influenced the change of attitude towards uncircumcised women by young men who will marry them.

INSTRUCTION FOR THE EXERCISE

Indicators should be SMART (Specific; Measurable; Available; Relevant; Time-Bound).

Indicators should measure:

- changes in the community compared to initial gender/situational analysis
- stages of behavioural/social change of community members (identify the stage of behaviour the different target groups are in, after project intervention)
- empowerment of women
- changes in decision-making power
- consensus of the community towards abandonment of FGM/C
- influence of external factors
- impacts of development activities
- abandonment of FGM/C

COMMUNITY BASED MONITORING AND EVALUATION METHODOLOGIES

As mentioned earlier the component of building community consensus and support forms a vital element within the WECC framework. Involving the community in monitoring allows for further sustainability of the project, creating a sense of ownership amongst community members. There are different approaches in how to involve the community in a participatory manner. Using participatory approaches and participatory monitoring & evaluation differs from the more conventional approaches to monitoring and evaluation in that it aims to engage key stakeholders more actively in reflecting and assessing the progress of their project and in particular the achievement of results. Over the past years, participatory approaches have gained an increased popularity in the field of development and are being adopted more in developmental programs.

Some Key Principals of Participatory Monitoring and Evaluation, *adapted from Canadian International Development Agency (CIDA) Result-based Participatory Monitoring and Evaluation, 2001,* **include:**

- *'**Participation**' - which means opening up the design of the process to include those most directly affected, and agreeing to analyse data together;*
- *The inclusiveness of PM&E requires '**negotiation**' to reach agreement about what will be monitored or evaluated, how and when data will be collected and analysed, what the data actually means, and how findings will be shared, and action taken;*
- ***'learning**' which becomes the basis for subsequent improvement, change and action;*
- *Since the number, role and skills of stakeholders, the external environment and other factors change over time, '**flexibility**' is essential.*
- *The importance of "handing over the stick" and creating the space for **respect** and **participation:***
- *Living with the community and **integrating** oneself with the local customs*

There are a wide range of methods and tools that have been developed to carry out participatory monitoring and evaluation. They all seek to compare the situation before and after a particular intervention, on set of events. The following are a few examples:

Visualised analysis - Visualisation techniques provide opportunities for creative reflection because they enable people to represent their own ideas in a way which they can discuss, modify and extend. Examples of some of these methods include: participatory mapping; photograph analysis; flow charts; Venn diagrams; daily and activity profiles; pie diagrams.

• **Interviewing and sampling methods** - examples of such techniques include: semi-structured interviewing; direct observation; focus group discussions; key informants; social maps.

• **Group and team dynamics method** - examples of such techniques include: team review sessions; interview guides; villager and shared presentations; process notes and diaries.

Community Based Monitoring for FGM/C

Using community-based monitoring techniques for FGM/C is still at a rudimentary stage. Different settings for conducting the monitoring could be at existing points of services such as:

- Health services (e.g. women attending ante-natal clinics, family planning clinics or child immunization)
- Education services (e.g. at primary or elementary schools through the teachers or nurses within the schools).

For all of the above, staff training may be required to notice changes amongst girls at risk, being able to identify and differentiate between the different types, etc and also understanding the social and cultural setting within which they are working. There are ethical and regulatory considerations that need to be clarified in monitoring, with special attention to informed consent.

Examples of Different Techniques for Community Based Monitoring of FGM/C

Voluntary Self-Reporting - Voluntary self-reporting, such as parents reporting on the status of their daughters before & after the project intervention. Unfortunately self-reporting brings in issues of validity, reliability and in some cases deception, such as occurred in the longitudinal study of the reproductive health project in Navrongo, Ghana. In Egypt following the Egyptian Demographic and Health Survey in 1995, a comparison of self-reporting with clinical findings was performed by the Egyptian Fertility Care Society in 1996, to allow for assessment of self-reporting for a sample of 1339 women in eleven clinics, with clinical examinations undertaken by gynaecologists. The findings unveiled a 6% discrepancy between the self-reporting (97%) and the actual clinical finings (93%), which is within the statistically acceptable variable. In this case self-reporting was closely compatible with clinical findings.

Observation of Cut-Status: Observation of cut-status after the project intervention provides an ultimate indicator of whether the girl is cut or not, but it is very hard to measure due to ethical and rights considerations. Observation of cut-status can be done through routine pelvic examination of gynaecological patients and during ante-natal care and delivery. This method of data gathering is non-invasive but compromises on lack of full representation of the sample.

Community Based Monitoring through "CARE" Methodology

As seen above there are different issues which arise in how community-based monitoring is conducted. Based on this, we recommend using a Creative, Appropriate Reliable and Ethical (CARE) method, which might assist in providing guidelines on which techniques and tools could be used in a particular setting. As the Publicly Declared Intent (PDI) is currently the first recommended indicator for assessing impact, it can be integrated within the monitoring systems developed. As an example: developing a monitoring system which will track the status of families whom have declared that they will not circumcise their girls, through an interview, a public declaration or announcement and follow-up through routine visits. Such a

follow up undertaken by the community is currently being undertaken by the **Positive Deviants** approach, which uses surveillance monitoring through records and family visits of at-risk girls:

"**Families of girls at-risk tracking**: *after 6 months, the focus shifts to the girls at-risk families. The local NGOs, with the Positive Deviant (PD), define the meaning of 'at-risk.' They decide the at-risk age, working on the specific community, and they also do mapping, trace and write down all the families that have girls, then during the workshop they discuss with each other (local NGO's & PDs) and define & decide what the at-risk age is in the given community. Every positive deviant choses families which they will be responsible for, and closely monitor. At this stage, focus is on the family, there is a kind of* ***tailoring****, the intervention itself is not pre-made. The local team the PD's, will continue on monitoring and tracking...an on-going interaction that supposedly will go on very closely. After speaking with each one of the family members, they decide how they can intervene, in order to archive stopping FGM/C. The shape of how it is done is for the PD's to decide. Becoming a community ownership...not a project at this stage...PD's supposedly continue monitoring & tracking, which goes on until the girl is not longer at risk*."
(Positive Deviants Methodology described by Sahar Mashhour, Grants Program Manager, CEDPA)

Drop-in Incidence and Prevalence
Drop-in incidence rates can be measured through community monitoring and drop-in prevalence rates can be measured through repeat national surveys such as the DHS or through independent local pre and post intervention surveys or through case control studies.

CONVENTION SHIFT IN SENEGAL*

In September 1996, women involved in a basic education program in Malicounda Bambara in Senegal decided to seek abolition of FGC in their village of about 3000 people. Using the communicative and organizational skills learned in their education program, the women proceeded to persuade the other women in the community, their husbands, and the traditional and religious leaders of the village that such a decision was needed to protect the health of their girl children and to respect human rights. On July 31, 1997 the village of Malicounda announced to the world its decision to abandon FGC and urged other villages to follow their example. Although some members of the Bambara ethnic group had stopped on an individual basis, no village had ever made a public and collective commitment to stop the practice. The commitment worked: public opinion continues to resolutely oppose FGC and deviators would be identified and shamed. This is the first unequivocal collective and contagious abandonment of FGC on record, and the event supports the convention hypothesis of FGC.

Their decision was controversial among those who had not worked through the Malicoundan's reasoning on the issue, and some neighboring Bambara, Mandinka, and Sosse people, both men and women, were angry and sent hostile messages to Malicounda. The women were hurt and depressed, yet defended their position, and even traveled to the villages of Nguerigne Bambara and Ker Simbara to discuss their commitment with women there in the basic education program. On November 6 1997, the women of Nguerigne Bambara decided to renounce FGC forever. On November 20 1997, the President of Senegal made a public declaration against FGC and called on the nation to emulate the women of Malicounda. At the same time, the people of Ker Simbara decided that they could not stop FGC without consulting with their extended family that lived in ten villages near Joal. This point also supports the convention hypothesis: the Ker Simbarans were aware that a change would have to involve the entire population among whom they commonly inter-married. Two men, one a facilitator in the basic education program, the other a 66-year old imam who had been a student of the basic education program, went from village to village to discuss FGC. The men were at first afraid of being chased out of the villages for talking about such a sensitive and controversial topic, but the Malicounda decision provided an opening for discussion. I infer that the demonstration effect was important: that the Malicoundans had succeeded at a collective abandonment and had avoided bad consequences.

Three representatives, including the village chief and two women, from each of the ten villages, gathered in Diabougou on February 14 and 15, 1998, along with delegations from Malicounda Bambara, Nguerigne Bambara, and Ker Simbara. These 50 representatives of 8000 people in 13 villages issued the Diabougou Declaration.

We declare:
Our firm commitment to end the practice of female circumcision in our community.
Our firm commitment to spread our knowledge and the spirit of our decision to our respective villages and to other communities still practicing female circumcision. . . .
We make a solemn appeal to the national and international community to quickly mobilize their efforts to ensure that girl children and women will no longer suffer the negative health effects associated with female circumcision.

The ten villages had not gone through the basic education program, rather they had been persuaded by the emissaries from Ker Simbara, but the ten villages petitioned in the declaration to have the basic education program brought to them as well.

* Jerry Mackie, *"Female Genital Cutting: The Beginning of the End", in Female 'Circumcision' in Africa: Culture, Controversy, and Change,* edited by Bettina Shell-Duncan and Ylva Hernlund, by Lynne Rienner Publishers Inc., 2000

THE COMMUNITY BASED EDUCATION PROGRAM IN SENEGAL*

TOSTAN's activities in the Kolda Region started in 1988, when UNICEF financed an experimental program of informal education for the development of the Pulaar language in 20 villages in the Departments of Kolda and Vélingara. The results of this experimental program were so popular with the local people and the regional authorities that TOSTAN was requested to extend the program to more communities. TOSTAN thus returned in 1996 to cooperate with a newly formed local NGO, KORASE, in launching an education program in the context of the pilot phase of PAPF, financed by the World Bank in 14 communities around Médina Chérif in Kolda. This education program led to the first public declaration in the Kolda Region on June 2 1998 of the abandonment of FGM/C and of early marriage. TOSTAN then sought and obtained support for extending the program further, again in cooperation with KORASE, to 23 more villages in the same area. UNICEF financed TOSTAN and at the same time, KORASE received funds from CEDPA to introduce the first part of the education program covering human rights, problem solving, health and environmental hygiene in 30 villages, in cooperation with another NGO, OFAD-NAFOORE. These two interventions led to two more public declarations, on November 27 1999 at Bagadadji including 105 communities, and on March 25 2001 at Mampatim including 108 villages.

To sustain and build on this movement for abandoning FGM/C in an area where it was practiced by almost 90 percent of women, TOSTAN sought and received funding from GTZ for a project carried out as follows:

- 90 communities were identified by TOSTAN, OFAD-NAFOORE and by local staff from the Ministries of Health and of the Family;
- A social mapping study of these 90 communities was undertaken by TOSTAN's local staff;
- Senior staff (coordinator, supervisors and facilitators) from OFAD were trained in all aspects of TOSTAN's basic education program, including teaching, administration, strategies for introduction, follow-up and evaluation;
- Community Management Committees were trained by the nine supervisors;
- One facilitator per community trained 30 participants in each community in the Pulaar and Mandingo languages. Classes, each of two hours, were held three times a week. From January to June 2001, classes covered human rights, problem solving and hygiene. During the rainy season, participants were given books to help them revise and remember what they had learnt in their classes, and they also carried out social mobilization activities. A total of 2,339 women and 221 men participated in the program.
- Follow-up of the classes in all 90 villages was undertaken by the coordinator, the supervisors, by members of OFAD-NAFOORE's staff and by TOSTAN's instructors;
- Inter-village meetings were held by the community management committees to exchange experiences and to take decisions concerning collective actions;
- Information and social mobilization activities were held in the 90 villages and in

other neighbouring communities by local staff of the Ministries of Health and of the Family;
- A public declaration was organized at Karcia on June 5, 2002, to declare the abandonment of FGC by 300 villages.

These activities were implemented through the following strategies:
- Involvement in project activities of local staff from the Ministries of Health and of the Family;
- Informing the traditional and religious leaders and the elected politicians of the area about project activities;
- Cooperation with, and building capacity of, a local NGO to carry out the project developed by TOSTAN;
- Choosing 10 neighboring villages in each targeted area to pursue social transformation of the area;
- Selection of facilitators and supervisors from the communities that participate in the program;
- Setting up and training community management committees to manage project activities and to ensure that progress can be sustained;
- Holding inter-village meetings in support of the project aims and to confirm collective decisions;
- Holding a Public Declaration.

Since 1997, TOSTAN has organized a public declaration by a large group of villages that have agreed to abandon FGM/C as a strategy to enable the people themselves to renounce a traditional practice without fear of social stigma. The declaration is not intended as an end in itself, but constitutes an important step in the process of finally abandoning FGM/C. The declaration is seen as a way of promoting human dignity, human rights and the health of girls and women. It is intended as a positive step, which should be a joyful occasion that reinforces the positive aspects of traditions as it marks an important moment in the life of the communities.

TOSTAN is aware that in launching any significant social movement that is intended to bring about profound changes, a small group of informed and enlightened people will be the first to commit themselves in the name of the community as a whole. Others will remain hesitant and sceptical. It is likely, also, that a small proportion within the community will remain opponents to this change, but it is anticipated that eventually the new behaviour (i.e.: not practicing FGM/C) will become the norm, rather than being practiced by a minority. TOSTAN has come to acknowledge the essential contribution to the process of social change made by this declaration, and so it is essential that the communities themselves consciously and actively pursue the process from within.

* Diop, Nafissatou and others, *The TOSTAN Program. Evaluation of a Community Base Education Program in Senegal,* Population Council – GTZ – Tostan, August 2004

FINAL CONCLUSIONS ON TOSTAN PROGRAM IN SENEGAL*

The convention theory, as reflected by events in the Senegalese villages, suggests a tripartite strategy of abandonment: basic education, public discussion and public declaration. Educational information must be from a credible source and must be non-directive. Public discussion is the period when a motivated core carries information to ever broader audiences. Information and discussion are standard techniques. What this approach adds, and explains, is public declaration within the local pool of marriage eligibles and results are promising.

Campaigns of broad publicity should continue because it is important that international, national, and local attitude change should continue to amass. Although it is not possible to explain why here, the critical mass definitely need not be as large as a majority. Nevertheless, some sufficient proportion of attitude change is required prior to convention shift, and that begins with broad publicity. Abandonment once begun is potentially contagious, and that has implications for reform planning. It is contagious because if one marriage pool successfully abandons FGC that directly raises the issue to overlapping marriage pools, and additionally because it demonstrates to similar populations that the beneficial shift can be made safely. Thus, it may be worthwhile to sharply concentrate effort on attitude change and then convention shift on some exemplary groups, and after success on their kin and neighbors and then on their coethnics. Concentration can operate at neighborhood, local, provincial, country, and regional levels.

Here are some more ideas about concentration. Generally, women more actively perpetuate FGC than do men. It is women's business. It may be possible to concentrate initially on women because if they are won over, they will persuade husbands, grandparents, religious and political figures. Of course it is also effective to win over influential people, local political and religious leaders with genuine authority. Obviously, it is desirable to extend the declarations in Senegal as rapidly as possible. If the Senegalese process continues to deliver dramatic results, then proven techniques should be extended to co-ethnics in neighboring countries. Furthermore, it may be easier initially to inspire attitude change and convention shift in countries or regions where there are respected ethnic groups that have never practiced FGC (as evidenced by the first successes in Senegal and Uganda). Another criterion for concentration is if the discrepancy between prevalence and attitude change is wide, as in Eritrea (unfortunately, trapped in tragic warfare at the moment). Additionally, it may be easier initially to trigger change in groups where FGC is shallow, that is, in groups towards the edges of the distribution without the exaggerated emphasis on chastity and fidelity, than in groups where FGC is deep, that is, in groups at the center of the distribution that are strongly connected to the modesty code.

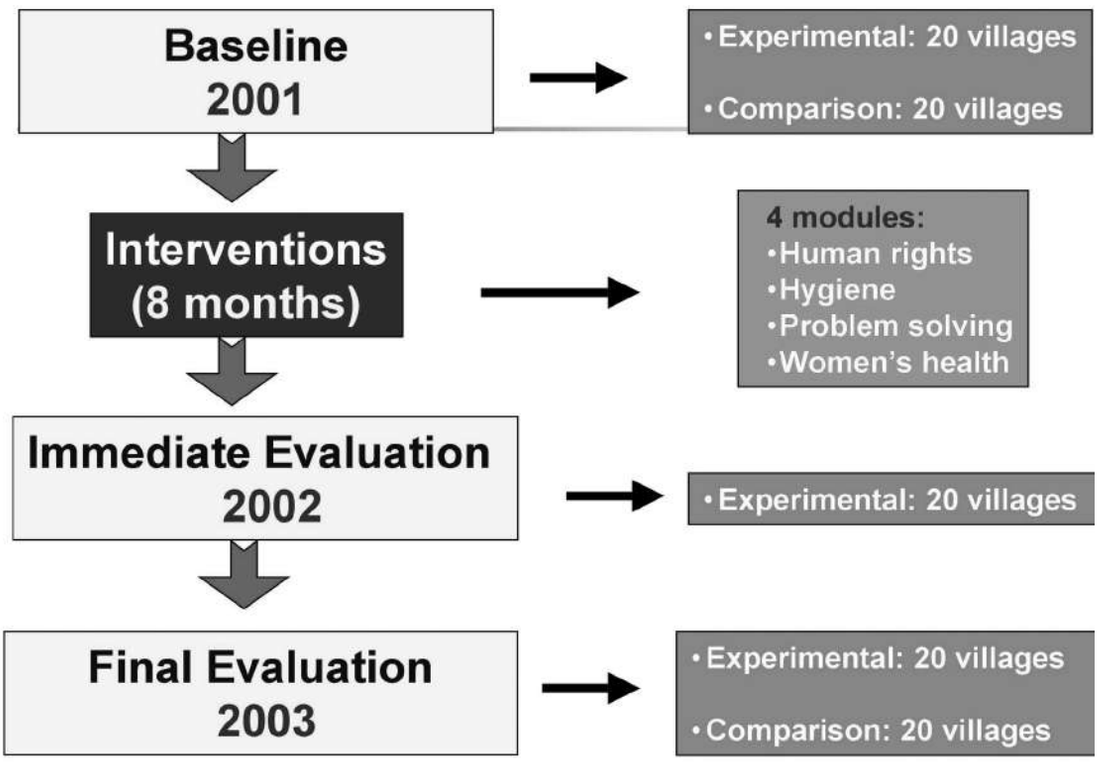
It would be instructive to test culturally adapted pledge associations in an urban area where there is already a wide discrepancy between prevalence and attitudes. The larger and more educated the population the easier it should be for those with changed attitudes to marry one another's children, provided there is a way they can

find one another (it might be harder initially to reach the less educated in an urban area, however, if they are less socially cohesive there than they were in their rural homes). Furthermore, an urban suitor may not consider that many more partners than a rural suitor, but in urban areas there are many overlapping marriage markets compared to only a few in a rural area. Thus, on a higher level, if, within a larger collection of overlapping marriage markets, a critical mass of marriage markets complete convention shifts, their overlap with other marriage markets can domino through the larger collection. No ethnic or status group anywhere should be ignored if they are ready for convention shift – successes are always more helpful for demonstration purposes than are failures. But all else equal, in an urban setting it may be most effective to concentrate on the most prestigious status groups, because their shift will inspire a shift among those who aspire to join those categories, and so on. These are provisional hypotheses, to be revised or rejected on the basis of program experiences.

The people who do FGC are honorable, upright, moral people who love their children and want the best for them. That is why they do FGC, and that is why they will decide to stop doing it, once a safe way of stopping is found. Since FGC will end sooner or later, it is better that we put our efforts into ending it sooner rather than later. Let's study good ways of stopping it, and let the people who still do FGC know what we and their neighbors in Africa have found out about ending it.

* Jerry Mackie, *"Female Genital Cutting: The Beginning of the End",* in *Female 'Circumcision' in Africa: Culture, Controversy, and Change,* edited by Bettina Shell-Duncan and Ylva Hernlund, by Lynne Rienner Publishers Inc., 2000

EVALUATION OF THE TOSTAN PROGRAM - 1



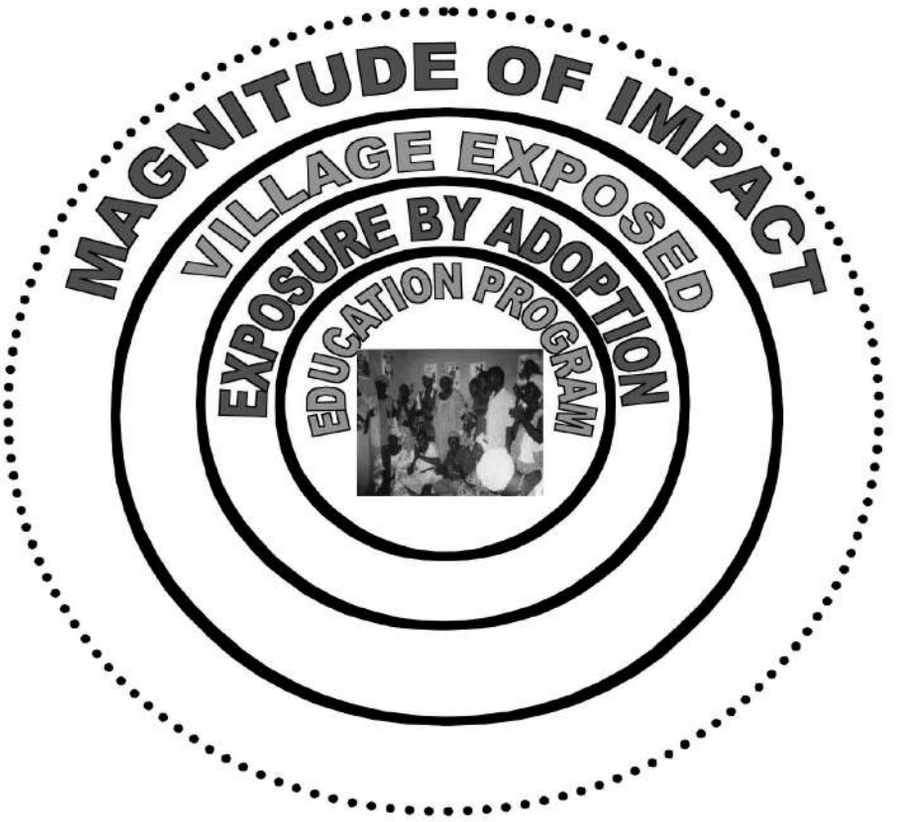
Population Council FRONTIERS IN REPRODUCTIVE HEALTH

Sample Sizes - Senegal

	Baseline	Post-intervention 1		Endline	
		Participants	Non participants	Participants	Non participants
Experimental					
Women	576	350	194	333	200
Men	373	85	198	82	185
Comparison					
Women	199	-	-	-	200
Men	184	-	-	-	198

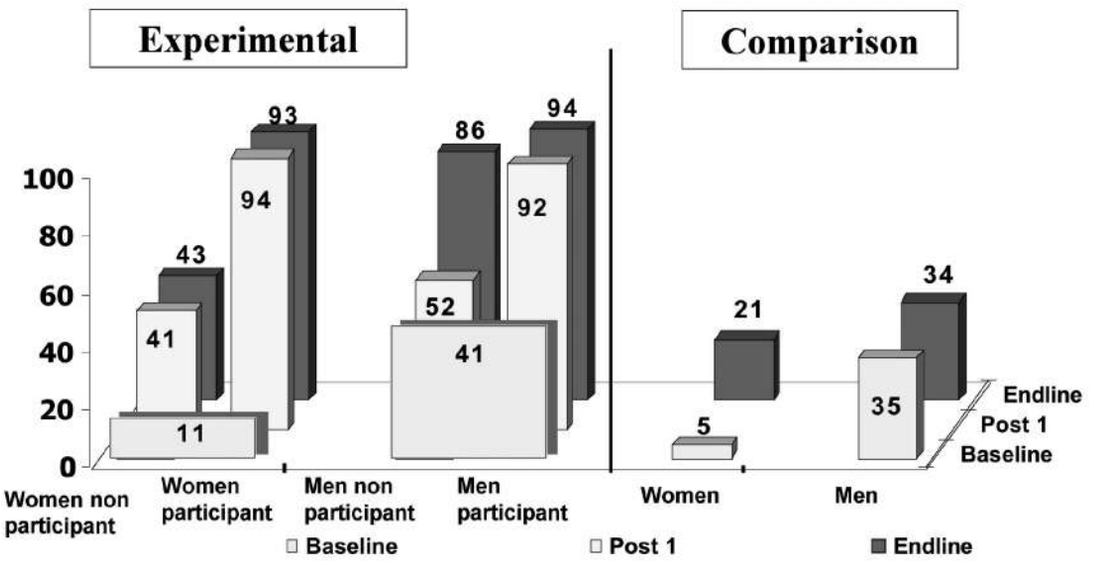
EVALUATION OF THE TOSTAN PROGRAM - 2

The Diffusion Model



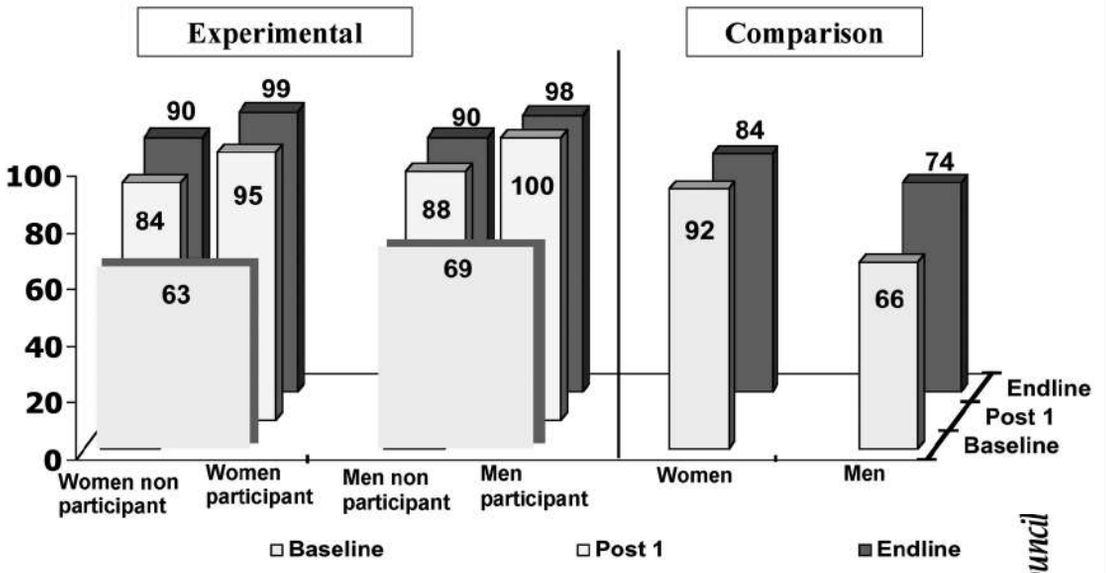
Population Council
FRONTIERS IN REPRODUCTIVE HEALTH

Significant increase in awareness of human rights in experimental group



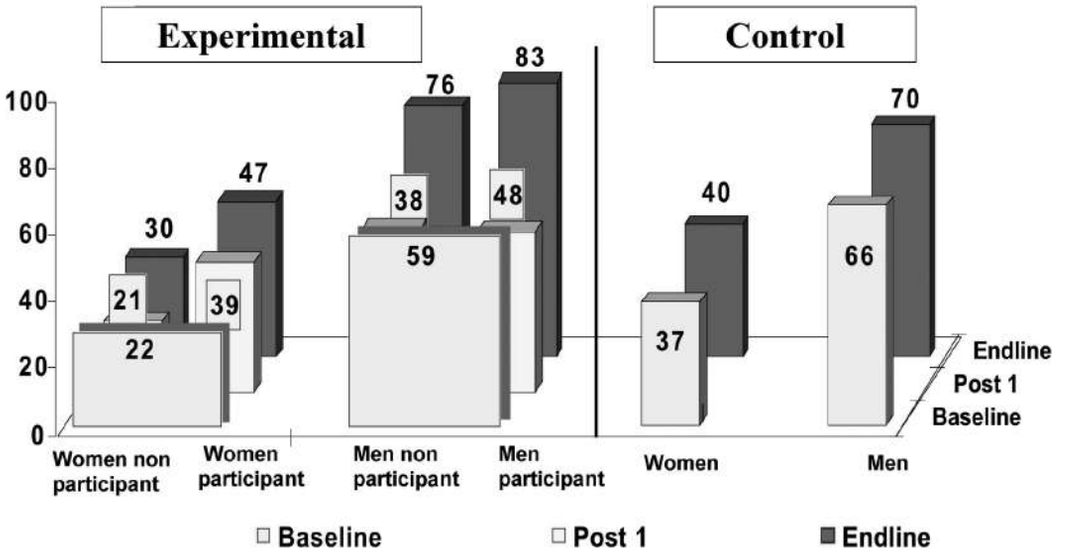
EVALUATION OF THE TOSTAN PROGRAM - 3

Significant increase in knowledge of contraceptive methods in experimental group



Population Council
FRONTIERS IN REPRODUCTIVE HEALTH

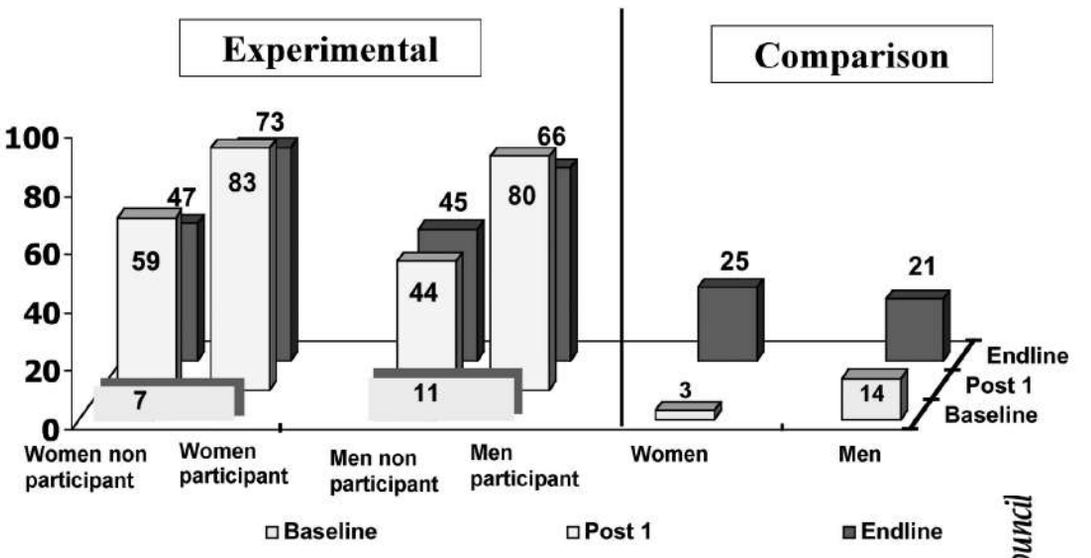
Significant increase in knowledge of STIs in experimental group



STI = Sexually Transmitted Infections

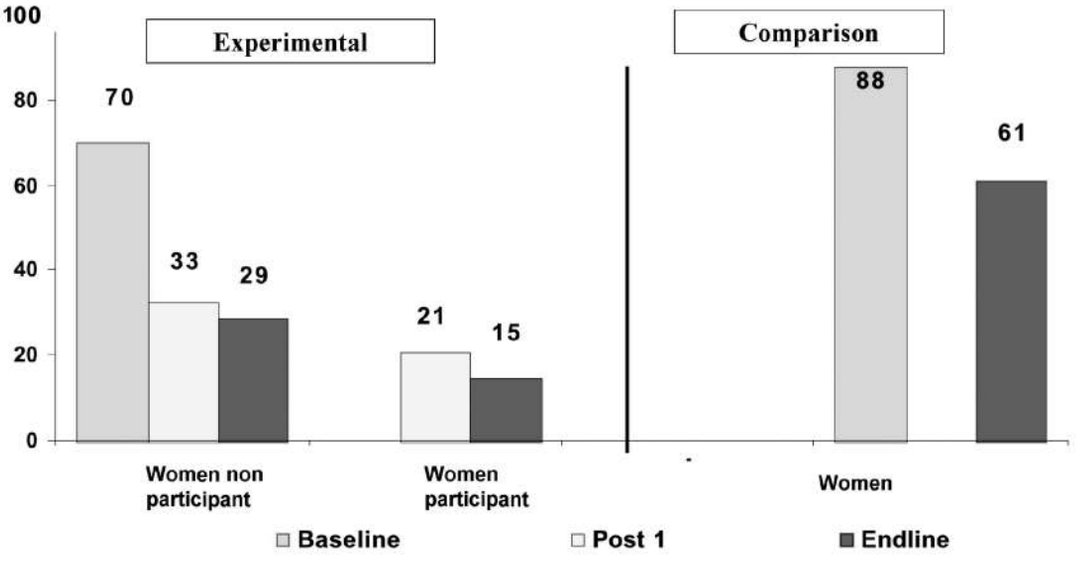
EVALUATION OF THE TOSTAN PROGRAM - 4

Significant increase of awareness of at least two consequences of Female Genital Cutting in experimental group



Population Council
FRONTIERS IN REPRODUCTIVE HEALTH

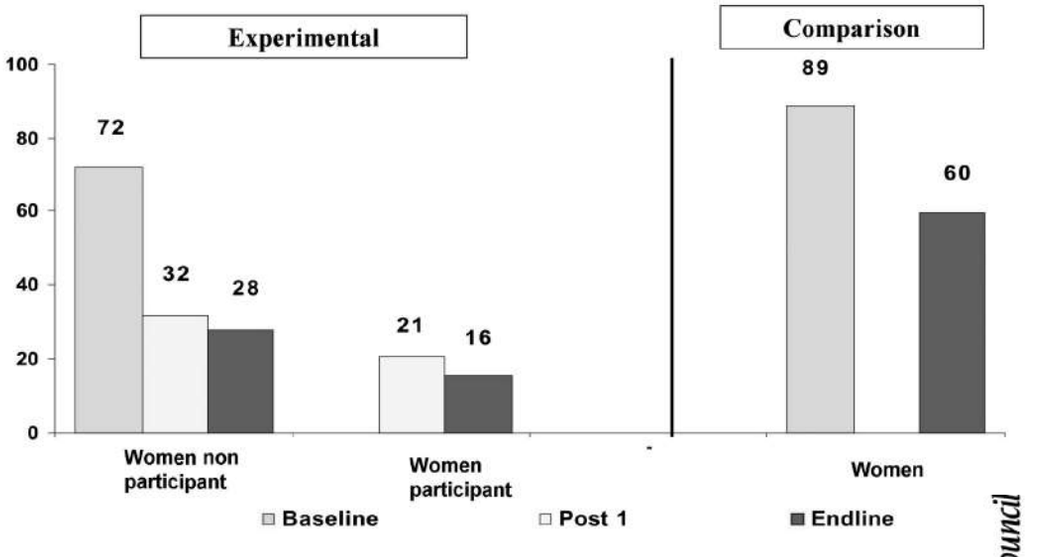
Significant decrease of women who think that FGC is necessary in experimental group



FGC is the acronym adopted by TOSTAN and Population Council

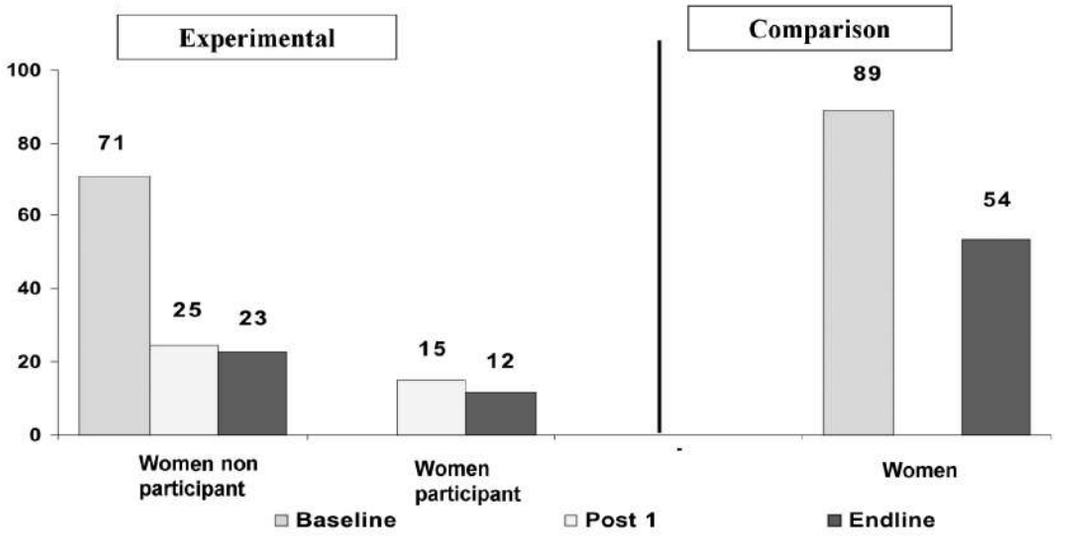
EVALUATION OF THE TOSTAN PROGRAM - 5

Significant decrease of women who approve FGC in experimental group



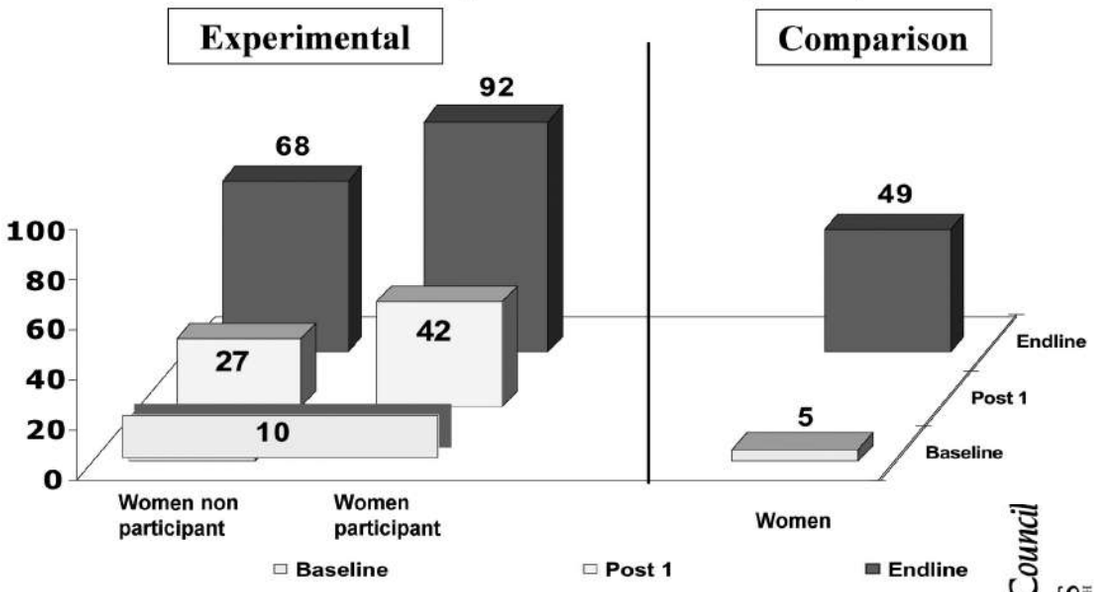
Population Council
FRONTIERS IN REPRODUCTIVE HEALTH

Significant decrease of women who will cut their daughters in the future in experimental group



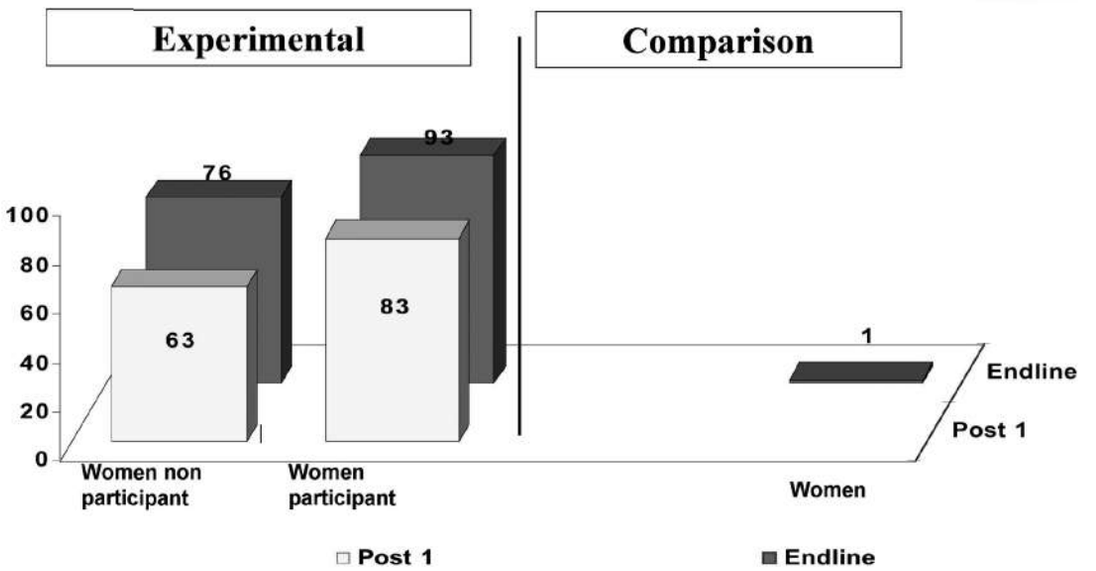
EVALUATION OF THE TOSTAN PROGRAM - 6

Significant increase of women that share information on FGC with others in experimental group



Population Council
FRONTIERS IN REPRODUCTIVE HEALTH

Significant increase of discussion about FGC in the experimental village during the past 12 months



Activity 4

MAINSTREAMING FGM/C PREVENTION: DEVELOP YOUR PROJECT

Time: 5 hours

Why do this activity?

This activity builds on the lessons learned in the previous modules, and offers a practical opportunity to develop a programme/project addressing one or more typical development issues (drought and water shortages, poverty and reduced economic opportunities, lacking healthcare facilities, etc.) as an entry point to mainstream FGM/C prevention activities by empowering women and involving the community at large.
In fact, the analysis carried out during the previous modules has reached the conclusion that FGM/C will come to an end when women themselves feel that they can abandon the practice without losing what the practice guarantees them: survival and security through marriage, reproduction and social recognition for their children, dignity and an accepted social role, including freedom of movement and some decision-making.
The “gender spectacles” we look through during this training course will allow us to recognize the “practical gender needs” as well as the “strategic gender needs” that crosscut with FGM/C.
This in turn will permit us to identify target groups, objectives, appropriate messages, and follow them up through the different “stages of behavioural change”, understanding which are the necessary interventions, resisting adverse pressure, and arrive to the point where the whole community have reached a consensus on the abandonment of FGM/C, and make it public through some sort of “public declared intent”.
The programme should be designed to build the supportive social and cultural environment necessary for women and families to adopt a different behaviour: ingredients for this environment include information through the media as well as policy and laws. Moreover, the proposed method will help to identify activities to be implemented to uphold the decision to abandon the practice, and to allow a smooth transition to a new collective behaviour.

Objectives

· To experiment the acquired skills for effective programming, including “gender planning”, “stages of behavioural change” and “women empowerment and community consensus” inputs.

· To define concrete paths to mainstream FGM/C prevention activities into different development programmes in order to bring about a long lasting behavioural change.

How to do the activity:

Step 1: 1 hour

Plenary introduction

Divide participants into small groups. Distribute Handout 2, 3 and 4 with the description of three districts of Kenya to each small group.

Handout

Distribute a copy of Handout 1 “Programming tool for mainstreaming FGM/C prevention in development programs and projects” and Handout 5 “Reminder for project development” to participants, and go through the first one in plenary, revising each step.

Note to facilitator

Programming tool for mainstreaming FGM/C prevention in development program and projects

Based on **Gender planning theory and practice** developed by economist Caroline Moser and extensively used by AIDOS in its overall development activity, and on the Women Empowerment and Community Consensus (WECC) model developed by RAINBO, the innovative tool for mainstreaming FGM/C prevention in development program and projects includes the following steps:

1. Conduct gender/situational analysis
2. Prioritisation of development problems
3. Identify working objectives for women’s empowerment without FGM/C
4. Identify the entry strategy/access to community
5. Expand the room for manoeuvre/choose project inputs for women’s empowerment and community consensus
6. Conduct progressive monitoring to adjust project to changes and avoid resistance.

1. Gender / situational analysis

- disaggregate target groups within the community
- look at household structure (extended family…)
- look at roles played by women and men, both in the household and in the community
- look at access/control over resources (including money, time, education, self esteem/value, reproduction, information, political participation…)
- identify gatekeepers: controlling women’s socialization and ensuring FGM/C
- identify stages of behavioural and social change of community members
- collect data/quality information on FGM/C “here and now”

This analysis will ultimately lead to

- **identifying practical gender needs (PGN) an and strategic gender needs (SGN) of women**
- **identifying development needs of the community**

Practical gender needs (PGNs) are the needs of men and women by virtue of their position within the gender division of roles and labour in a

given society. It is usually a response to an immediate need. For example in a rural society, to have water near the household is a PGN for women, which is part of their responsibility within the gender division of labour. If we look at health, having access to family planning is a PGN for women. PGN are aimed at actions which make the performance of existing gender roles more efficient.

Strategic gender needs (SGN), on the contrary, are derived by the subordinate position of women with respect to men. They reflect an alternative for a more equitable division of labour.

Data and quality information on FGM/C "here and now" might be gathered answering to the following questions:

- FGM/C prevalence rate among women and girls?
- What type of FGM/C is performed?
- Who performs the practice?
- What age at performance?
- What are the main reasons given by women / community members to justify/support FGM/C?
- Which are the attitudes towards the possibility of abandoning the practice?
- What do people know about FGM/C?
- Were there previous campaigns/interventions?
- Is FGM/C perceived as a power-gaining tool by women?

2. Prioritisation of development problems

Build a "cause and effect" list of development problems for the community and for the women especially, and choose to address those that offer the best entry point(s) to include activities aiming at preventing/abandoning FGM/C, through the achievement of

- empowerment of women without FGM/C

- community consensus around the changes in behaviour that empowerment of women without FGM/C brings about

3. Identify working objectives for women's empowerment without FGM/C

Use **gender consultation** and **community dialogue** to identify the **working objectives**, which are the objectives directly linked to the achievement of strategic gender needs (SGN) of women, and that will be monitored along the whole project time framework, in order to adjust them to changes emerging during project implementation.

Through gender consultation and community dialogue:

- identify the **entry strategy** to meet SGN of women, thus bringing a change in traditional gender roles and gender socialization processes
- identify **stages of behavioural change** that different social actors (target groups) are already going through
- identify **assets = supporters** of the abandonment of FGM/C (and eventually to women's empowerment) and **constraints = resistors**, in order to build the necessary community consensus to meet SGN
- build a **data baseline** to **monitor progress** and redefine ongoing working objectives, adapted to changing power dynamics

4. identify the entry strategy / access to the community

Look at power dynamics and stages of behavioural/social change (adopters of innovation), and answer the following questions:

- what can be done?
- what is NOT possible? (because it will elicit resistance / refusal by community and/or by specific actors, such as community leaders, elders, religious leaders..)
- who is ready to contribute/support women's empowerment?
- who will openly oppose it?
- how should the issue of FGM/C be addressed?

This leads to definining the **room for manoeuvre** for the project/program.

5. Expand the room for manoeuvre / choose project inputs for women's empowerment and community consensus inputs

The room for manoeuvre, the acceptance of the project by the community and the active participation of their members to project activities, can be expanded through activities aimed at women's empowerment without FGM/C and at community consensus around it:

- choose development areas where gender equality/women's empowerment will benefit the whole community
- choose areas where FGM/C is perceived as a power gaining tool by women
- build supportive structures/institutions for women's empowerment, including full participation of women
- choose appropriate messages (culturally sensitive)
- work with supporters (assets) to move resistors (constraints) towards a different grade of acceptance of the innovation (new behaviour: abandoning FGM/C)
- move to collective decision making: **public declared intent to change behaviour/public declaration to abandon FGM/C**
- build a conducive and sustainable environment for change, where new gender roles and power balances, including the abandonment of FGM/C, can be maintained

6. Conduct progressive monitoring

- Look at women's empowerment without FGM/C. Thus through the project's activities women **gained**
  - power over…
  - power to…
  - power with…
  - power within…

- Use quantity/quality data/information gathered through gender/situational analysis as a baseline: what changed in the community after intervention?
- Look at social change: which changes in stages of behaviour happened among the project's target groups?
- Identify unexpected results: were there positive/negative unexpected outcomes of activities implemented during the project?

7. Move forward / scale up

The results of the monitoring process will contribute to the definition of **new working objectives** and a renewed **entry strategy** to further expand the room for manoeuvre to achieve women's empowerment without FGM/C, build community consensus around it and improve overall development conditions of the community.

Progressive monitoring and final evaluation will also contribute to:

- define how to scale up activities
- identify possibilities for adaptation and/or replication of project activities in other areas
- include other stakeholders/target groups in project activities.

Step 2: 5 hours

Small group activity

Invite participants in the small groups to develop their project proposal to address one of the specific development problems emerging from the District description, using the combined programming tools in the Handout, and considering the following while developing their proposal:

1. address practical / strategic gender needs, thus contributing to women's self empowerment;

2. addressing community needs in order to open up entry points and build the social and cultural environment favouring behavioural change;

3. aim at reaching a community consensus on the abandonment of FGM/C stated through a "public declaration" in order to have a tool for later monitoring lasting decision;

4. include appropriate indicators to monitor implementation of activities.

Invite each group to work only on one specific development issue and to list minimum 3 messages they deem appropriate for each activity/target group.

Handout

Ask each group to present their project/program according to following model (Handout 2, "Guidelines for project development and presentation"):

Note to facilitator

Guidelines for project development and presentation

1. Short presentation of the district (read from case study)
2. Results of situational and gender analysis: describe condition of women and of community
3. Practical / strategic needs identified/chosen and development problem prioritised
4. Working objectives for women's empowerment without FGM/C
5. Stages in behavioural change: who are the supporters/assets and who the resistors/constraints towards women's empowerment without FGM/C?
6. Entry strategy/access to community
7. Expand the room for manoeuvre: list project activities according to target group
8. Messages selected
9. Move to decision stage: which form of "public declared intent" to abandon the practice is foreseen?
10. Indicators for monitoring activities
11. Activities to ensure maintenance of decision taken and reinforce behavioural change process (empowerment of women).

Step 3: 2 hours

Ask each group to present their programme/project. Invite comments and appreciation by other participants.

Materials:

- Flipchart
- Felt-tip pens
- Handouts for the small groups

Handouts:

- Handout 1: “Programming tool for mainstreaming FGM/C prevention in development program and projects”
- Handout 2: “Guidelines for project development and presentation”
- Handout 3: Scenario 1
- Handout 4: Scenario 2
- Handout 5: Scenario 3

PROGRAMMING TOOL FOR MAINSTREAMING FGM/C PREVENTION IN DEVELOPMENT PROGRAM AND PROJECTS

Based on **Gender planning theory and practice** developed by economist Caroline Moser and extensively used by AIDOS in its overall development activity, and on the Women Empowerment and Community Consensus (WECC) model developed by RAINBO, the innovative tool for mainstreaming FGM/C prevention in development program and projects includes the following steps:

1. Conduct gender / situational analysis
2. Prioritisation of development problems
3. Identify working objectives for women's empowerment without FGM/C
4. Identify the entry strategy / access to community
5. Expand the room for manoeuvre / choose project inputs for women's empowerment and community consensus
6. Conduct progressive monitoring to adjust project to changes and avoid resistance.

1. Gender / situational analysis

- disaggregate target groups within the community
- look at household structure (extended family…)
- look at roles played by women and men, both in the household and the community
- look at access / control over resources (including money, time, education, self esteem/value, reproduction, information, political participation…)
- identify gatekeepers: controlling women's socialization and ensuring FGM/C
- identify stages of behavioural and social change of community members
- collect data/quality information on FGM/C "here and now"

This analysis will ultimately lead to

- **identifying practical gender needs (PGN) and strategic gender needs (SGN) of women**
- **identifying development needs of the community**

Practical gender needs (PGN) are the needs of men and women by virtue of their position within the gender division of roles and labour in a given society. It is usually a response to an immediate need. For example in a rural society, to have water near the household is a PGN for women, which is part of their responsibility within the gender division of labour. If we look at health, having access to family planning is a PGN for women. PGN are aimed at actions which make the performance of existing gender roles more efficient.

Strategic gender needs (SGN), on the contrary, are derived by the subordinate position of women with respect to men. They reflect an alternative for a more equitable division of labour.

Data and quality information on FGM/C "here and now" might be gathered answering to the following questions:

- FGM/C prevalence rate among women and girls?
- What type of FGM/C is performed?
- Who performs the practice?
- What age is performance?
- What are the main reasons given by women / community members to justify/support FGM/C?
- Which are the attitudes towards the possibility of abandoning the practice?
- What do people know about FGM/C?
- Were there previous campaigns/interventions?
- Is FGM/C perceived as a power gaining tool by women?

2. Prioritisation of development problems

Build a "cause and effect" list of development problems for the community and for the women especially, and choose to address those that offer the best entry point(s) to include activities aiming at preventing/abandoning FGM/C, through the achievement of

- empowerment of women without FGM/C

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Use **gender consultation** and **community dialogue** to identify the **working objectives**, which are the objectives directly linked to the achievement of strategic gender needs (SGN) of women, and that will be monitored along the whole project time framework, in order to adjust them to changes emerging during of project implementation.

Through gender consultation and community dialogue:

- identify the **entry strategy** to meet SGN of women, thus bringing a change in traditional gender roles and gender socialization processes
- identify **stages of behavioural change** that different social actors (target groups) are already going through
- identify **assets = supporters** of the abandonment of FGM/C (and eventually to women's empowerment) and **constraints = resistors**, in order to build the necessary community consensus to meet SGN
- build a **data baseline** to **monitor progress** and redefine ongoing working objectives, adapted to changing power dynamics

4. identify the entry strategy / access the community

Look at power dynamics and stages of behavioural/social change (adopters of innovation), and answer to the following questions:

- what can be done?
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This contributes to defining the **room for manoeuvre** for the project/program.

5. Expand the room for manoeuvre / choose project inputs for women's empowerment and community consensus inputs

The room for manoeuvre, the acceptance of the project by the community and the active participation of their members to project activities, can be expanded through activities aimed at women's empowerment without FGM/C and with community consensus around it:

- choose development areas where gender equality/women's empowerment will benefit the whole community
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- Look at social change: which changes in stages of behaviour happened among the project's target groups?
- Identify unexpected results: were there positive/negative unexpected outcomes of activities implemented during the project?

7. Move forward / scale up

The results of the monitoring process will contribute to the definition of **new working objectives** and a renewed **entry strategy** to further expand the room for manoeuvre to achieve women's empowerment without FGM/C, build community consensus around it and improve overall development conditions of the community.

Progressive monitoring and final evaluation will also contribute to:

- define how to scale up activities
- identify possibilities for adaptation and/or replication of project activities in other areas
- include other stakeholders/target groups in project activities

GUIDELINES FOR PROJECT DEVELOPMENT AND PRESENTATION

1. Short presentation of the district (read from case study)
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5. Stages in behavioural change: who are the supporters/assets and who the resistors/constraints towards women's empowerment without FGM/C?
6. Entry strategy/access to community
7. Expand the room for manoeuvre: list project activities according to target group
8. Messages selected
9. Move to decision stage: which form of "public declared intent" to abandon the practice is foreseen?
10. Indicators for monitoring activities
11. Activities to ensure maintenance of decision taken and reinforce behavioural change process (empowerment of women).

SCENARIO 1

Kajiado District is one of the 18 Districts within the Rift Valley Province and is located in the Southern part of the Province. It borders the Republic of Tanzania to the Southwest, Taita Taveta District to the Southeast, Nairobi City to the Northeast, Kiambu District to the North and Narok District to the West.

The District is divided into 7 divisions namely: Ngong, Magadi, Isinya, Central, Namanga, Mashuru and Loitokitok. The estimated population for Kajiado in 2002 was 464,883 comprising 236,249 male and 228,634 female. The estimated population growth rate is 4.5 percent per annum and life expectancy at birth is 43 years.

According of the last Census (1999) the female population of reproductive age (15-49 years) was 96,559 (about 23.8 percent of the total population) and was projected to increase to 154,992 by the year 2010.

The major cause of poverty in Kajiado District is illiteracy. Other causes include frequent droughts that wipe out large herds of domestic animals and livestock, HIV/AIDs poor infrastructure, acute water shortage and pressure on land.

In rural districts like Mashuru, Magadi and Central, poverty is aggravated by frequent droughts, which sometimes kill livestock from acute water shortages. The poor also affect with the environment by selling firewood, over-exploitation of water resources and charcoal burning and are more vulnerable to nutrition-related illnesses and respiratory infections due to poor shelter.

A major effect of poverty is the high rate of school drop-outs, as parents cannot meet education costs. The number of Primary Schools in Kajiado is 198 scattered all over the vast district and resulting in long distances between schools. The total primary enrolment in 1999 was 54,278 with 55.8% of boys and a lower 50% of girls.

Although potential Secondary School pupils aged 14-17 years were 35,754 (18,069 boys and 17,685 girls) in 1999, only 2,918 boys and 1,855 girls were enrolled in Secondary Schools. Thus, there is a very low transition from Primary to Secondary Schools. This is especially true for girls who are forced into early marriages, FGM/C and other harmful practices, and therefore denied access to education.

In Kajado district the majority Communities are Masaai and Kikukyu whit FGM/C rate at 93.4 % and 34% respectively.

SCENARIO 2

Kisii District is one of the twelve districts of Nyanza Province in southwest Kenya, and is divided into five local authorities and eleven administrative districts. The district capital is Kisii. The district is mostly hilly and is dissected by rivers flowing west into Lake Victoria, notably the River Gucha and River Mogusi. It lacks infrastructures like electricity, telecommunications and good roads, inhibiting the full exploitation of natural resources.

Kisii district is one of the most densely populated in Kenya, with around 50% of the population below the age of 15. The cause of high population growth is believed to be the cultural practice of having many children for security in old age, leading to low use of family planning methods (acceptance is 60-65%). In most areas the sex ratio is disproportionate due to labour migration to other districts and cities.

Due to the high population density, almost all land in Kisii district is put to maximum agricultural use. Land is subdivided within families, meaning that plots are becoming ever-smaller and the average farm is only 15,000 m^2 in area. This has ensured that a large population of Kisiis' migrate to neighbouring districts and far flung countries to earn a living. Intensive farming in hilly regions has increased the rate of soil degradation and erosion, while the application of farm chemicals has polluted surface and groundwater sources. More than 90% of rural household energy needs come from wood, but the district is no longer self-reliant and other sources such as biogas are being encouraged. Tea and coffee processing and soda bottling constitute Kisii district's manufacturing industry, but retail and wholesale businesses exist in market centres despite the lack of cooling facilities for preserving perishables. The annual growth rate in paid employment is 3.5%, but this is barely keeping up with the current population growth rate. The informal sector is involved in repair, metal fabrication, furniture making and the sale of secondhand clothes, while the soapstone which is found in the area of Tabaka provides a reasonable resource for the carving industry.

Among Kisii FGM/C average is 96%, while the total average in Kenya is 73% of women aged 15-49.

SCENARIO 3

Machakos District is one of the thirteen districts that form Easter Province. The district covers an area of 6,281.4 kms most of which is semi-arid and is crossed by the Mombasa Road highway that links Kenya from the coast to the Ugandan border.

The district's population was 906,644 according to the 1999 Population Census consisting of 442,891 male and 463,753 female representing 48.8% and 51.2% of the population respectively. Growing at a rate of 1.7%, the population is expected to rise to 1,056,535 by 2008.

The majority of the population of the district is young with 510,507 or 56.3% under 20 years old.

The district had 63.3 % of its population below the poverty lie. And official results after the poverty assessment exercise in 2000, showed that 66.2 percent of the population was poor.

In the year 2001, Machakos had over 110 health facilities spread across the district. The doctor/population ratio is about 1:62,325 showing over-utilization of doctors. The average distance to a health facility is 5 Kms. The most prevalent diseases are Malaria and skin diseases, while childhood diseases include anaemia, marasmus, eye infection, pneumonia, malaria, etc.

HIV/AIDs in Machakos is a major health problem with the prevalence averaging 15%. With regard to bed occupancy, about 50% of the hospital beds are occupied by patients with HIV/AIDS related diseases.

Majority of HIV/AIDS patients are found in Machakos Town and its environs and in all towns along the Mombasa highway. Cases are being reported in the small and up coming towns in the district like Wamuyu and, Matuu. HIV/AIDS incidences along the major highway and upcoming towns are attributed to the long-distance truck drivers/touts and, sex workers.

The biggest challenge facing the district is the increasing cases HIV/AIDS despite an awareness level of over 85%. It also faces the challenges of providing medical care for the infected and support for the affected. Currently the district estimates that there are over 15,000 children in need of special care and this number is expected to rise due to the increasing number of HIV/AIDS orphans. HIV/AIDS rate is higher among girls or women.

Gender disparities are manifested through school enrolment, property ownership, access to credit and discrimination in places of work among others. Domestic violence is often gender based like wife battering, sexual abuse to girl child, rape, sexual harassment and intimidation. Moreover the 36.4% of the girls have undergone the practice of FGM/C.