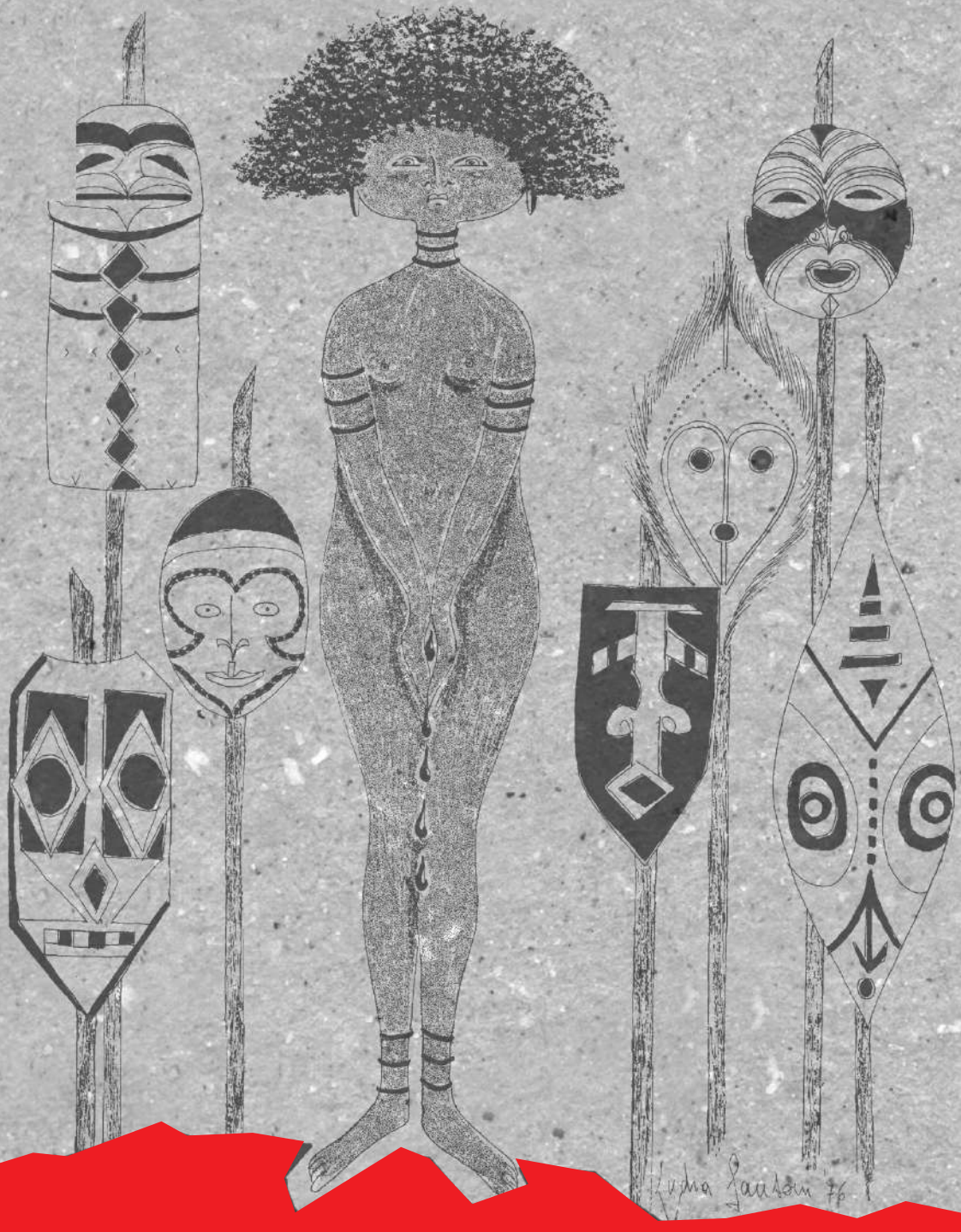
Mainstreaming the fight against FGM/C

A training manual



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. In order to make PRSPs gender sensitive and effective in reducing poverty, all stakeholders within the PRSP process 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 country poverty reduction strategy which also integrates components on FGM/C.
Therefore, FGM/C should be addressed as a component in all anti-poverty 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, 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.
With a grant from the International Bank for Reconstruction and Development AIDOS, in collaboration with the Centre for Reproductive Rights of New York, has developed this prototype training manual “Mainstreaming the fight against FGM/C”, to be used by skilled trainers for training of government officials and directors and programme officers of NGOs, in order to make them understand correctly the facts about the practice and be knowledgeable about the most innovative and successful interventions. In this way they will be able, with the technical assistance of local specialised NGOs and institutions, to design programmes/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: Cristiana Scoppa, Giovanna Ermini and myself from AIDOS, Laura Katzive and Pardiss Kebriaei from CRR.
The manual, while it is original in its approach and contents, draws from the experience of several other organisations and individuals, whose work has been analysed and utilised. AIDOS would like to thank all the institutions and NGOs that have contributed materials, and especially RAINBO, TOSTAN, the Population Council, PATH, Macro International, TAMWA, WHO, UNICEF, GTZ. They have been indicated in the references to the various activities.
The modules on gender and sexual and reproductive health and rights have been adapted from a manual “Reproductive Health for All: Taking Account of Power Dynamics between Men and Women” that AIDOS developed under the EC/UNFPA Asia Initiative on RH, in collaboration with the Women's Health Project of the University of the Witwatersrand, South Africa.
This prototype manual was tested during a ten days Training of Trainers course held in Bagamoyo, Tanzania, in December 2004. Fifteen skilled trainers from Eritrea, Kenya, Tanzania, Somalia and Sudan, working with Governments and NGOs, were trained on the use of the manual and gave precious feedback for its finalisation.
This prototype manual needs to be adapted and tested at country level.

Daniela Colombo
AIDOS President

CONTENTS

OVERALL OBJECTIVES

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

a) a gender issues
b) a violation of human rights
c) a serious infringement of sexual and reproductive rights of women/girls
d) a practice that has serious consequences on women's health

2. To understand the cultural environment and the reasons behind the practice

3. To analyse the causes of the persistence of the practice

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

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

6. To suggest ways of mainstreaming the fight for the abandonment of FGM/C into development programmes/projects

7. To understand the impact of legal and policy measures to stop FGM/C

COURSE STRUCTURE

Module	Activity	Time for activity	Total time for module
Introduction	1. Getting to know the issues and each other	20 minutes	2 hours and 30 minutes
	2. Names & carifying hopes and expectations	1 hour and 10 minutes	
	3. Developing a group contract	30 minutes	
	4. Introduction to course content and methods	30 minutes	
Module 1 Gender, gender analysis, gender planning	1. The social construction of gender	2 hours	8 hours and 40 minutes
	2. Differentiating between sex and gender	1 hour	
	3. Division of labour	1 hour	
	4. Access to and control of resources	1 hour	
	5. FGM/C as a gender issue	1 hour and 40 minutes	
	6. Gender planning	1 hour	
	7. Empowerment	1 hour	
Module 2 FGM/C as a violation of women's rights	1. Human rights from a personal perspective	1 hour and 15 minutes	4 hours and 25 minutes
	2. What is human rights law?	45 minutes	
	3. Which rights does FGM/C violate?	1 hour and 40 minutes	
	4. Duties of governments concerning human rights	45 minutes	
Module 3 Sexual and reproductive health and rights	1. Reproductive rights	1 hour and 50 minutes	4 hours and 25 minutes
	2. Sexual rights	1 hour	
	3. FGM/C and reproductive health	1 hour and 25 minutes	
Module 4 Understanding FGM/C in changing societies	1. Origins and evolution of FGM/C over time	2 hours	8 hours and 40 minutes
	2. Myths and realities behind the practice	2 hours and 10 minutes	
	3. A religious practice? An Islamic practice?	2 hours	
	4. A women's affair?	2 hours and 30 minutes	
Module 5 Programming for the prevention of FGM/C	1. Who? Target groups for preventing FGM/C	2 hours	11 hours
	2. How? Different approaches for different settings	2 hours	
	3. Steps in behavioural change: A case study	2 hours	

Module	Activity	Time for activity	Total time for module
	4. Abandoning FGM/C: interaction between women and the community	1 hour	
	5. Prevention of FGM/C as a development issue	4 hours	
Module 6 Legal and policy measures to stop FGM/C	1. What role can law play in preventing FGM/C	1 hour and 30 minutes	6 hours and 55 minutes
	2. What does the law say about FGM/C in your country?	45 minutes	
	3. Who can use the law to stop FGM/C?	1 hour and 30 minutes	
	4. How can the law be used to stop FGM/C? Looking at criminal law	1 hour and 10 minutes	
	5. How can the law be used to stop FGM/C? Considering other legal measures	2 hours	

COURSE TIMETABLE

Day	Time	Module / Activity
Day 1	Morning	Introduction Module Module 1 / Activity 1
	Afternoon	Module 1 / Activity 2 Module 1 / Activity 3
Day 2	Morning	Module 1 / Activity 4 Module 1 / Activity 5 Module 1 / Activity 6
	Afternoon	Module 1 / Activity 7 Module 2 / Activity 1
Day 3	Morning	Module 2 / Activity 2 Module 2 / Activity 3 Module 2 / Activity 4
	Afternoon	Module 3 / Activity 1 Module 3 / Activity 2
Day 4	Morning	Module 3 / Activity 3 Module 4 / Activity 1
	Afternoon	Module 4 / Activity 2
Day 5	Morning	Module 4 / Activity 3 Module 4 / Activity 4
	Afternoon	Module 5 / Activity 1
Day 6	Morning	Module 5/ Activity 2 Module 5 / Activity 3
	Afternoon	Module 5/ Activity 4 Module 5 / Activity 5 (first part)
Day 7	Morning	Module 5 / Activity 5
	Afternoon	Module 6/ Activity 1 Module 6 / Activity 2
Day 8	Morning	Module 6/ Activity 3 Module 6 / Activity 4
	Afternoon	Module 6/ Activity 5 Closing ceremony

INTRODUCTION TO THE COURSE

Purpose of this manual

The manual has been conceived 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.

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.

Testing and adaptation

The manual was tested and refined during a ten days ToT course, with 15 trainers coming from various countries in Eastern Africa. The participants in the course were chosen both from Government institutions and NGOs, so that each of them could give the most valuable contribution. Thus we present a tested prototype manual in which the principles illustrated within each activity remain constant, but the scenarios, case studies and data should be adapted to be locally specific and relevant.

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.

Activity 1

GETTING TO KNOW THE ISSUES AND EACH OTHER

Time: 20 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 :

- Rural life
- Women's role in the family
- Maternal deaths
- Human rights
- Violence against women
- Female genital mutilation / cutting
- AIDS
- Men's role in parenting

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:1 hour and 10 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:30 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:

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.

Note to facilitator

Materials:

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

Activity 4

INTRODUCTION TO COURSE CONTENT AND METHODS

Time:30 minutes

Why do this activity?

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.

How to do this activity?

Overheads

Put up the overhead 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 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.

Main points you can make to describe the course structure:

Module 1: “Gender, gender analysis, gender planning” begins by ensuring that all participants mean the same thing by “gender” and have a shared agreement on why it is important to promote gender equity/equality. The module builds a common understanding of how power relations between men and women are constructed, maintained and reinforced. It goes on identifying 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. The module ends with some elements of gender planning and the concept of women's empowerment.

Module 2: “FGM/C as a violation of women's rights” stresses the fact that FGM/C is a violation of the human rights of women and that the Governments have the duty to ensure the enjoyment of human rights in their jurisdictions. In order to clarify governments' role for the prevention of FGM/C, the module provides participants with the conceptual and factual foundations of human rights law, particularly the law relating to women's rights to be free from FGM/C.

Module 3: “Reproductive and sexual health and rights” is based on the consideration that in order to fight for the abandonment of FGM/C, it is crucial to understand without prejudices the concepts of sexual and reproductive rights as defined in the Programme of Action approved at the International Conference on Population and Development (ICPD), held in Cairo in 1994, and in the Platform for Action approved at the Fourth World Conference on Women (FWCW), held in Beijing in 1995. The module ends with a brief description of the consequences of FGM/C on the physical and psychological health of women and girls.

Module 4: “Understanding FGM/C in changing societies” gives participants an understanding about the origins and evolution over time of the practice and how it became prevalent in certain areas of Africa. It further discusses the myths and realities behind the practice and its religious implications, in order to understand the complexity of FGM/C and why women continue to perform it, notwithstanding the harmful consequences on health.

Module 5: “Programming for the prevention of FGM/C” intends to make participants knowledgeable about the different approaches to programmes for the prevention and abandonment of FGM/C and to understand the positive and negative effects of different types of interventions for different target groups. The methodology used by the NGO TOSTAN is explained in details. The module also stresses the importance of research, monitoring and evaluation, based on RAINBO analysis. It finally suggests ways of mainstreaming FGM/C prevention activities in development programmes /projects and promoting creative programming in connection with the broader and national development agendas.

Module 6: “Legal and policy measures to stop FGM/C” discusses the various laws and policies that Governments have enacted and encourages participants to think about how they may use law to support

Note to facilitator

efforts to stop FGM/C. The legal and policy measures can be used by advocates to protect individual women, promote greater awareness of women's rights, seek greater governmental accountability for wide-spread tolerance of FGM/C and guide the behaviour of governmental representatives. It is up to judges, lawyers, law enforcement officials, medical personnel and members of civil society to give force to the laws and policies. This module discusses the many challenges that can be faced in using the law.

Overheads:

- Overhead 1: Overall objectives of the course
- Overhead 2: Structure of the course

OVERALL OBJECTIVES OF THE COURSE:

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

a) a gender issues
b) a violation of human rights
c) a serious infringement of sexual and reproductive rights of women/girls
d) a practice that has serious consequences on women's health

2. To understand the cultural environment and the reasons behind the practice

3. To analyse the causes of the persistence of the practice

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

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

6. To suggest ways of mainstreaming the fight for the abandonment of FGM/C into development programmes/projects

7. To understand the impact of legal and policy measures to stop FGM/C

STRUCTURE OF THE COURSE:

MODULE 1

Gender, gender analysis, gender planning

MODULE 2

FGM/C as a violation of women's rights

MODULE 3

Reproductive and sexual health and rights

MODULE 4

Understanding FGM/C in changing societies

MODULE 5

Programming for the prevention of FGM/C

MODULE 6

Legal and policy measures to stop FGM/C

MODULE 1

GENDER, GENDER ANALYSIS, GENDER PLANNING

Module objective:

- To have a common understanding of the concept of 'gender' and related terms (gender equity, gender analysis, gender planning), empowerment of women 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 rational behind gender planning and how this relates to FGM/C.

Activities:

Activity 1: Social construction of gender (2 hours)
Activity 2: Differentiating sex from gender (1 hour)
Activity 3: Division of labour (1 hour)
Activity 4: Access to and control of resources (1 hour)
Activity 5: FGM/C as a gender issue (1 hour and 40 minutes)
Activity 6: Gender planning (1 hour)
Activity 7: Empowerment (1 hour)

Total time: 5 hours and 40 minutes

Activity 1

THE SOCIAL CONSTRUCTION OF GENDER

Time: 2 hours

Why this activity?

This activity explores how individuals are socialised into their roles as men and women and to identify the various agents and institutions in society that reinforce these gender roles. This is done by looking at how participants, as young children, were introduced to gender norms and roles. This activity is useful to help participants recognise how the process of socialisation works such that both men and women in a particular society share that society's understanding of how men and women are socialised and the value attached to these socially determined roles. It also highlights how both men and women are agents in the process of socialisation. The activity aims to illustrate how gender is constructed, maintained and reinforced.

The concept of 'gender' is relatively new. In addition, it does not exist as a single word in many languages. For this reason it is important to develop a shared language on how to talk about culturally determined power relations and role differences between men and women. This activity as well as activity 2 should be used to develop a shared language and understanding between the facilitator and participants. Whatever word or words are used, they need to make clear the meaning of 'gender' as it is used in this manual. The way we are using gender is described as follows:

Definition

What is meant by gender?

The term gender refers to the economic, social and cultural attributes and opportunities associated with being male or female. In most societies, being a man or a woman means not only having different biological characteristics, but facing different expectations about the appearance, qualities, behaviour and work appropriate to being male or female. Relations between women and men - whether in the family, the workplace or the public sphere - also reflect understandings of the talents, characteristics and behaviour appropriate to women and men. Gender thus differs from sex in that it is social and cultural in nature rather than biological. Gender attributes and characteristics vary among societies and change over time.
Gender norms are the way that society expects women and men to

behave. These norms are not only about differences in how women or men, girls or boys should behave. They are also about the different values associated with being a girl or a boy, a woman or a man. For example, in some societies families rejoice when a boy is born, but mourn when a girl is born. This indicates that boys and girls are not only considered to be different from each other, but that the gender norm is that boys are valuable to society, whereas girls are not. As another example, in most societies it is considered acceptable for a man to beat his wife or daughters, but not acceptable for a woman to beat her husband. This indicates that women have less value than men.
Gender roles are one part of gender norms. “Roles” refer to the activities which are considered appropriate and acceptable for boys or girls; men or women. We will explore gender roles in more detail in Activity 3.

Objectives

- To identify the social processes and institutions which shape our understanding of what it means to be a boy or a girl, a man or a woman
- To understand how individuals experience the moment of recognition that they are a boy or a girl
- To understand that the concept of ‘gender norms’ refers to the values society associates with being a boy or a girl, a woman or a man
- To identify how gender norms not only identify a difference between being a girl or boy, man or woman, but value manhood over womanhood

How to do the activity

Overhead

This session consists of three steps. The first is an individual activity in which each participant writes down his/her first experience of realising that he or she was ‘different’ from members of the opposite sex. Show the overhead 1 and explain the difference between sex and gender.

The second step consists of sharing these experiences in pairs.

The third step is a plenary discussion which centres around the specific experiences narrated, and tries to collate the information to build a general picture of how each of them were socialised into gender roles.

Step 1: 15 minutes

Individual work

Ask each individual to think as far back as possible in their lives and recall one incident when they first realised that being different from boys if they are girls, and vice versa, meant that they were expected to behave differently and were treated differently. Emphasise that we are asking them to remember differences about behaviour, not about physical differences. If they are thinking of things that have to do with changes at puberty, that is physical and 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: 10 minutes

Small group work

Ask participants to get into pairs and share their stories.

Step 3: 1 hour 35 minutes

Plenary discussion

Call the group back together. On a flip chart have columns for age, people involved, where, what the incident was about, and feelings associated with it.
Ask each pair to report on the other person's story to the large group and write the essential details under the specific columns.
Go through each column. Discussing results from each variable (age, people involved, where, what the incident was about, feelings associated with it), ask the group to identify similarities and differences, and make these clear if they do not come out.

Note to facilitator

Points to bring out in discussion

Age

The youngest age is usually interesting to note as it makes the point about how early socialisation begins.

People involved

Family members, religious leaders, teachers, are usually the first groups of people who influence a child's life. To start moving beyond childhood ask the question, 'Later on in life who continued to treat you differently from boys/girls or had different expectations from you?' Colleagues at work, men and women in social circles, the media are usually mentioned.

Where

This often corresponds with the kinds of people involved. The home or family for example, at play, school or mosque for peers and teachers and adults in general. Later in life, the list of where the reinforcement of similar messages occur, gets extended to include the work place, social circles and the media.
Make the point that these are social institutions which reinforce social norms and values that girls and boys, women and men are not only different from each other, but also that they are not equal; that boys and men have more value than women. You should be able to use an example given by a participant to illustrate this, particularly where participants describe how they felt at the time.

What the incident was about

Usually this includes:
Division of labour along sex lines: the kind of household chores girls are expected to do as opposed to boys, such as girls working inside the home and boys outside, girls working for others in the home, e.g. cooking, dish washing, cleaning the house and washing of clothes, girls doing things for the boys that boys can do but are not expected to do like serving the food, cleaning up after themselves and doing their washing.
Physical segregation of boys and girls: being told not to play with members of the opposite sex, or not to engage in any activity that will bring them in physical contact with members of the opposite sex.
The kinds of games girls and boys play, where girls are encouraged to be soft and gentle and boys to be rough, toys that are bought also differ.
The place where play takes place: often girls are inside the house or within earshot and eyesight while boys can go far and be unreachable. This may be linked to the household chores, e.g. the reason why girls are not to go far may be because they simultaneously have to be seeing to the cooking pots. It may also be that the tasks girls have to perform leave so little time for play in between that they cannot afford to go very far.
Mobility: girls' their movements are controlled, and known by everyone, while it is acceptable that boys can be anywhere without anyone knowing where they are.
Emotional responses: girls and boys are expected to respond differently to the same stimulus; while it is acceptable for girls to cry, for boys it is seen as is weakness, girls are encouraged to bear pain because it is a way of life while boys are expected to avoid situations that will inflict pain on them.
Intellectual responses: girls are to be seen not heard and there is an expectation that girls are not to talk or express their opinion.

How they felt

In most groups, women express negative feelings towards the specific incident. Feelings of resentment, anger, disappointment, frustration, confusion, feeling "less than the other", rejection, isolation, and loneliness. Men, on the other hand, have often expressed positive feelings: "feeling better than", "feeling like a man", feeling powerful and respected.

Main Points

Main points to come out:

From the exercise participants will have seen how society treats boys and girls differently, and expects them to behave differently from each other. Society also values boys and girls differently. These differences are known as 'gender' differences. At this point you can use the definition of 'gender' presented under 'Why this activity' to explain the concept to participants. You can also come to an agreement about what wording you will use for 'gender' for the rest of the course.
In addition, draw out the following points:

Gender norms and roles are learnt; boys and girls are taught to behave in a different way.

Socialisation into gender norms begins early in life.

This includes learning to be different in terms of:

Appearance and dress

Activities and hobbies

Behaviour

Emotions displayed

Responsibilities

Intellectual pursuits and so on.

Gender norms are taught and reinforced by various social institutions: the family, the school, religion, society as represented by peers and neighbours, to mention a few.

Men play a significant role as women in socialising girls and boys into their gender roles.

Society prescribes specific roles for girls and boys, women and men, but values them differently. In almost all societies girls and women are valued less than boys and men. This unequal value is the source of discrimination and oppression for women and accounts for the less important status given to women in society.

Materials:

- Paper and pens for each participant.
- Prepared sheets of flipchart paper with age, people involved, where, what the incident was about, and feelings associated with it, written on.
- Felt-tip pens.
- Something to stick the flipchart to the wall with.

Activity 2

DIFFERENTIATING BETWEEN SEX AND GENDER

Time:1 hour

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 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: 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.
Read out the statements one by one. For each ask people who have an ‘S’ written next to the statement to raise their hands, then ask those with a ‘G’ to raise their hands. This way the group will see if there is consensus or not.

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. It is possible that the participants will 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 2: 20 minutes

Handout

Now the group moves to how ‘sex’ and ‘gender’ link to health issues. Distribute Handout: Health-related statements about women and men. Again people are asked to mark the handouts as either ‘S’ or ‘G’ and again you distribute them and read out the questions, getting the group to indicate how people 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 3: 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 you already have up. This section will also give them a deeper understanding of the concept of gender. While running this discussion, draw on the examples given by participants during activity 1. These examples will allow you to illustrate

the 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 of sex. Tell them that what they have done in the previous two exercises is to define the difference between sex and gender.
They saw 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 so that you show 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 before the revolution 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

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 be exploring how gender relationships have to do with access to and control of and over resources and benefits.

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. Amongst African agricultural workers, women are paid 40-60 per cent of male wages.

4. Women can breast-feed babies, men can bottle-feed babies.
5. In Ancient Egypt men stayed at home and did the weaving.
Women handled family business. Women inherited property, men did not.

6. Men's voices break at puberty, women's do not.
7. According to the United Nations, women do 67% of the world's work, yet their earnings for it amount to only 10% of the world's income.

8. 2 million girls are mutilated every year.

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 cannot ride bycicles, boys can.

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. Boys and men suffer from haemophilia, whereas girls and women are usually only carriers.

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 ovary cancer, men have prostate cancer.

9. Infibulated women suffer from mestrual blood retention.

10. In deprived rural areas girls suffer from malnutrition more than boys.

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 3

DIVISION OF LABOUR

Time: 1 hour

Why do this activity?

The concept of 'gender' is complex. The following activities deepen participants' understanding of the concept of 'gender'. 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 undervaluation 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

Handout Distribute Handout: The 24-hour day.

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 - such groups may be farmers, poor town dwellers, middle class where both husband and wife work, etc. Ensure that each group has chosen a different social group.
Ask the group 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 the 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 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

In concluding 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 normative 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 to raise children, but the daily work of 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 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 that many of women's roles are not paid for and that 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 it is time for men to start sharing reproductive work, that is domestic tasks and care of children, with women.

Draw out that 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.

Step 4: 5 minutes

Handout 2

Action

Give out Handout: The lie of the land

Ask one participant to read the cartoon.

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

Handout 3

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

Materials:

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

Handouts:

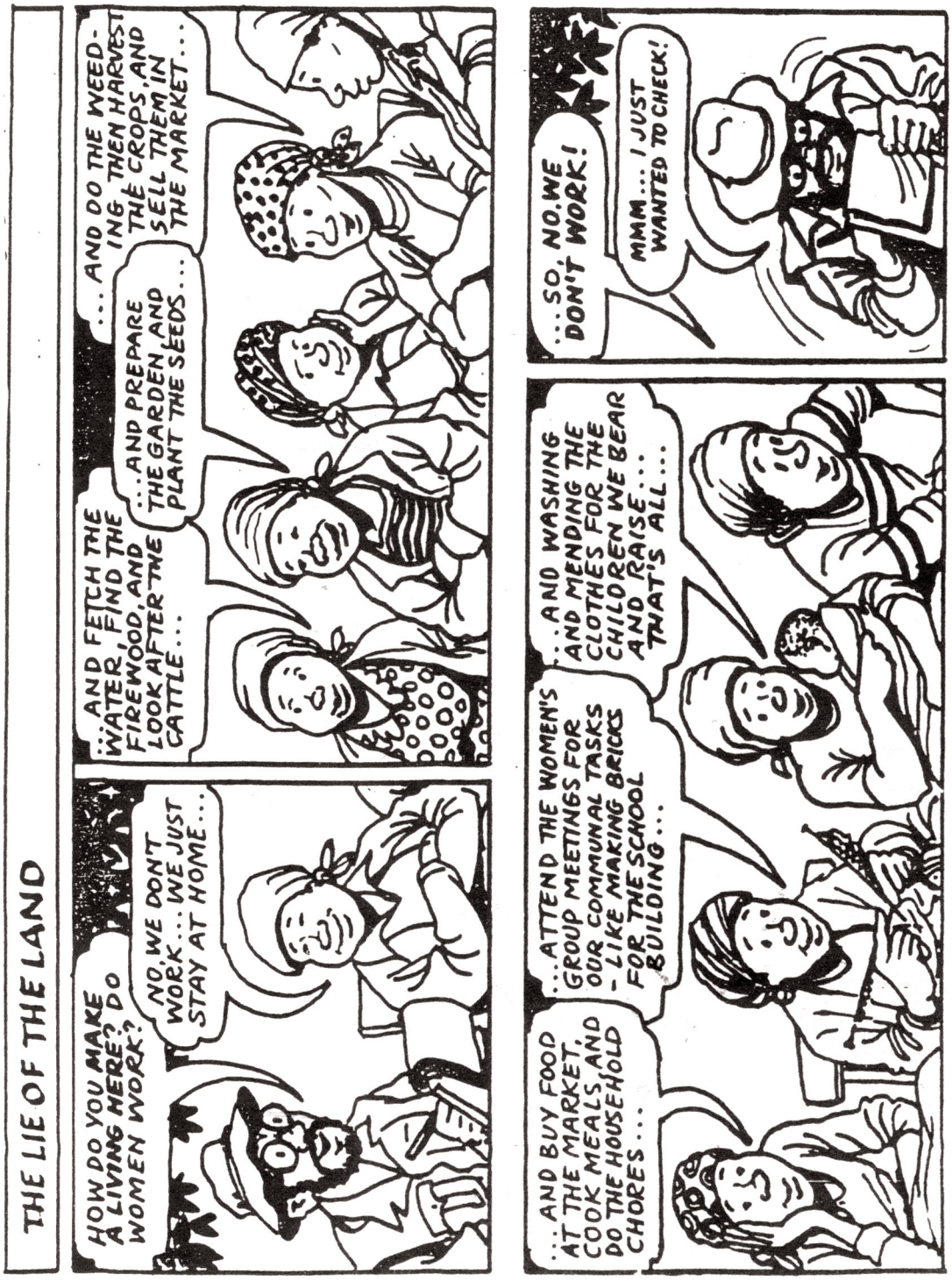
- Handout 1: The 24-hour day
- Handout 2: The lie of the land
- Handout 3: Working Women

THE 24-HOUR DAY:

MAN'S ACTIVITY	PAID YES/NO	WAGE PER HOUR	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 EARNINGS	TOTAL HOURS WORKED		TOTAL DAY'S EARNINGS

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 fire-wood and water collection: 10 times the hours of men. This carries over to girls, whose household work takes about 3.7 times the hours of boys.

- 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 of 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 4

ACCESS TO AND CONTROL OF RESOURCES

Time: 1 hour

Why do this activity?

This activity identifies how men and women, having different roles, have differential access to resources - whether economic, political / decision-making, informational, internal, 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 undermines women's health. This tool, linked with division of labour from the previous exercise, is necessary in order to build participants' ability to identify the diverse dimensions of gender inequality underlying health problems and health services that they want to address.

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 do a 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 her respond.

Ask the actor playing the man:

'How did you feel playing this role?' and let 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.

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 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 man who inherits. 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 least income, since 'women's work' is given less value in society than 'men's work'.

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 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.

This applies likewise to decision-making positions in private sector companies, in trade unions. In all cases the leadership tend 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 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.

Note to facilitator

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; 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 - 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 not likely to use up time in making use of health services. Also, the opening times of a health service may determine whether or not a health service 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 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:

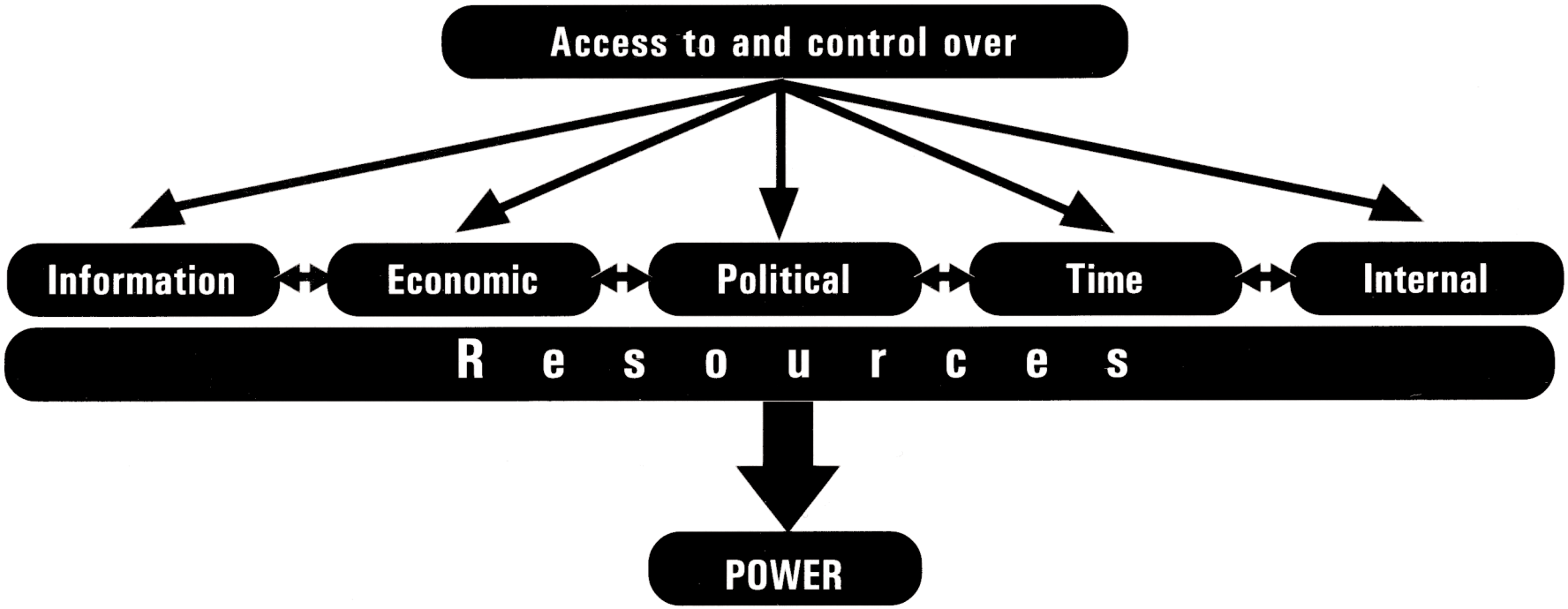
- Handout 1: Differential access to and control of resources between men and women in selected Asian countries
- Handout 2: Range of resources
- Handout 3: Role-play on access to and control over resources gives you some roles for volunteer actors to play. Decide if you want to use this role-play or to make

different roles so that the role play will give you examples and issues you can use when describing the different kinds of roles and resources in society. The role play should also illustrate men and women's differential access to and control over these resources. You do not make copies of the handout for participants. You just give each volunteer a copy of his or her role.

Readings:

- 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 school enrolment		Secondary school enrolment		Percent illiterate >15 years		Adult + 15 economic activity rate 1995/97		Percent women in the adult labour force 1995/97	Percent parliamentary seats in single lower chamber occupied by women 1999	Percent women at ministerial level 1998
	W	M	W	M	W	M	W	M			
KENYA	85	85	22	26	25	12	74	89	46	4	0
TANZANIA	66	67	5	6	34	16	83	89	49	16	13

1 UNFPA, *The State of the World Population, Lives Together Worlds Apart, Men and Women in a Time of Change,* New York, 2000
2 United Nations, *The World's Women 2000, Trends and Statistics,* New York, 2000

RANGE OF RESOURCES

Economic 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 and informal education
· Non-formal education
· Opportunities to exchange information and opinions

Time

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

Internal 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 lands 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 townfor good money. You want to do this because you need more money to buy a gift for your best friend's wedding.

Activity 5

FGM/C AS A GENDER ISSUE

Time: 1 hour and 40 minutes

Why do this activity?

The word gender defines the social identity, roles and values ascribed to women and men. In Africa, for millions of girls FGM/C has been an essential step into their socializazion as women. The expression “female circumcision” so often heard to define FGM/C seems to equalise the practice to male circumcision and explains why anthropologists have understood FGM/C as a rite of passage: to adulthood, but also to womanhood. A woman must be ready for her adult life as a wife and mother. Understanding the complexity of this process is the aim of this activity.

Objectives:

- To understand how FGM/C contributes to the definition of women’s identity
- To recognize FGM/C as a gender issue
- To link FGM/C to the other elements that build women’s gender role and place in society as a condition of unequality.

How to do this activity:

Step 1: 40 minutes

Individual reading

Distribute Handout 1 “ Anthropology of female genital mutilation” and tell participants they have 30 minutes to read it carefully, noting the points that strike them most.

Step 2: 1 hour

Plenary

Conduct the discussion in plenary, following the different paragraphs of the paper, and using the questions below as a guideline:

Note to facilitator

1. Do you agree with the definition of the practice given by WHO?

2. FGM, FGC, FGM/C, female circumcision, other expressions... which is the most appropriate? When?

3. Is FGM/C the survival of something very arcaic?

4. How FGM/C contributes to the construction of women's identity?

5. And how does FGM/C contribute to defining gender relations?

6. Can you recognize the
· relational
· economical
· hierarchical
· historical
· context specific
· istitutional
gender dimensions of FGM/C?

7. Does FGM/C contribute also to the personal and political dimensions of gender relationships?

Materials:

• Handout for each participant

Handouts

• Handout 1: Anthropology of Female Genital Mutilation

Readings:

• Carla Pasquinelli, *"Anthropology of FGM"*, in *Stop FGM*, proceedings from the Expert Consultation on Legal Tools to Prevent FGM, organised by AIDOS and NPWJ in Cairo, 21-12 June 2003, http://www.stopfgm.org

ANTHROPOLOGY OF FGM

1. What is FGM?

Female genital mutilation[1] was the name given during the III Conference of the Inter-African Committee on traditional practices affecting the health of women and children to all those traditional practices involving the removal and/or alteration of part of a woman's external genitals. The populations of the countries where it is practiced do not accept the strong negative connotation contained in the term and have other expressions. Every group uses terminology passed down by tradition and the words vary greatly from one ethnic group or region to another, also according to the type of mutilation practiced. When Somalian women, for example, speak to each other, they often use the more domestic and evocative name of "stitching". But generally speaking, all the populations where this type of operation on the female body is common prefer the term circumcision. It is a neutral term improperly used to compare female genital mutilation with male circumcision where the operation is limited to removal of the piece of skin surrounding the gland without provoking any mutilation of the male body. This linguistic transfer has the result of concealing the destructive effects of FGM on most women, giving it a more familiar, reassuring image.

According to the World Health Organization (WHO) classification, there are four main types of FGM:

Type I consists of excision of the prepuce, with partial or total excision of the clitoris (clitoridectomy). The traditional name for this kind of mutilation is *sunna*.

Type II – excision, consisting of the removal of the prepuce and all or part of the labia minora along with the clitoris.

Type III, infibulation or Pharaonic circumcision, the most brutal form, consisting of part or all of the clitoris and the removal of the labia minora and, particularly in the past but still in rural areas today, the stitching/narrowing of the vagina to form a tiny opening no larger than a grain of rice or a millet seed to allow discharge of urine or the menstrual flow.

Type IV includes a series of procedures, from slight pricking, piercing or incising of the clitoris to let out a few drops of blood to different types of manipulation that vary greatly from one ethnic group to another, including cauterization of the clitoris, cutting the vagina (*gishiri*), and introduction of corrosive substances into the vagina to narrow or dry it.

All of these procedures, performed for the most part without anesthesia by traditional practitioners, mean a high mortality rate, health complications and psychological problems. For clitoridectomies, performed on a large majority of the women, and the *sunna*, the results from a medical-health point of view, are not as serious as for excision or for infibulation.

Female genital mutilation is primarily an African custom, since experts consider cases found outside of Africa of recent importation. While *sunna* is also practiced in the north, the other forms are common especially along the strip of the sub-Sahara: infibulation in eastern Africa and clitoridectomy in western Africa. The area is a vast one, with a heterogeneous population of ethnic groups with different languages, cultures and religions, but they all have in common the same economic-

symbolic system based on the relationship between FGM and the brideprice.

Given its social nature, it is used for all the women in any one ethnic or social group according to set times and periods. Generally speaking, the girls are all operated on during a given season or month of the year, according to periodic cycles that vary from one ethnic group to another. Even the age when the operation is performed changes according to the ethnic group and type of mutilation. If we want to be extremely synthetic, we could say that clitoridectomy is practiced in the period from early infancy (from the 3rd to the 40th day of life) especially in Christian societies but also in some animistic and Moslem societies, and between 4 and 14 years in most Moslem and animistic societies. The age of infibulation various from 3 to 13 years and intervention in the neonatal period is rare.

2. A Long Silence

The origin of female genital mutilation is obscure, from a remote past that, according to some, dates back to the Pharaohs, while for others it originated with ancient Rome. In any event, the origin is made even more shadowy by the silence that has always surrounded it and helped make it a taboo subject for African peoples, as well as to protect it from the curiosity of Westerners.

Many things lie behind this silence: First, there is a world of women closed unto themselves, a world of interiors, suspended between expectation and the fear of cutting away part of their daughters' bodies in ceremonies that mothers have directed for centuries. Second, there is an outside world, a world of men who hold themselves aloof and distant, but that bases its strategies of power on this regulation of the female body. What keeps these very distant two worlds together and has given them cohesiveness is a bloody, brutal practice that grips the entire region of the sub-Sahara and is the symbolic expression of a complex economic and social system of marriage strategies widespread throughout the area. It is a mechanism of domination based on the brideprice, i.e. the compensation that the family of the future husband pays to the family of the future bride. In exchange, the husband receives a virgin, meaning circumcised – be it excised or infibulated – who can be sent right back and the price, cattle or money, returned, if she has not been properly operated upon. The value of the wife depends on her virginity and FGM is a sort of protection which inhibits desire and temptation for pre-marital relations in the woman. But above all, it preserves and defends her from rape.

This silence also includes the tacit complicity of the West. First during colonialism and then with its development co-operation policies, the West has preferred to ignore FGM in various ways, entrenching itself behind a rather uncommon form of respect for local traditions. A veil of silence has fallen that not even ethnologists – those studying the customs and traditions of others – have been able to break. With the exception of the testimony that appeared towards the end of the 17th century in those extraordinary documents of travelers' diaries, little research has been conducted on FGM. And that little bit of research that has been conducted is incomplete, partly because for a long time, the only people who were in the field were men, and as such had rare access to, and lacked interest in, the female world.

In recent years, that silence was sealed by a refusal of those directly affected to speak out. This position was adopted by African women during the 1980 Conference of

Copenhagen[2] when they dodged pressure from American feminists who insisted on including FGM on the political agenda. The Africans rejected the initiative as interference in their lives and political choices.

Then, something changed. It is difficult to say when or how the conspiracy of silence that for centuries had placed FGM outside history started to crumble. But for the last several years, the silence has given way to myriad voices that are transforming FGM into a new social issue related to respect for human rights and the safeguarding of the health of women and girls.

This movement out of the shadows is the result of years of sensitization campaigns promoted by international and African non-governmental organizations and various UN agencies. But it is also the outcome of legislative measures adopted by national governments. Generally speaking, it is a signal that even this archaic, secret practice is now affected by the process of modernization in keeping with dramatic events that are changing the lives and face of many African populations: war, emigration and expansion of Islamic fundamentalism.

3. The origin of FGM/C

It is not easy to reconstruct the origin of FGM given the variety of forms and the fact that the practice is spread widely throughout the African continent. There is no lack of hypotheses however. According to some, excision dates back to ancient Egypt but also ancient Rome, where it was practiced on slaves and seems related to considerations of the female body as property. Infibulation was also found in Rome, though performed originally only on males. A sort of pin, *fibula*, was applied to young men to keep them from having sexual relations. But the center of female infibulation seems to have been the Egypt of the Pharaohs, as the name "Pharaonic circumcision" seems to suggest.

All the same, the real origin of female genital mutilation seems destined to remain unknown for now. We do know for certain that Islam was not responsible for introducing the practice of FGM in Africa and that it was already present on the continent well before the spread of the religion. It is a native practice, deeply rooted in the 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 Islam is frequently attributed as the origin of female genital mutilation in Africa 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 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 the translation of the name Allah, made it much more tolerant of female genital mutilation. Greater opposition came from the Christians who were often in open conflict with local cultures, the most clamorous case of which was the rebellion against the missionaries who forbid the practice of excision on Kikuyu women in Kenya in 1929.

The different attitude of Christianity and Islam is also reflected in the number of

women subjected to FGM in the two groups. The figures are clear: while the percentages in the Christian area, where clitoridectomy is prevalent, ranges between 20 and 50 percent, in the Moslem regions, particularly the Horn of Africa where infibulation is a prerequisite, the percentage is between 80 and 100 percent. With time, identification of Islam with the native tradition became so complete that it subsequently became the main agent for the diffusion of FGM outside of Africa, exporting it to Indonesia and Malaysia, among others.

While Islam was not at the origin of the practice on the African continent, instead of combating it as the Christian churches did, Islam gave the practice legitimacy, defended and justified it, thus helping to perpetuate and spread it. Today, this close identification of traditional cultures is becoming a problem. Part of Islam, including the fundamentalist clergy training in Saudi Arabia, are trying to distance themselves from the most destructive forms such as excision and infibulation. They are attempting to attribute the practice to its rightful owner, tribal culture, that difficult heritage that collides with the fundamentalist ambitions to "Islamize" modernity.

4. Initiation Rites

The problem of origin is a false one since, rather than providing understanding to remove the reasons for the presence of FGM, it encourages the idea of the survival of something archaic, lessening the idea that FGM is still a very active institution in determining the life of relations and exchanges on which the social organization of most African societies is based. The fact that it is so deeply rooted is due to a complex group of factors that have some common features while varying from one ethnic group to another. The affinity lies in the basic role that this type of traditional practice has in the construction of gender identity and the formation of ethnic belonging, as well as the definition of relations between the sexes and between generations.

Before examining in detail all these aspects affected by the symbolism of female genital mutilation, we need to define its nature. By traditional practices, we mean those habitual acts, of common use, that were transmitted from the past generation and will quite probably be transmitted to the next. Female genital mutilation is therefore a particular type of traditional practice. Specifically, it is a rite of passage, those ceremonial practices that guide, control and regulate change in status, role and age of persons, thus marking the various phases of the life cycle, transforming them into an ordered path of life that makes senses and meets the needs of identity and recognition.

In particular, 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 the "social essence" of 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 he or she is and should be.

Rites bring people to the knowledge and acknowledgement of a pre-existing difference, like that which separates the sexes, making it exist as "social difference". Indeed, rites of passage have been defined as "acts of social magic" in virtue of this symbolic power. This is not only because they can create differences out of nothing when they notify peo-

ple of their new identity but also because they make the community acknowledge as legitimate what is really an arbitrary limit that creates a fundamental division in the social order, like that between the married and the unmarried, the initiated and the uninitiated and the even more radical division between men and women.

5. Construction of Gender Identity

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. Gender is a process of the definition of self according to the connection to cultural models historically built on the difference between the sexes. 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, on the other hand, 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 constructed and, at present, seems fairly unchangeable.

In African societies, the creation of gender identity is first of all, a physical manipulation of the body and also a metaphor. With respect to the ceremonial aspects of the rites of initiation, which take care of the symbolic control o f the passage of status, female genital mutilation does something more: it carves the woman's gender identity into her body. And it does so in two ways, first, by changing the morphology of her body and then by shaping its expressiveness.

FGM removes the "male" part of the female genitalia, the clitoris which is compared to a small penis. Thus, it erases the original bisexuality based on the presence in both sexes of rudimentary genital organs of the other sex. In the male, it is the prepuce which is removed, because it is considered a residue of femininity since it resembles a sheathe. Actually, these two operations are complimentary since one hides the female genital organ and the other uncovers the male organ. Only through excision of her male parts can a girl fully become a woman. That way, despite the fact that construction of gender identity is primarily a symbolic process, this physical manipulation of the body reinforces the impression that female identity is produced and maintained through circumcision. Thus, we have a sort of naturalization of the procedure that the culture uses to construct belonging to a sex, making any attempt to end this, at an individual or collective level, very difficult.

Along with manipulation of the woman's body, mutilation forms the physical appearance, proportion and harmony among the various parts, the *exis*, posture and bearing, giving a woman's body what 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 wrought 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 behavior 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.

We can therefore consider female genital mutilation as a "sexual marker". Not only does it remove any ambivalence in a woman's body with regard to gender identity, but it also naturalizes the difference between sexes, hiding the cultural construction in gender membership.

We have already seen how female genital mutilation acquires its meaning within the sphere of initiation rites and are the main event. There are also cases when the ceremonial aspect is reduced to a minimum and FGM becomes the ritual performance itself. Every operation takes place according to a ritualized sequence that is repeated unchanged from mother to daughter. It is held in a separate place at a ceremonial time with a woman from the outside and is handled in secret in a female community that opens to welcome the entire community, or neighborhood if they are in a city, once the operation is complete. Public celebrations or recognition of the woman's new status are almost always accompanied by gifts that are highly symbolic in colors and forms.

6. Expectations and Representations

There are a wide number of case histories that vary immensely according to the type of mutilation, the girls being initiated, and local habits and traditions. But still, the practice is carried out according to a ritual sequence marked by the three phases of separation, waiting and aggregation that mark every rite of passage.

The first phase is separation when the girls to be operated upon are taken away from home at dawn and brought together in a place far from prying eyes where the operation will be performed. The second phase is a threshold, as it were, a period of time suspended between the suffering due to the operation and the healing of the wounds, which the girls pass laying on the ground with their legs bound, far away from their families, waiting to heal. The third and last phase is that of aggregation, when they are returned to the joyous community and showered with gifts to celebrate their entry into the world of women.

Everywhere, we see the same multicolored scenario of women, mothers, traditional practitioners, sisters, aunts, grandmothers, neighbors and girls excited about becoming women like the others, excited and fearful in the face of that knife or razor blade that will allow them to join the female world only by destroying the most conspicuous demonstration of their femininity. There is strong social pressure from their peers and the specter of social alienation without the possibility of deliverance for those who refuse, mothers or daughters. What is at play here is the coupling of purity/impurity supported by an ethic based upon feelings of shame which form a terrible deterrent when grouped together. Local explanations of the practice are of the same sort and generally based on stereotypes that can all be traced to the need to control and limit female sexuality, seen as something ungovernable and threatening.

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.

But there are two important relationships at play here: between the sexes and between the generations (mother and daughter in particular) which initiation rites make extremely visible and dramatic. The mother-daughter relationship is much more ambiguous and controversial than that between the sexes, basically an asymmetrical relationship of domination, based on the marital strategy which we will discuss below.

In the mother-daughter relationship, we find rivalries and destructive instincts that are condensed, expressed and neutralized in the period of time required for the ritual performance. This is true from the point of view of the daughters who see in the rite a legitimization of their own sense of guilt at taking over their mothers' position, and from the point of view of the mothers who "betray" their daughters' trust, becoming persecutors and thus expressing their envy for their reproductive capacity. Then, all is forgotten, including torture and suffering, once the "passage" has taken place.

At the rite's end, only the bodies preserve the memory in the form of a scar appointed to represent the sign of membership in one's ethnic group.

7. Bodies, Ethnic Boundaries and Community Belonging

Female genital mutilation is also the entrance into one's own community, an entry ritual like baptism for Catholics. As such, it is a point of no return that separates those on the inside from those outside. This is true for all members of the community, men and women, even though it takes effect in different ways. In African society, not only female bodies are mutilated. Especially in the past, young men's bodies were subjected to cruel, painful intervention.

For both, they were signs left on their bodies by the cultural order, "symbolic wounds", which every social group used to write its name, impressing a mark that transforms the person into a bearer of his/her own culture. It is a mark of belonging but also of subordination which binds individuals to a collective identity and at the same time, makes them objects of a disciplinary strategy according to different procedures for the two sexes.

Female genital mutilation in particular represents that "ethnic boundary" that is the internal marking of community membership, converting it into a biological expression, canceling the unnatural nature and conditions of its production. It is a form of "endo-binding" that marks the boundaries between "us", meaning both the local community and the enlarged form of the "imaginary community" which is the nation, and is destined to become increasingly important with the process of change that is taking place thanks to emigration. This character of ethnic boundaries emerges and is confirmed in the widespread tendency towards endogamy, the choice of one's partner from among one's own group.

Female genital mutilation is the means by which a woman recognizes herself and is recognized as a member of her community. Refusing to submit to the practice means con-

demning herself to alienation and rejection and thus to a net loss of that irreplaceable symbolic resource which is belonging and community recognition. But the scars left by genital mutilation also play an important role in preserving the memory of a social group; they are the silent deposit transmitted through women's bodies. This incorporated memory, transfigured in nature, turns women into the discrete custodians of collective identity, passed from one generation to another. It is their bodies, bodies that are confiscated by symbols of a community affiliation, that are the real tie between past and present, and maintain it over time. These bodies are an incarnate memory of the community that has transformed its women into bearers of a complex economic and symbolic system through which every ethnic group can recognize and confirm its existence through time.

FGM is therefore the sign of a double belonging: to the community and to gender. It is the condition of possibility and recognition.

8. The Brideprice

From exactly where is the symbolic effectiveness of female genital mutilation derived? From where does it receive its power to confer sense to the actions of social subjects, legitimizing community belonging and gender identity?

As long as it is dealt with in an isolated manner, the practice will remain obscure and indecipherable, just as cultural facts always appear arbitrary. In order to understand something more, we need to place them within the context that gives them significance. By context, we mean a structure of meanings shared by part of the social group that establishes and gives sense to their actions.

The context that imparts sense to the cultural practice of female genital mutilation and the behavior of the people involved is a complex system of matrimonial strategies, based on the brideprice. Their corollary is a number of fixed features affecting each other, such as combined marriage, the young age of the bride and polygamy. These are accompanied by a series of secondary features that vary from one ethnic group to another: marriage by abduction, the advanced age of the groom, some food taboos during pregnancy and puerperium, some rules of purity and sexual practices, such as *gishiri*, and other more closely related to mutilation, but that are not significant for our analysis.

In other words, female genital mutilation is a fundamental component of marriage in Africa since it assists in regulating management of resources and the complex network of exchange and social relationships.

Marriage in Africa is a union defined by a series of contractual obligations between the two families, within which the people with the power to combine marriages are always a group of co-resident males generally representing three genealogical generations, i.e. elderly men or grandfathers, normal adults or fathers, and young men or sons. They are the ones who choose the groom. Marriage is always a union combined by relatives. It is rarely a free choice of the couple and when it is, the approval to the marriage depends on the blessing of the two families. The two groups of relatives also have the right to decide on the amount of the bridewealth that the groom must pay to the bride's family.

By bridewealth, we mean all the goods that the groom's family hands over to the bride's family on the occasion of the marriage. In other words, the bridewealth is the reverse

equivalent of our dowry. It is the groom who pays the family of the bride as compensation for the loss of a woman and her services. But note that, despite the negotiations between the two parties regarding the amount and terms of payment, this is not a commercial transaction. Indeed, it is in order to avoid this kind of misunderstanding, that the more neutral term "bridewealth" (instead of brideprice) is used. The bridewealth is a gift given in exchange for the woman's fertility. It represents compensation for the transfer of certain rights. The brideprice is the equivalent of something that is transferred from the birth group to the groom's group, but in the African context, it is not the person of the woman that is given but only the right over her (for her work, sexuality and fertility), and over her children.

Since the bridewealth is the compensation paid in exchange for the woman's fertility, and most of all for her purity, the function of FGM in preserving her inviolability, the chastity of daughters but also to encourage their fertility, according to local belief, is clear. The brideprice is therefore the compensation that the family of the future husband pays the family of the future wife in exchange for not just any woman but a virgin, intact and closed, well closed in the case of Somalian, Eritrean or Ethiopia women, or properly excised in order to discourage pre-matrimonial desires and relations. It is an indispensable condition and the penalty for non-fulfillment is that the hapless girl is sent right back to her family on her wedding night. This is the task of FGM: by ensuring control of female sexuality, it guarantees the purity which is indispensable for marriage.

In many societies, the marriage transaction is the most important economic transaction of a person's life. The amount and makeup of the brideprice are set by custom, which varies from one ethnic group to another and generally depend on the social status of the negotiating parties. While the bridewealth was once calculated mostly in cattle, today it is offered or requested in monetary terms.

9. Strategies for Regulation

At this point, it is clear enough that the brideprice is not only a resource of vital importance for every family, but an institution implying rigid rules. It is a way of making a girl desirable, starting with her virginity, her pubescence, docility, and so on. In this context, every woman becomes a fundamental resource for her family group who must reach marriage in the best condition possible, i.e. chaste. This is what female genital mutilation is used for. In popular belief, the surest means of protecting the virginity of future brides is infibulation, of preserving chastity, is excision.

Female genital mutilation is a way of regulating the female body in order to pursue a strategy of subjugation of women. It is the stigma that the social groups impress on their bodies, according to procedures that are not simply an exterior form that conditions them from the outside. It is something built up inside to train them according to schemes of docility that prepare them to be taken over by a world of men that is extraneous and aloof, basing its strategy of power on this extraneousness. Their power is not exercised by a repression of instincts, or on a mechanism of coercion based on dominion of the command/obedience type, which must be practiced daily to be effective. Instead, it is inscribed on women's bodies through mutilation and disciplines her once and for all at the moment it is performed.

FGM is the very form with which power is inscribed in bodies, since it does not lead to

coercive procedures of condition but to the actual construction of the body. It is a form of control of the female body whose aim is to prepare the girl for the marriage exchange which the family group relies upon as a fundamental economic and social resource. The bridewealth is an important custom not only in terms of patrimony but especially because it is cash in hand to allow her brothers to marry in turn. But the marriage of a daughter is not only a way of procuring funds; it is also a useful way of acquiring relatives.

In conclusion, female genital mutilation is a symbolic practice that is not only a determining factor in social reproduction but acquires significance within a marriage system supported by the institution of the brideprice or bridewealth. As mentioned earlier, its main features are combined marriages, the young age of the bride, the advanced age of the groom and polygamy. Keeping this complex economic-symbolic system in mind allows us to greatly expand our analysis and lets us monitor the system in detail, highlighting lateral movements or imperceptible changes that, in the long term, will erode the practice's possibility of survival.

In order to erode the practice, we have to stop looking at female genital mutilation as a de-contextualized cultural practice, an exotic eccentricity, only capable of communicating the obscurity of cultural phenomena. That only plays into the hands of those who attempt to build a substantive case for cultural differences in order to turn them into objects of discrimination.

First published in *Antropologia delle mutilazioni genitali femminile. Una ricerca in Italia,* by Carla Pasquinelli, AIDOS, Rome, 2000

Activity 6

GENDER PLANNING

Time: 1 hour

Why do this activity?

This activity gives participants some basic elements for gender planning, which will be used later in Module 5 to better understand how to integrate the fight against FGM/C in development programmes/projects

Objectives

- To clarify the meaning and the usefulness of gender planning tools

How to do the activity

The activity synthesises the methodology of gender planning developed by the Development Planning Unit of the University of London. It consists in a lecture given by the trainer with the use of some graphics, included in Handout 1, that he/she has to draw on a writing board.
After the end of the lecture he/she will distribute copies of the text to the participants or can make additional handouts with the various definitions.

Lecture

The difference between Practical Gender Needs and Strategic Gender Needs

What we have been involved in the previous activities is what we would call an initial gender analysis. We have started looking to the different role that men and women have in societies and the 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, the economist of the London School of Economics, Caroline Moser, makes 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 among women depending on social class, ethnic group, etc. Therefore it is not good 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, 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.
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 the 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 this distinction between PGNs and SGNs, planners become more aware of making distinction between projects that target PGNs from those that have as an objective addressing 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 to disentangle these interventions one from the other. In this way we know that if we deal with SGNs we are challenging existing gender roles.
We could then start a project with 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 division of labour, by giving them access to income on their own right, this might challenge the gender division of labour and empower the 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 the gender analysis is to understand the mechanisms underlying the 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, we have to look at the household structure, we have to look at the different roles of men and women, 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 which 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 are the gender needs which are not met because these are the symptoms of the problem. And then we need to ask ourselves why these gender needs were 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 is a cause of another problem.

I want to make two points here: the first is that gender analysis is an on going process. It is not something that stops with the preparation and identification of a project. It is an ongoing process because we need constantly to redefine our problems in a changing context. It may be that we need to ask different kinds of questions at different points of the cycle. The 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 roles and needs .

The second important point is that we need to ask ourselves a question: who defines gender needs?
Is it the professional, the politician, 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, interrogate not only the political or community leaders, but also the women of the community , listening to the people who are committed to gender issues in the country.
We need to be aware, we need to have "gender spectacles" on when we are talking about a consultation because, if we do not, we will find ourselves only talking to certain persons and not talking to others.

When we prioritize our problems, we have a much better way of seeing where we start, where we can actually put our finger in order to start.
Actually it is very useful to start to move into action by identifying working objectives (WO). You should not confuse them with the objectives of the programme/project. These are objectives used specifically to introduce gender into a particular programme or project. They are working objectives in the sense that they may be redefined as we go along in the process. We may find that we have to change and adjust them as we go through the programme/project.
We can tackle many more problems by identifying the correct point at which to enter into action.
This is a very critical way of understanding how to use resources efficiently because we do not have many resources so the ones that we use have to be effective: 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 try to see at what point we can introduce the issue of gender, where it is appropriate to introduce gender. It may be not appropriate at certain points; it may be easier at other points.

And this is why we need to identify an entry strategy (ES). An ES is a very simple and prioritised and tactical set of actions designed to expand the room for manoeuvre at a particular socio-economic junction or point, so that we can overcome the 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 have always to keep in mind that, because the gender relations represent a set of power relations, they often resist change. Because they find their expression in institutions of the practice of our society, they are not easy to change: they resist change. This is the case with FGM/C. Therefore to bring 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 the conditions whereby we can 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 identify what is possible to do 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 a 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 up so that we can do things.

In order to identify the room for manoeuvre, first we have to understand which are the constraints. What are the constraints to achieving our working objectives? We need also to understand what are the assets and by assets we do not mean just resources, but we also mean opportunities for opening what we have. If we can identify the constraints and the 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 the decision of the identification of the project. Our WO will be to prepare documentation and then have an entry strategy for how to do it, who should do it, what kind of qualification they have, 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 that we had before and we can move to 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 how we actually are achieving what we want to do. 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 in an old perspective. For example, training may be an ES in order to develop the organisational capacity to cope with properly developing and implementing gender aware policy, programmes and projects.

Finally we might get to the point where we actually can identify a number of policies, programmes and projects which are really gender aware. But generally there are an awful lot of steps before we get to the point where we actually have gender aware policy, 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 you need to be aware of the problems you probably are going to face.

In other words, we might find that in the identification stage we have to do both analysis and gender consultation. We may find in the preparation stage that we have to talk about gender analysis. Maybe we also need to start developing organisationally in order to cope with appropriate preparation of policy, programmes and projects. We may need to put into action a number of ES in order to achieve this as well. The preparation stage may take a number of months to do and therefore we 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 her that may be necessary at different point of the project cycle.

Materials

- Handouts: Copies of Handouts for each person

Handouts

- Handout 1: A Gender Planning Process

Readings

- Caroline Moser, *"Gender Planning and Development Theory, Practice and Training*" Routledge, Nov. 1993

A GENDER PLANNING PROCESS

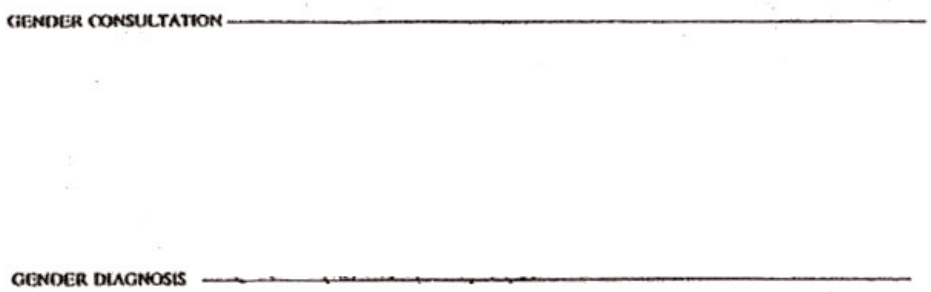


FIGURE 1

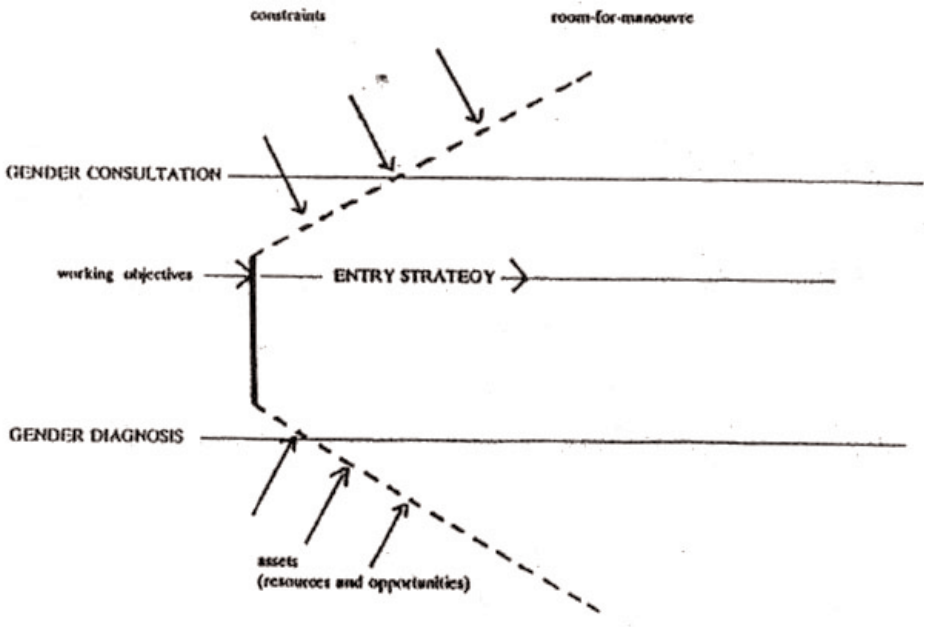


FIGURE 2

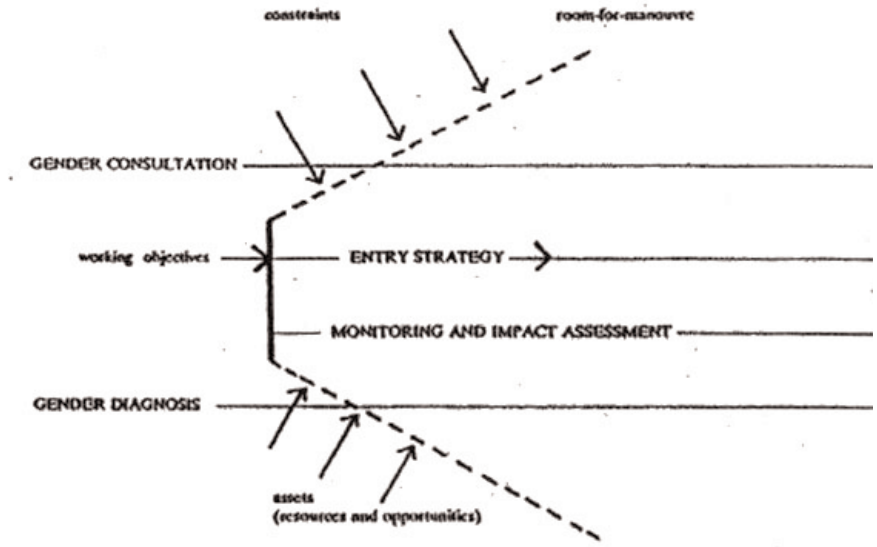


FIGURE 3

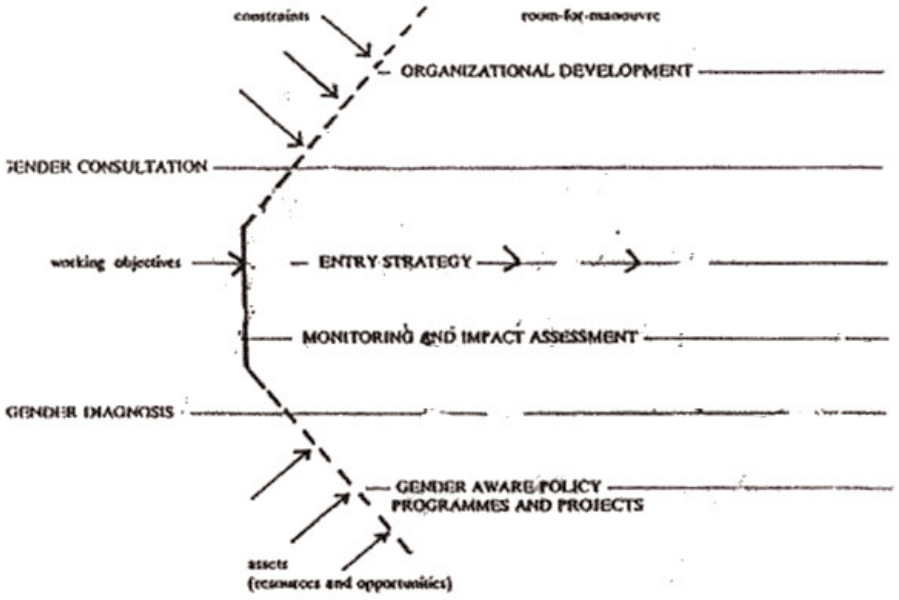


FIGURE 4

Activity 7

EMPOWERMENT

Time: 1 hour

Why do this activity?

The international community has come to recognise that it is necessary to support women in gaining the confidence and skills to be able to protect and promote their own rights; but that this cannot be achieved within a narrow approach of service provision. Rather, active steps need to be taken to change the conditions of women's lives and their status in society.

The empowerment of women can be facilitated, but it is not a 'top-down' exercise. Empowerment is about accessing power which is held by those who control 'material assets, intellectual resources and ideology'. Women are frequently powerless, in that they control neither material resources nor decision-making power. They may not even have control over the resources they use daily - from the land they work, to their labour, to their bodies.

The exercise provided asks participants to consider three different approaches to empowerment - integrated development, economic empowerment, and consciousness raising. They all emphasise different dimensions of empowerment. A lesson from experience is, however, that different aspects of empowerment are linked and that progress in one area cannot be sustained without attention to others. For example, reproductive rights (rights to choose how many children to have and when) cannot be fully exercised where women's lack of independent economic resources undermines their freedom to make choices.' (Oxaal 1997)

Organisations of women, or other popular organisations as well as local/national istitutions 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 the grassroots 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.

NGOs and Government Officials need to interrogate their role in promoting improvements in women's status in society. In addition, however, they need to interrogate what role they can play in the empowerment of women to achieve such changes. They need to consider how men can contribute towards women's empowerment.

This activity aims to help NGOs and Government Officials understand the types of activities which can support women's empowerment, and to consider how such activities might go beyond building solidarity amongst women and meeting basic needs, and towards building women's ability to promote fundamental changes in their social status in society (self empowerment).

It aims to help them identify what roles are appropriate for men to play in women's empowerment activities.

Objectives

- To describe and assess different approaches to empowerment
- To describe why empowerment is central to the achievement of sexual and reproductive rights and health
- To identify actions that their own organisations can take to promote women's empowerment
- To identify the roles that men can play in empowerment of women

How to do this activity

Step 1: 10 minutes

Plenary

Define 'Empowerment' after brainstorming by participants. Briefly describe the genesis of the word empowerment. Introduce this session by talking about the commitment of the ICPD and the Beijing PoA to women's empowerment and that the international community has come to recognise that it is necessary to support women in gaining the confidence and skills to be able to protect and promote their own rights; but that this cannot be achieved within a narrow approach of service provision. Rather, active steps need to be taken to change the conditions of women's lives and, most importantly, their status in society. Tell participants that the Empowerment of women is one of the MDGs (Millennium Development Goals)

Handout

Distribute the Handout: Empowerment and the status of women (ICPD). Ask a participant to read out the handout. Then explain that the handout again refers to agreements amongst countries of the world about what they should be aiming to achieve. Brief the participants on the concept of empowerment using the points below.

Point out that one of the complex issues NGOs and Government Women's Units and institutions face is around their role in relation to empowerment. Different organisations play different roles.

- Some provide services;
- Some undertake advocacy for changes in policies or programmes;
- Some monitor government delivery on its commitments to international agreements

- Some support grassroots organisations in mobilising, identifying their priorities for action, and getting their voices heard.

Within each of these activities, the question arises as to how NGO and Government Women's Units activities should support the empowerment of women:

1. the process of building women's confidence and ability to speak for themselves and
2. the process of changing gender norms, that is the way society values and treats women.

While the first process is usually done by women with women, both men and women need to facilitate the second process - changing social values.

Empowerment is critical for the achievement of gender equality / equity. The activity on "Access and control of resources" identified 'internal resources' as important resources to control. This means that women and men need to have confidence and self-esteem. This is central to empowerment. However, even with control over these resources, without control over decision-making, economic, informational and other resources, one cannot achieve gender equality/ equity or sexual and reproductive rights and health, nor even challenge FGM/C. This exercise therefore explores different dimensions of empowerment and different approaches to achieving empowerment. Participants should consider the limitations of different approaches.

A related question that NGOs and Government Women's Units need to consider is how they ensure that all of their work supports the process of improving the position of women in society, irrespective of the specific interests of their donors or of government.

Main points

Tell participants that this session will consider

- what sorts of actions can empower women
- how NGOs and Government Women's Units can promote women's empowerment in all of their activities.

Note to facilitator

It is important that participants do not feel that men are being left out. Men have critical roles to play in creating an enabling environment for women's empowerment. Both as individuals, in their sexual, family and community relationships, and through the work that they do, men should be working towards gender equality /equity. And gender equality / equity requires women's empowerment.

However, it is also legitimate for women to organise alone, without men, for some activities to promote empowerment.

Many men also feel disempowered at times. For men to take a stand against gender inequity requires their own empowerment. Men describe how they are ridiculed when they do domestic work, or when they show emotions. They too need the confidence and capacity to act to promote equality / equity. Some organisations are directing their attention to men's role in disempowering women. They are trying to get men to self-reflect, empowering men to change gender norms about how men should behave. In this way, they are working with men to create an enabling environment for women's empowerment.

As the reading suggests, many activities required for women's empower-

ment go far beyond issues of consciousness, to questions of control over various kinds of resources. Here too, men have a role to play.
Encourage participants to think about the roles of men and women when they do this activity so that you avoid a situation in which men feel left out and do not recognise that both men and women have responsibility for promoting women's empowerment. Empowering girls/women without including boys/men in the process will automatically raise a conflict in the society.

Also, walk around and listen to the group discussions. Push participants to critique the different approaches.

Step 2: 50 minutes

Small groups

Handout

Divide participants into groups, ideally with everyone from one NGO in the same group. Give them Handout: Empowerment: Three Approaches and "Questions for discussion". Ask them to read this handout and then discuss the questions on the handout.
There is no need for a report-back on this exercise.

Materials:

- Copies of Handouts for each participant.

Handouts:

- Handout 1: Empowerment and the status of women (ICPD)
- Handout 2: Empowerment: three approaches
- Handout 3: Questions for discussion

EMPOWERMENT AND THE STATUS OF WOMEN

"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 of 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 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" (ICPD PoA 4.1)

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. (ICPD PoA 4.5)

"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 childbearing, breast-feeding and child rearing with participation in the work-force". (ICPD PoA 4.4)

EMPOWERMENT: THREE APPROACHES

Three experimental approaches to empowering women have been undertaken in South Asia: integrated development, economic empowerment, and consciousness-raising. While these approaches differ from each other in concept, most organizations working on the ground take a mix of approaches. Common to all three is the importance placed on group formation to build solidarity among women.

The integrated development approach views women's development as key to the advancement of family and community. It therefore provides a package of interventions to alleviate poverty, meet basic survival needs, reduce gender discrimination, and help women gain self-esteem. This approach proceeds either by forming women's collectives that engage in development activities and tackle social problems such as dowry, child marriage and male violence, ... or by employing an 'entry point' strategy, pursuing a specific activity, such as a literacy class or health programme, to mobilise women into groups.

The economic empowerment approach attributes women's subordination to lack of economic power. It focuses on improving women's control over material resources and strengthening women's economic security. Groups are formed using two methods: organising women around savings and credit, income generation, or skills training activities; or by occupation or location. These groups may work in a range of areas, including savings and credit, training and skills development, new technologies or marketing, as well as provide such ancillary supports as child care, health services, literacy programmes, and legal education and aid.

The consciousness-raising approach asserts that women's empowerment requires awareness of the complex factors causing women's subordination. This approach organises women into collectives that tackle the sources of subordination. Education is central and is defined as a process of learning that leads to new consciousness, self-worth, societal and gender analysis, and access to skills and information. In this approach, the groups themselves determine their priorities. Women's knowledge of their own bodies and ability to control reproduction are also considered vital. The long-term goal is for the women's groups to be independent of the initiating organisation This approach uses no particular service 'entry point' and attempts to be open-ended and non-directive. It gives considerable emphasis to fielding 'change agents' who are trained to catalyse women's thinking without determining the directions in which a particular group may go."

Source: Batliwala, S., *'The meaning of women's empowerment: new concepts from action'.* In Sen, G., Germain, A. and Chen, L., (eds.) *Population Policies Reconsidered: Health, Empowerment and Rights,* Boston, Harvard University Press, 1994:127-138

QUESTIONS FOR DISCUSSION

1. To what extent do each of these approaches aim to meet women's needs in their daily lives, and to what extent do they attempt to improve women's status in society? To what extent do they challenge inequity between women and men?

2. Can economic empowerment facilitate gender equity/equality in general? For example, do women who own their own land, or earn and control their own incomes necessarily have sexual and reproductive rights?

3. Can consciousness raising alone facilitate gender equity/equality in general? For example, can women who are confident of their own right to control their sexuality always do so? Can women who are confident that they also have the right to choose with their husbands if and when to have children always do so? If not, why not? What other factors need to be addressed?

4. Consider how your organisation (institution) approaches the question of women's empowerment.

5. What specific steps does it take in its programmes?

6. What approach does it take? Integrated development? Economic empowerment? Consciousness-raising? How?

7. Does your organisation's (institutions') approach adequately promote women's ability to give their contribution to society? If so, how?

8. Does it specifically promote women's right to participate in decisions about reproduction and sexuality? If so, how?

9. Does it recognise that women should drive their own processes? If so, how?

10. Does it build men's understanding of and commitment to gender equality / equity and empowerment?

MODULE 2

FGM/C AS A VIOLATION OF WOMEN'S RIGHTS

Module objective:

- To have a common understanding of the broad global and regional agreement that FGM/C violates the rights of women and girls
- To have a common understanding of the human rights that are violated by FGM/C
- To understand that international human rights law requires governments to take action to stop the practice of FGM/C

Why this module?

FGM/C has for decades been recognized as a danger to women's health. Since the 1980s, the practice has increasingly been considered a human rights violation. Addressing FGM/C as a violation of international human rights law places responsibility for the practice with governments, who have a duty to ensure the enjoyment of human rights in their jurisdictions. Those who advocate for measures to stop FGM/C can invoke this governmental duty by using the language of law and human rights. In order to clarify governments' role in stopping FGM/C, this module provides participants with the conceptual and factual foundations of human rights law, particularly the law relating to women's right to be free from FGM/C.

Activities:

Activity 1: Human rights from a personal perspective (1 hour and 15 minutes)
Activity 2: What is human rights law? (45 minutes)
Activity 3: Which rights does FGM/C violate? (1 hour and 40 minutes)
Activity 4: Duties of government concerning human rights (45 minutes)

Total time: 4 hours and 25 minutes

Activity 1

HUMAN RIGHTS FROM A PERSONAL PERSPECTIVE

Time: 1 hour and 15 minutes

Why do this activity?

In order to understand that the comprehension of rights is the first step for consciousness raising and behavioral change.

Objectives

- To become aware that the promotion or violation of rights is easily identifiable and relevant to everyone's life

How to do the activity

This activity consists of three sections. The first is in small groups. The second is a report-back and discussion in the whole group, where participants should reach conclusions. The last is meant to combine suggestions by participants with the existing human rights instruments (Universal Declaration of Human Rights).

Step 1: 25 minutes

Small groups

The first activity is to take place with no reference or access to any human rights document. Participants work in groups to identify situations in which they feel a right was violated. Divide participants into groups of five. Give each person the handout "Personal accounts of rights violated", which describes what they should do. Tell the groups that they have 25 minutes for their discussion, and to make notes on the rights which they feel were relevant to the stories they shared to report back to the whole group.

Step 2: 25 minutes

Whole group report-back

Ask the first group to report on the rights that they considered relevant to their group. What did they see as important? Note the rights that are mentioned on the board or flip chart. When listing the rights, put these in two separate columns: one for civil/political rights and another for

economics/social and cultural rights. Each group then adds to the list rights that have not been mentioned yet. Put rights which are not internationally recognised under the column category to which it is most closely related. At this point, do not go into the stories behind the rights.

Some of the rights that might be mentioned include:

- right to entertainment
- right to health
- right to security
- right to be treated equally
- right to respect
- right to emotional fulfilment
- right to information
- right to equal salaries
- right to dignity
- right to earn an income and support a family
- right to make decisions concerning one's life
- right to higher education

Step 3: 25 minutes

The Universal Declaration of Human Rights

Plenary

Distribute copies of The Universal Declaration of Human Rights. Invite participants to read them individually. Go over each of the rights listed on the board or flip chart and ask participants to identify which article in the Declaration most closely addresses it.

Main points for closing the discussion

Main Points

There are identifiable violations of rights and obstacles to enjoying rights. Most of the rights protections for the issues we are concerned with are covered in international human rights documents, but existing standards need to evolve and be applied to new situations.
There are different interpretations of rights. But the provisions in the Universal Declaration of Human Rights are written in such a way that all of the concerns can be covered. It is necessary to be clear about how rights language is being used: for advocacy, to make policy, to hold governments accountable, and so on.

Materials:

- Flipchart and felt tip pens.
- Handouts for each participant.

Handouts:

- Handout 1: "Personal Accounts of Rights being Violated"
- Handout 2: The Universal Declaration of Human Rights.

PERSONAL ACCOUNTS OF RIGHTS BEING VIOLATED

You have 20 minutes to finish these tasks. Appoint one member of the group to report back to the whole group.

1. Thinking back on your own life spend two minutes alone **recalling one incident** when you felt a right was violated.

2. **Sharing**
   Share your story with the rest of the group if you feel comfortable to

3. **Name the rights**
   At the end of each story, the person sharing should try to name which rights she or he thinks were relevant to the story and in what ways. Write these down. Group members are then free to suggest other rights which they feel were relevant.

4. **Develop a list**
   Start a list of rights from these contributions. Each person shares a story until everyone who wants to speak has had a turn. As the list of rights grows, each time a right relates to more than one person's story put an X next to it. If the group is large, try to restrict the stories to avoid repetition.

5. **Look for systematic differences**
   Are there systematic differences in the violation of rights that different members of your group have reported on? In other words, are women more at risk of experiencing a rights violation and more likely to report violation of the right to non-discrimination, compared to others?

UNIVERSAL DECLARATION OF HUMAN RIGHTS

Adopted and proclaimed by General Assembly Resolution 217 (A) (III) of 10 December 1948.

PREAMBLE

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world. Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common People, Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law, Whereas it is essential to promote the development of friendly relations between nations,

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in cooperation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,

Now, therefore, The General Assembly, Proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Article I
All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2
Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3
Everyone has the right to life, liberty and security of person.

Article 4
No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5
No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6
Everyone has the right to recognition everywhere as a person before the law.

Article 7
All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8
Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9
No one shall be subjected to arbitrary arrest, detention or exile.

Article 10
Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 11
1. Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.
2. No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12
No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13
1. Everyone has the right to freedom of movement and residence within the borders of each State.
2. Everyone has the right to leave any country, including his own, and to return to his country.

Article 14
1. Everyone has the right to seek and to enjoy in other countries asylum from persecution.
2. This right may not be invoked in the case of prosecutions genuinely arising from non-politicalcrimes or from acts contrary to the purposes and principles of the United Nations.

Article 15
1. Everyone has the right to a nationality.
2. No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16
1. Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.
2. Marriage shall be entered into only with the free and full consent of the intending spouses.
3. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17
1. Everyone has the right to own property alone as well as in association with others.
2. No one shall be arbitrarily deprived of his property.

Article 18
Everyone has the right to freedom of thought, conscience and religion; this right includes free-

dom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19
Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20
1. Everyone has the right to freedom of peaceful assembly and association.
2. No one may be compelled to belong to an association.

Article 21
1 . Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.
2. Everyone has the right to equal access to public service in his country.
3. The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22
Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23
1. Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.
2. Everyone, without any discrimination, has the right to equal pay for equal work.
3. Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.
4. Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24
Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25
1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26
1. Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.
2. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.
3. Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27
1. Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

2. Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28
Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29
1. Everyone has duties to the community in which alone the free and full development of his personality is possible.
2. In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.
3. These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30
Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

Activity 2

WHAT IS HUMAN RIGHTS LAW?

Time: 45 minutes

Why do this activity?

Increasingly, governments, the international community and civil society have recognized that FGM/C is a violation of a woman's human rights. This recognition creates great potential for advocacy at both the international and national levels. While human rights are often invoked as a set of values or moral principles, they also carry significant legal implications. Implicit in the concept of human rights is the understanding that governments have a binding duty to protect the rights of all people in their jurisdictions. Human rights law, therefore, can help advocates argue forcefully for government action to stop FGM/C In order to tap this potential, this activity provides an overview of the sources of human rights law and the mechanisms for its enforcement.

Objectives

- To learn the legal significance of human rights norms
- To learn where and how these norms are enforced

How to do the activity

Step 1: 15 minutes

Individual reading

Distribute copy of Handout 1: Human Rights Backgrounder. Tell participants to read it by themselves, as well as brief discussion below.

Step 2: 30 minutes

Plenary discussion

Conduct the discussion according to the following questions:

1. Who is protected by human rights law?
2. What makes an action a human rights violation, as opposed to

just a crime?

3. Given that it is difficult to enforce human rights law, is it really law?

4. Are some rights more important than others?

5. What does human rights law require governments to do?

6. What does human rights law require governments not to do?

Explain to participants the significance of the international agreements: the population conferences, such as the ICPD held in Cairo, and the 'women's conferences such as the Fourth World Conference on Women (FWCW) held in Beijing happen every 5/10 years. Countries come together to see how they are doing and what they can improve. Countries are supposed to implement these agreements. Also multi-national agencies, such as the United Nations Population Fund (UNFPA), Unicef, The World Health organisation (WHO) are supposed to change their policies and programmes to match the agreements made at international conferences. However, these 'five-ten-year' conferences are not legally binding.

The only international agreements which are legally binding are treaties such as The Convention on the Elimination of All Forms of Discrimination Against Women, known as Women's Convention or CEDAW, or the Convention on the Rights of the Child. Countries choose to sign and ratify these agreements, after which, they are accountable to implement them. United Nations bodies which monitor these agreements ask each country to report on implementation every few years. In this way they are monitored. NGOs can send the monitoring bodies information to help them monitor. These NGO reports are called 'shadow reports'. This helps to hold governments accountable.

If your participants' country has signed or ratified these agreements, then your participants can use this to lobby their countries to implement the agreements. If their country has not signed, NGOs can advocate for them to sign, and thereby become part of international consensus. Tell participants that they can find their own country's reports on the internet.

Explain then that human rights law can be enforced in a variety of ways.
It is important to recognize that most of the human rights protected in international and regional instruments may also be enshrined in national-level legal instruments. Consequently, human rights advocates may be able to rely on these national-level instruments without invoking international norms.

Note to facilitator

Handouts:

- Handout 1: Human Rights Backgrounder

HUMAN RIGHTS BACKGROUNDER

Most contemporary human rights are based on international treaties signed by governments in the post-World War II era. Human rights have been codified in legal instruments at both the international and regional levels. In general, these treaties have sought to establish universal standards by recognizing fundamental rights of people and by requiring governments to take actions to ensure that such rights are respected. Most human rights treaties frame their guarantees in short, general statements and interpretations of the scope of these treaties is usually an on-going process.

The standards set by governments at the national level around the world are key to the development of human rights. In addition, often a United Nations committee that deals with a particular human rights treaty issues recommendations that set forth the scope of some aspects of the treaty in question. The international community may also gradually help interpret human rights principles, particularly when they are involved in negotiating global action plans at high profile international conferences.

Three of the earliest and most authoritative human rights instruments are: the Universal Declaration of Human Rights (the Universal Declaration), the International Covenant on Civil and Political Rights (the Civil and Political Rights Covenant), and the International Covenant on Economic, Social and Cultural Rights (the Economic, Social and Cultural Rights Covenant). Strong legal support for the right of women and girls to abandon FGM/C is also found in more recent treaties, such as the Convention on the Elimination of all Forms of Discrimination Against Women (Women's Convention) and the Convention on the Rights of the Child (Children's Rights Convention). These international treaties have been supplemented by regional treaties, including the African Charter on Human and People's Rights (the Banjul Charter), and the European Convention for the Protection of Human Rights and Fundamental Freedoms (the European Convention), which contain provisions protecting the rights of women and girls. Nearly all of the African countries in which FGM/C is practiced are parties to the Banjul Charter.

In 2003, the African Union adopted a protocol to the Banjul Charter on the Rights of Women in Africa. While this instrument has so far been adopted by only nine African countries (far short of the 15 required in order for the protocol to enter into force), it is already a highly significant legal development. It is the first international instrument that has specifically cited FGM/C as a violation of women's rights and called upon governments to take action to stop the practice.

PROTOCOL TO THE AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS ON THE RIGHTS OF WOMEN IN AFRICA

Article 5
Elimination of Harmful Practices
States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to
recognised international standards. States Parties shall take all necessary legislative and other measures to eliminate such practices, including:

a) creation of public awareness in all sectors of society regarding harmful practices through information, formal and informal education and outreach programmes;

b) prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalisation and para-medicalisation of female genital mutilation and all other practices in order to eradicate them;

c) provision of necessary support to victims of harmful practices through basic services such as health services, legal and judicial support, emotional and psychological counselling as well as vocational training to make them self-supporting;

d) protection of women who are at risk of being subjected to harmful practices or all other forms of violence, abuse and intolerance.

Additional sources of international human rights law include:

- declarations and resolutions adopted by inter-governmental international organizations, such as the Declaration on the Elimination of Violence Against Women, which has been adopted by the General Assembly and which characterizes FGM/C as a form of violence;

- documents adopted at international and regional conferences. These include the Programme of Action of the ICPD and the Beijing Declaration and Platform for Action, both of which call upon governments to take action against FGM.

Activity 3

WHICH RIGHTS DOES FGM/C VIOLATE?

Time: 1 hour and 40 minutes

Why do this activity?

Subjecting girls and women to FGM/C violates a number of rights protected in international and regional instruments. This activity will lead participants to articulate which rights are violated and why. Analysis of this type can significantly bolster advocacy campaigns to stop FGM/C, particularly those aimed at gaining greater government support for activities aimed at ending the practice.

Objectives:

- To identify human rights violated by FGM/C
- To develop arguments for why FGM/C violates these rights

How to do this activity:

Step 1: 30 minutes

Group work

The participants break up into groups of maximum five. Together they read again through the Universal Declaration and come up with a list of rights that are violated by the practice of FGM/C. Tell them to write the list of rights on a flip chart

Step 2: 30 minutes

Plenary discussion

The participants are brought back to plenary. The lists are put on the wall. Then the trainer goes through each right and asks participants why they believe that right is violated. The trainer points out whether participants' interpretations of the treaties are consistent with international legal interpretations.

Step 3: 20 minutes

The Handout “Human Rights Violated by FGM/C” is distributed to the group and the trainer goes through the document

Step 4: 20 minutes

Give the Participants Handouts 2 and 3 and tell them to read them by themselves.

Handouts:

- Handout 1: Human Rights Violated by FGM/C
- Handout 2: CEDAW
- Handout 3: The Children’s Rights Convention
- Handout 4: Universal Declaration of Human Rights (from Activity 1)

HUMAN RIGHTS VIOLATED BY FGM/C

1. The Right to be Free from Gender Discrimination

The right to be free from gender discrimination is guaranteed in numerous international human rights instruments. Article 1 of the Women's Convention takes a broad view of discrimination against women, defining it as "any distinction, exclusion, or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment, or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil, or any other field." FGM/C is a practice aimed primarily at controlling women's sexuality and subordinating their role in society. When a woman undergoes FGM/C, she is a victim of discrimination based on sex that compromises the recognition and enjoyment of her fundamental rights and liberties.

2. The Rights to Life and to Physical Integrity

The rights to life and to physical integrity are considered core human rights. The right to life is protected by a number of international instruments, including the International Civil and Political Rights Covenant. The Human Rights Committee, the body that monitors implementation of the Civil and Political Rights Covenant, interprets the right to life as requiring governments to adopt "positive measures" to preserve life. FGM/C can be seen to violate the right to life in the rare cases in which death results from the procedure.

The right to physical integrity, while often associated with the right to freedom from torture, has roots in a number of broader human rights principles, including the inherent dignity of the person, the right to liberty and security of the person, and the right to privacy. Acts of violence that threaten a person's safety, such as FGM/C, violate a person's right to physical integrity. Also implicit in the principle of physical integrity is the right to make independent decisions in matters affecting one's own body. An unauthorized invasion of a person's body represents a disregard for that fundamental right. Violations of the right to physical integrity are most obvious when girls and women are forcibly restrained during the procedure. No less compromising of physical integrity is the subjection of non-protesting girls and women to FGM/C without their informed consent.

3. The Right to Health

Under Article 12 of the Economic, Social and Cultural Rights Covenant, individuals are entitled to enjoy "the highest attainable standard of physical and mental health." The Committee on the Elimination of Discrimination against Women (CEDAW), the body that monitors implementation of the Women's Convention, in its recent General Recommendation on Women and Health, recommended that governments devise health policies that take into account the needs of girls and adolescents who may be vulnerable to traditional practices such as FGM/C.

The complications associated with FGM/C often have severe consequences for a woman's physical and mental health. But even in the absence of complications,

where FGM/C results in the removal of bodily tissue necessary for the enjoyment of a satisfying and safe sex life, a woman's right to the "highest attainable standard of physical and mental health" has been compromised. In addition, subjecting a person to health risks in the absence of medical necessity should be viewed as a violation of that person's right to health.

4. The Rights of the Child

Because children generally cannot adequately protect themselves or make informed decisions about matters that may affect them for the rest of their lives, international human rights law grants children special protections. The right of the child to these protections has been affirmed in the Children's Rights Convention. Article 1 defines a "child" as a person below the age of 18 unless majority is attained earlier under the law applicable to the child. Article 3 affirms that "the best interests of the child shall be a primary consideration." While this principle may be broadly interpreted to accommodate varying cultural views on what constitutes a child's best interest, such interpretations should be consistent with the Convention's other specific protections.

The international community has generally regarded FGM/C as a violation of children's rights because FGM/C is commonly performed upon girls between the ages of four and 12, who are not in a position to give informed consent. The Children's Rights Convention requires States Parties to take "all suitable effective measures to abolish traditional practices that are prejudicial to the health of children." The concern to stop traditional practices that are harmful to health is also evident in the African Charter on the Rights and Welfare of the Child (the African Charter), which was adopted by the Organization for African Unity in 1990.

5. What about competing rights claims?

The use of human rights principles to condemn the practice of FGM/C has given rise to counter-arguments, also drawn from international human rights law. **The right to culture, the rights of minorities,** and (despite the absence of a religious duty to practice FGM/C) **the right to religious freedom** are often raised to suggest that FGM/C should not be subject to government interference. Some have argued that the right to enjoy one's own culture and to choose one's own religion should not be subject to government intervention, and that government action to prevent FGM/C is an intolerable intrusion. This view is not, however, supported by international human rights law, which limits these rights to protect individual human rights, health, and safety. It is up to the government to decide how to put an end to FGM/C while respecting the rights of minorities and the rights to culture and to freedom of religion.

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (CEDAW)

Adopted and opened for signature, ratification and accession by General Assembly Resolution 34/180 of 18 December 1979

· Noting that the Charter of the United Nations reaffirms faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women,

· Noting that the Universal Declaration of Human Rights affirms the principle of the inadmissibility of discrimination and proclaims that all human beings are born free and equal in dignity and rights and that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, including distinction based on sex,

· Noting that the States Parties to the International Covenants on Human Rights have the obligation to ensure the equal rights of men and women to enjoy all economic, social, cultural, civil and political rights,

· Considering the international conventions concluded under the auspices of the United Nations and the specialised agencies promoting equality of rights of men and women,

· Noting also the resolutions, declarations and recommendations adopted by the United Nations and the specialised agencies promoting equality of rights of men and women,

· Concerned, however, that despite these various instruments extensive discrimination against women continues to exist,

· Recalling that discrimination against women violates the principles of equality of rights and respect for human dignity, is an obstacle to the parti-cipation of women, on equal terms with men, in the political, social, economic and cultural life of their countries, hampers the growth of the prosperity of society and the family and makes more difficult the full development of the potentialities of women in the service of their countries and of humanity,

· Concerned that in situations of poverty women have the least access to food, health, education, training and opportunities for employment and other needs,

· Convinced that the establishment of the new international economic order based on equity and justice will contribute significantly towards the promotion of equality between men and women,

· Emphasizing that the eradication of apartheid, all forms of racism, racial discrimination, colonialism, neo-colonialism, aggression, foreign occupation and domination and interference in the internal affairs of States is essential to the full enjoyment of the rights of men and women,

· Affirming that the strengthening of international peace and security, the relaxation of international tension, mutual co-operation among all States irrespective of their social and economic systems, general and complete disarmament, in particular nuclear disarmament under strict and effective international control, the affirmation of the principles of justice, equality and mutual benefit in relations among countries and the realization of the right of peoples under alien and colonial domination and foreign occupation to self-determination and independence, as well as respect for national sovereignty and territorial integrity, will promote social progress and development and as a consequence will contribute to the attainment of full equality between men and women,

· Convinced that the full and complete development of a country, the welfare of the world and the cause of peace require the maximum participation of women on equal terms with men in all fields,

· Bearing in mind the great contribution of women to the welfare of the family and to the development of society, so far not fully recognized, the social significance of maternity and the role of both parents in the family and in the upbringing of children, and aware that the role of women in procreation should not be a basis for discrimination but that the upbringing of children requires a sharing of responsibility between men and women and society as a whole,

· Aware that a change in the traditional role of men as well as the role of women in society and in the family is needed to achieve full equality between men and women,

· Determined to implement the principles set forth in the Declaration on the Elimination of Discrimination against Women and, for that purpose, to adopt the measures required for the elimination of such discrimination in all its forms and manifestations.

Have agreed on the following:

PART I

Article I
For the purposes of the present Convention, the term "discrimination against women" shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

Article 2
States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:

(a) To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realization of this principle;
(b) To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women;
(c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;
(d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;
(e) To take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise;
(f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;
(g) To repeal all national penal provisions which constitute discrimination against women.

Article 3
States Parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.

Article 4
1. Adoption by States Parties of temporary special measures aimed at accelerating de facto equality between men and women shall not be considered discrimination as defined in the present Convention, but shall in no way entail as a consequence the maintenance of unequal or separate standards; these measures shall be discontinued when the objectives of equality of opportunity and treatment have been achieved.

2. Adoption by States Parties of special measures, including those measures contained in the present Convention, aimed at protecting maternity shall not be considered discriminatory.

Article 5
States Parties shall take all appropriate measures:

(a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary 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 men and women;

(b) To ensure that family education includes a proper understanding of maternity as a social function and the recognition of the common responsibility of men and women in the upbringing and development of their children, it being understood that the interest of the children is the primordial consideration in all cases.

Article 6
States Parties shall take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women.

PART II

Article 7
States Parties shall take all appropriate measures to eliminate discrimination against women in the political and public life of the country and, in particular, shall ensure to women, on equal terms with men, the right:

(a) To vote in all elections and public referenda and to be eligible for election to all publicly elected bodies;
(b) To participate in the formulation of government policy and the implementation thereof and to hold public office and perform all public functions at all levels of government;
(c) To participate in non-governmental organizations and associations concerned with the public and political life of the country.

Article 8
States Parties shall take all appropriate measures to ensure to women, on equal terms with men and without any discrimination, the opportunity to represent their Governments at the international level and to participate in the work of international organizations.

Article 9
1. States Parties shall grant women equal rights with men to acquire, change or retain their nationality. They shall ensure in particular that neither marriage to an alien nor change of nationality by the husband during marriage shall automatically change the nationality of the wife, render her stateless or force upon her the nationality of the husband.

2. States Parties shall grant women equal rights with men with respect to the nationality of their children.

PART III

Article 10
States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women:

(a) The same conditions for career and vocational guidance, for access to stu-dies and for the achievement of diplomas in educational establishments of all categories in rural as well as in urban areas; this equality shall be ensured in pre-school, general, technical, professional and higher technical education, as well as in all types of vocational training;
(b) Access to the same curricula, the same examinations, teaching staff with qualifications of the same standard and school premises and equipment of the same quality;

(c) The elimination of any stereotyped concept of the roles of men and women at all levels and in all forms of education by encouraging coeducation and other types of education which will help to achieve this aim and, in particular, by the revision of textbooks and school programmes and the adaptation of teaching methods;
(d) The same opportunities to benefit from scholarships and other study grants;
(e) The same opportunities for access to programmes of continuing education, including adult and functional literacy programmes, particularly those aimed at reducing, at the earliest possible time, any gap in education existing between men and women;
(f) The reduction of female student drop-out rates and the organization of programmes for girls and women who have left school prematurely;
(g) The same opportunities to participate actively in sports and physical education;
(h) Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.

Article 11
1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular:

(a) The right to work as an inalienable right of all human beings;
(b) The right to the same employment opportunities, including the application of the same criteria for selection in matters of employment;
(c) The right to free choice of profession and employment, the right to promotion, job security and all benefits and conditions of service and the right to receive vocational training and retraining, including apprenticeships, advanced vocational training and recurrent training;
(d) The right to equal remuneration, including benefits, and to equal treatment in respect of work of equal value, as well as equality of treatment in the evaluation of the quality of work;
(e) The right to social security, particularly in cases of retirement, unemployment, sickness, invalidity and old age and other incapacity to work, as well as the right to paid leave;
(f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

2. In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work, States Parties shall take appropriate measures:

(a) To prohibit, subject to the imposition of sanctions, dismissal on the grounds of pregnancy or of maternity leave and discrimination in dismissals on the basis of marital status;
(b) To introduce maternity leave with pay or with comparable social benefits without loss of former employment, seniority or social allowances;
(c) To encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of child-care facilities;
(d) To provide special protection to women during pregnancy in types of work proved to be harmful to them.

3. Protective legislation relating to matters covered in this article shall be reviewed periodically in the light of scientific and technological knowledge and shall be revised, repealed or extended as necessary.

Article 12
1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Article 13
States Parties shall take all appropriate measures to eliminate discrimination against women in other areas of economic and social life in order to ensure, on a basis of equality of men and women, the same rights, in particular:

(a) The right to family benefits;
(b) The right to bank loans, mortgages and other forms of financial credit;
(c) The right to participate in recreational activities, sports and all aspects of cultural life.

Article 14
1. States Parties shall take into account the particular problems faced by rural women and the significant roles which rural women play in the economic survival of their families, including their work in the non-monetized sectors of the economy, and shall take all appropriate measures to ensure the application of the provisions of the present Convention to women in rural areas.

2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:

(a) To participate in the elaboration and implementation of development planning at all levels;
(b) To have access to adequate health care facilities, including information, counselling and services in family planning;
(c) To benefit directly from social security programmes;
(d) To obtain all types of training and education, formal and non-formal, including that relating to functional literacy, as well as, inter alia, the benefit of all community and extension services, in order to increase their technical proficiency;
(e) To organize self-help groups and co-operatives in order to obtain equal access to economic opportunities through employment or self employment;
(f) To participate in all community activities;
(g) To have access to agricultural credit and loans, marketing facilities, appropriate technology and equal treatment in land and agrarian reform as well as in land resettlement schemes;
(h) To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications.

PART IV

Article 15
1. States Parties shall accord to women equality with men before the law.

2. States Parties shall accord to women, in civil matters, a legal capacity identical to that of men and the same opportunities to exercise that capacity. In particular, they shall give women equal rights to conclude contracts and to administer property and shall treat them equally in all stages of procedure in courts and tribunals.

3. States Parties agree that all contracts and all other private instruments of any kind with a legal effect which is directed at restricting the legal capacity of women shall be deemed null and void.

4. States Parties shall accord to men and women the same rights with regard to the law relating to the movement of persons and the freedom to choose their residence and domicile.

Article 16
1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:

(a) The same right to enter into marriage;
(b) The same right freely to choose a spouse and to enter into marriage only with their free and full consent;
(c) The same rights and responsibilities during marriage and at its dissolution;
(d) The same rights and responsibilities as parents, irrespective of their marital status, in matters relating to their children; in all cases the interests of the children shall be paramount;
(e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights;

(f) The same rights and responsibilities with regard to guardianship, wardship, trusteeship and adoption of children, or similar institutions where these concepts exist in national legislation; in all cases the interests of the children shall be paramount;
(g) The same personal rights as husband and wife, including the right to choose a family name, a profession and an occupation;
(h) The same rights for both spouses in respect of the ownership, acquisition, management, administration, enjoyment and disposition of property, whether free of charge or for a valuable consideration.

2. The betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory.

PART V

Article 17
1. For the purpose of considering the progress made in the implementation of the present Convention, there shall be established a Committee on the Elimination of Discrimination against Women (hereinafter referred to as the Committee) consisting, at the time of entry into force of the Convention, of eighteen and, after ratification of or accession to the Convention by the thirty-fifth State Party, of twenty-three experts of high moral standing and competence in the field covered by the Convention. The experts shall be elected by States Parties from among their nationals and shall serve in their personal capacity, consideration being given to equitable geographical distribution and to the representation of the different forms of civilisation as well as the principal legal systems.

2. The members of the Committee shall be elected by secret ballot from a list of persons nominated by States Parties. Each State Party may nominate one person from among its own nationals.

3. The initial election shall be held six months after the date of the entry into force of the present Convention. At least three months before the date of each election the Secretary-General of the United Nations shall address a letter to the States Parties inviting them to submit their nominations within two months. The Secretary-General shall prepare a list in alphabetical order of all persons thus nominated, indicating the States Parties which have nominated them, and shall submit it to the States Parties.

4. Elections of the members of the Committee shall be held at a meeting of States Parties convened by the Secretary-General at United Nations Headquarters. At that meeting, for which two thirds of the States Parties shall constitute a quorum, the persons elected to the Committee shall be those nominees who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.

5. The members of the Committee shall be elected for a term of four years. However, the terms of nine of the members elected at the first election shall expire at the end of two years; immediately after the first election the names of these nine members shall be chosen by lot by the Chairman of the Committee.

6. The election of the five additional members of the Committee shall be held in accordance with the provisions of paragraphs 2, 3 and 4 of this article, following the thirty-fifth ratification or accession. The terms of two of the additional members elected on this occasion shall expire at the end of two years, the names of these two members having been chosen by lot by the Chairman of the Committee.

7. For the filling of casual vacancies, the State Party whose expert has ceased to function as a member of the Committee shall appoint another expert from among its nationals, subject to the approval of the Committee.

8. The members of the Committee shall, with the approval of the General Assembly, receive emoluments from United Nations resources on such terms and conditions as the Assembly may decide, having regard to the importance of the Committee's responsibilities.

9. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under the present Convention.

Article 18
1. States Parties undertake to submit to the Secretary-General of the United Nations, for consideration by the Committee, a report on the legislative, judicial, administrative or other measures which they have adopted to give effect to the provisions of the present Convention and on the progress made in this respect:

(a) Within one year after the entry into force for the State concerned;
(b) Thereafter at least every four years and further whenever the Committee so requests.

2. Reports may indicate factors and difficulties affecting the degree of fulfilment of obligations under the present Convention.
Article 19
1. The Committee shall adopt its own rules of procedure.
2. The Committee shall elect its officers for a term of two years.

Article 20
1. The Committee shall normally meet for a period of not more than two weeks annually in order to consider the reports submitted in accordance with article 18 of the present Convention.

2. The meetings of the Committee shall normally be held at United Nations Headquarters or at any other convenient place as determined by the Committee.

Article 21
1. The Committee shall, through the Economic and Social Council, report annually to the General Assembly of the United Nations on its activities and may make suggestions and general recommendations based on the examination of reports and information received from the States Parties. Such suggestions and general recommendations shall be included in the report of the Committee together with comments, if any, from States Parties.

2. The Secretary-General of the United Nations shall transmit the reports of the Committee to the Commission on the Status of Women for its information.

Article 22
The specialised agencies shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention as fall within the scope of their activities. The Committee may invite the specialized agencies to submit reports on the implementation of the Convention in areas falling within the scope of their activities.

PART VI

Article 23
Nothing in the present Convention shall affect any provisions that are more conducive to the achievement of equality between men and women which may be contained:
(a) In the legislation of a State Party; or
(b) In any other international convention, treaty or agreement in force for that State.

Article 24
States Parties undertake to adopt all necessary measures at the national level aimed at achieving the full realisation of the rights recognised in the present Convention.

Article 25
1. The present Convention shall be open for signature by all States.
2. The Secretary-General of the United Nations is designated as the depositary of the present Convention.
3. The present Convention is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.

4. The present Convention shall be open to accession by all States. Accession shall be effected by the deposit of an instrument of accession with the Secretary-General of the United Nations.

Article 26
1. A request for the revision of the present Convention may be made at any time by any State Party by means of a notification in writing addressed to the Secretary-General of the United Nations.

2. The General Assembly of the United Nations shall decide upon the steps, if any, to be taken in respect of such a request.

Article 27
1. The present Convention shall enter into force on the thirtieth day after the date of deposit with the Secretary-General of the United Nations of the twen-tieth instrument of ratification or accession.

2. For each State ratifying the present Convention or acceding to it after the deposit of the twen-tieth instrument of ratification or accession, the Convention shall enter into force on the thirtieth day after the date of the deposit of its own instrument of ratification or accession.

Article 28
1. The Secretary-General of the United Nations shall receive and circulate to all States the text of reservations made by States at the time of ratification or accession.

2. A reservation incompatible with the object and purpose of the present Convention shall not be permitted.

3. Reservations may be withdrawn at any time by notification to this effect addressed to the Secretary-General of the United Nations, who shall then inform all States thereof. Such notifica-tion shall take effect on the date on which it is received.

Article 29
1. Any dispute between two or more States Parties concerning the interpretation or application of the present Convention which is not settled by negotiation shall, at the request of one of them, be submitted to arbitration. If within six months from the date of the request for arbitra-tion the parties are unable to agree on the organization of the arbitration, any one of those par-ties may refer the dispute to the International Court of Justice by request in conformity with the Statute of the Court.

2. Each State Party may at the time of signature or ratification of the present Convention or accession thereto declare that it does not consider itself bound by paragraph I of this article. The other States Parties shall not be bound by that paragraph with respect to any State Party which has made such a reservation.
3. Any State Party which has made a reservation in accordance with paragraph 2 of this article may at any time withdraw that reservation by notification to the Secretary-General of the United Nations.

Article 30
The present Convention, the Arabic, Chinese, English, French, Russian and Spanish texts of which are equally authentic, shall be deposited with the Secretary-General of the United Nations.

THE CHILDREN'S RIGHTS CONVENTION

Convention on the Rights of the Child, G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), entered into force Sept. 2 1990.

PREAMBLE

The States Parties to the present Convention,
Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,
Bearing in mind that the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom,
Recognizing that the United Nations has, in the Universal Declaration of Human Rights and in the International Covenants on Human Rights, proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,
Recalling that, in the Universal Declaration of Human Rights, the United Nations has proclaimed that childhood is entitled to special care and assistance,
Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community,
Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding,
Considering that the child should be fully prepared to live an individual life in society, and brought up in the spirit of the ideals proclaimed in the Charter of the United Nations, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity,
Bearing in mind that the need to extend particular care to the child has been stated in the Geneva Declaration of the Rights of the Child of 1924 and in the Declaration of the Rights of the Child adopted by the General Assembly on 20 November 1959 and recognized in the Universal Declaration of Human Rights, in the International Covenant on Civil and Political Rights (in particular in articles 23 and 24), in the International Covenant on Economic, Social and Cultural Rights (in particular in article 10) and in the statutes and relevant instruments of specialized agencies and international organizations concerned with the welfare of children, '
Bearing in mind that, as indicated in the Declaration of the Rights of the Child, "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth",
Recalling the provisions of the Declaration on Social and Legal Principles relating to the Protection and Welfare of Children, with Special Reference to Foster Placement and Adoption Nationally and Internationally; the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules) ; and the Declaration on the Protection of Women and Children in Emergency and Armed Conflict,
Recognizing that, in all countries in the world, there are children living in exceptionally difficult conditions, and that such children need special consideration,
Taking due account of the importance of the traditions and cultural values of each people for the protection and harmonious development of the child,
Recognizing the importance of international co-operation for improving the living conditions of children in every country, in particular in the developing countries,
Have agreed as follows:

PART I

Article 1
For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

Article 2
1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.
2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

Article 3
1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.
2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.
3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Article 4
States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.

Article 5
States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

Article 6
1. States Parties recognize that every child has the inherent right to life.
2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 7
1. The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and. as far as possible, the right to know and be cared for by his or her parents.
2. States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless.

Article 8
1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.
2. Where a child is illegally deprived of some or all of the elements of his or her identity,

States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.

Article 9
1. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately and a decision must be made as to the child's place of residence.
2. In any proceedings pursuant to paragraph 1 of the present article, all interested parties shall be given an opportunity to participate in the proceedings and make their views known.
3. States Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests. 4. Where such separation results from any action initiated by a State Party, such as the detention, imprisonment, exile, deportation or death (including death arising from any cause while the person is in the custody of the State) of one or both parents or of the child, that State Party shall, upon request, provide the parents, the child or, if appropriate, another member of the family with the essential information concerning the whereabouts of the absent member(s) of the family unless the provision of the information would be detrimental to the well-being of the child. States Parties shall further ensure that the submission of such a request shall of itself entail no adverse consequences for the person(s) concerned.

Article 10
1. In accordance with the obligation of States Parties under article 9, paragraph 1, applications by a child or his or her parents to enter or leave a State Party for the purpose of family reunification shall be dealt with by States Parties in a positive, humane and expeditious manner. States Parties shall further ensure that the submission of such a request shall entail no adverse consequences for the applicants and for the members of their family.
2. A child whose parents reside in different States shall have the right to maintain on a regular basis, save in exceptional circumstances personal relations and direct contacts with both parents. Towards that end and in accordance with the obligation of States Parties under article 9, paragraph 1, States Parties shall respect the right of the child and his or her parents to leave any country, including their own, and to enter their own country. The right to leave any country shall be subject only to such restrictions as are prescribed by law and which are necessary to protect the national security, public order (ordre public), public health or morals or the rights and freedoms of others and are consistent with the other rights recognized in the present Convention.

Article 11
1. States Parties shall take measures to combat the illicit transfer and non-return of children abroad.
2. To this end, States Parties shall promote the conclusion of bilateral or multilateral agreements or accession to existing agreements.

Article 12
1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Article 13
1. The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.
2. The exercise of this right may be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:
(a) For respect of the rights or reputations of others; or

(b) For the protection of national security or of public order (ordre public), or of public health or morals.

Article 14
1. States Parties shall respect the right of the child to freedom of thought, conscience and religion.
2. States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.
3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.

Article 15
1. States Parties recognize the rights of the child to freedom of association and to freedom of peaceful assembly.
2. No restrictions may be placed on the exercise of these rights other than those imposed in conformity with the law and which are necessary in a democratic society in the interests of national security or public safety, public order (ordre public), the protection of public health or morals or the protection of the rights and freedoms of others.

Article 16
1. No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation.
2. The child has the right to the protection of the law against such interference or attacks.

Article 17
States Parties recognize the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health. To this end, States Parties shall:
(a) Encourage the mass media to disseminate information and material of social and cultural benefit to the child and in accordance with the spirit of article 29;
(b) Encourage international co-operation in the production, exchange and dissemination of such information and material from a diversity of cultural, national and international sources;
(c) Encourage the production and dissemination of children's books;
(d) Encourage the mass media to have particular regard to the linguistic needs of the child who belongs to a minority group or who is indigenous;
(e) Encourage the development of appropriate guidelines for the protection of the child from information and material injurious to his or her well-being, bearing in mind the provisions of articles 13 and 18.

Article 18
1. States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.
2. For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.
3. States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.

Article 19
1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
2. Such protective measures should, as appropriate, include effective procedures for the esta-

blishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

Article 20
1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.
2. States Parties shall in accordance with their national laws ensure alternative care for such a child.
3. Such care could include, inter alia, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

Article 21
States Parties that recognize and/or permit the system of adoption shall ensure that the best interests of the child shall be the paramount consideration and they shall:
(a) Ensure that the adoption of a child is authorized only by competent authorities who determine, in accordance with applicable law and procedures and on the basis of all pertinent and reliable information, that the adoption is permissible in view of the child's status concerning parents, relatives and legal guardians and that, if required, the persons concerned have given their informed consent to the adoption on the basis of such counselling as may be necessary;
(b) Recognize that inter-country adoption may be considered as an alternative means of child's care, if the child cannot be placed in a foster or an adoptive family or cannot in any suitable manner be cared for in the child's country of origin; (c) Ensure that the child concerned by inter-country adoption enjoys safeguards and standards equivalent to those existing in the case of national adoption;
(d) Take all appropriate measures to ensure that, in inter-country adoption, the placement does not result in improper financial gain for those involved in it;
(e) Promote, where appropriate, the objectives of the present article by concluding bilateral or multilateral arrangements or agreements, and endeavour, within this framework, to ensure that the placement of the child in another country is carried out by competent authorities or organs.

Article 22
1. States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties.
2. For this purpose, States Parties shall provide, as they consider appropriate, co-operation in any efforts by the United Nations and other competent intergovernmental organizations or non-governmental organizations co-operating with the United Nations to protect and assist such a child and to trace the parents or other members of the family of any refugee child in order to obtain information necessary for reunification with his or her family. In cases where no parents or other members of the family can be found, the child shall be accorded the same protection as any other child permanently or temporarily deprived of his or her family environment for any reason , as set forth in the present Convention.

Article 23
1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.
2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child. 3. Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the dis-

abled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development
4. States Parties shall promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.

Article 24
1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
(a) To diminish infant and child mortality;
(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
(d) To ensure appropriate pre-natal and post-natal health care for mothers;
(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
(f) To develop preventive health care, guidance for parents and family planning education and services.
3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Article 25
States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Article 26
1. States Parties shall recognize for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realization of this right in accordance with their national law.
2. The benefits should, where appropriate, be granted, taking into account the resources and the circumstances of the child and persons having responsibility for the maintenance of the child, as well as any other consideration relevant to an application for benefits made by or on behalf of the child.

Article 27
1. States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.
2. The parent(s) or others responsible for the child have the primary responsibility to secure, within their abilities and financial capacities, the conditions of living necessary for the child's development.
3. States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this

right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.
4. States Parties shall take all appropriate measures to secure the recovery of maintenance for the child from the parents or other persons having financial responsibility for the child, both within the State Party and from abroad. In particular, where the person having financial responsibility for the child lives in a State different from that of the child, States Parties shall promote the accession to international agreements or the conclusion of such agreements, as well as the making of other appropriate arrangements.

Article 28
1. States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:
(a) Make primary education compulsory and available free to all;
(b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;
(c) Make higher education accessible to all on the basis of capacity by every appropriate means;
(d) Make educational and vocational information and guidance available and accessible to all children;
(e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.
2. States Parties shall take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child's human dignity and in conformity with the present Convention.
3. States Parties shall promote and encourage international cooperation in matters relating to education, in particular with a view to contributing to the elimination of ignorance and illiteracy throughout the world and facilitating access to scientific and technical knowledge and modern teaching methods. In this regard, particular account shall be taken of the needs of developing countries.

Article 29
1. States Parties agree that the education of the child shall be directed to:
(a) The development of the child's personality, talents and mental and physical abilities to their fullest potential;
(b) The development of respect for human rights and fundamental freedoms, and for the principles enshrined in the Charter of the United Nations;
(c) The development of respect for the child's parents, his or her own cultural identity, language and values, for the national values of the country in which the child is living, the country from which he or she may originate, and for civilizations different from his or her own;
(d) The preparation of the child for responsible life in a free society, in the spirit of understanding, peace, tolerance, equality of sexes, and friendship among all peoples, ethnic, national and religious groups and persons of indigenous origin;
(e) The development of respect for the natural environment.
2. No part of the present article or article 28 shall be construed so as to interfere with the liberty of individuals and bodies to establish and direct educational institutions, subject always to the observance of the principle set forth in paragraph 1 of the present article and to the requirements that the education given in such institutions shall conform to such minimum standards as may be laid down by the State.

Article 30
In those States in which ethnic, religious or linguistic minorities or persons of indigenous origin exist, a child belonging to such a minority or who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language.

Article 31
1. States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.
2. States Parties shall respect and promote the right of the child to participate fully in cultural

and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity.

Article 32
1. States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.
2. States Parties shall take legislative, administrative, social and educational measures to ensure the implementation of the present article. To this end, and having regard to the relevant provisions of other international instruments, States Parties shall in particular: (a) Provide for a minimum age or minimum ages for admission to employment;
(b) Provide for appropriate regulation of the hours and conditions of employment;
(c) Provide for appropriate penalties or other sanctions to ensure the effective enforcement of the present article.

Article 33
States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

Article 34
States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:
(a) The inducement or coercion of a child to engage in any unlawful sexual activity;
(b) The exploitative use of children in prostitution or other unlawful sexual practices;
(c) The exploitative use of children in pornographic performances and materials.

Article 35
States Parties shall take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form.

Article 36
States Parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.

Article 37
States Parties shall ensure that:
(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age;
(b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time;
(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances;
(d) Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Article 38
1. States Parties undertake to respect and to ensure respect for rules of international humanitarian law applicable to them in armed conflicts which are relevant to the child.
2. States Parties shall take all feasible measures to ensure that persons who have not attained the age of fifteen years do not take a direct part in hostilities.

3. States Parties shall refrain from recruiting any person who has not attained the age of fifteen years into their armed forces. In recruiting among those persons who have attained the age of fifteen years but who have not attained the age of eighteen years, States Parties shall endeavour to give priority to those who are oldest.
4. In accordance with their obligations under international humanitarian law to protect the civilian population in armed conflicts, States Parties shall take all feasible measures to ensure protection and care of children who are affected by an armed conflict.

Article 39
States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

Article 40
1. States Parties recognize the right of every child alleged as, accused of, or recognized as having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society.
2. To this end, and having regard to the relevant provisions of international instruments, States Parties shall, in particular, ensure that:
(a) No child shall be alleged as, be accused of, or recognized as having infringed the penal law by reason of acts or omissions that were not prohibited by national or international law at the time they were committed;
(b) Every child alleged as or accused of having infringed the penal law has at least the following guarantees:
(i) To be presumed innocent until proven guilty according to law;
(ii) To be informed promptly and directly of the charges against him or her, and, if appropriate, through his or her parents or legal guardians, and to have legal or other appropriate assistance in the preparation and presentation of his or her defence;
(iii) To have the matter determined without delay by a competent, independent and impartial authority or judicial body in a fair hearing according to law, in the presence of legal or other appropriate assistance and, unless it is considered not to be in the best interest of the child, in particular, taking into account his or her age or situation, his or her parents or legal guardians;
(iv) Not to be compelled to give testimony or to confess guilt; to examine or have examined adverse witnesses and to obtain the participation and examination of witnesses on his or her behalf under conditions of equality;
(v) If considered to have infringed the penal law, to have this decision and any measures imposed in consequence thereof reviewed by a higher competent, independent and impartial authority or judicial body according to law;
(vi) To have the free assistance of an interpreter if the child cannot understand or speak the language used;
(vii) To have his or her privacy fully respected at all stages of the proceedings. 3. States Parties shall seek to promote the establishment of laws, procedures, authorities and institutions specifically applicable to children alleged as, accused of, or recognized as having infringed the penal law, and, in particular:
(a) The establishment of a minimum age below which children shall be presumed not to have the capacity to infringe the penal law;
(b) Whenever appropriate and desirable, measures for dealing with such children without resorting to judicial proceedings, providing that human rights and legal safeguards are fully respected.
4. A variety of dispositions, such as care, guidance and supervision orders; counselling; probation; foster care; education and vocational training programmes and other alternatives to institutional care shall be available to ensure that children are dealt with in a manner appropriate to their well-being and proportionate both to their circumstances and the offence.

Article 41
Nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of the child and which may be contained in:

(a) The law of a State party; or
(b) International law in force for that State.

PART II

Article 42
States Parties undertake to make the principles and provisions of the Convention widely known, by appropriate and active means, to adults and children alike.

Activity 4

DUTIES OF GOVERNMENTS CONCERNING HUMAN RIGHTS

Time: 45 minutes

Why do this activity?

This activity is conducted in order to understand to what extent governments have a duty to ensure that girls and women are empowered to abandon FGM/C. Human rights law provides not only a legal framework for articulating FGM/C harms to women and girls. It also makes clear that governments have a duty to act to stop the practice. This activity gives participants an opportunity to articulate government duties to stop FGM, grounded in human rights law.

Objectives

- To articulate government duties to take action to stop FGM
- To review the specific language of treaties that name government duties to promote women's rights

How to do this activity

Step 1: 45 minutes

Lecture

The trainer outlines the framework of government duties under international human rights law. Throughout the lecture, - contained in Handout 1- questions are posed to participants and the trainer writes down responses on flipcharts. At the end of the discussion, trainer summarizes government duties to stop FGM/C and hands out the Table on Treaty Ratification by country (Handout 2)

Materials:

- Handout 1: Duties of Governments
- Handout 2: Table: Treaty ratification by country

DUTIES OF GOVERNMENTS

As a general rule, international human rights law governs the actions of states, not of private individuals. However, the fact that FGM/C is typically performed by private individuals does not relieve states of accountability for the practice. Under international human rights law, governments are bound not only to refrain from violating people's rights, but also to ensure that rights are universally enjoyed in their jurisdictions. Governments may thus be held responsible for failing to take steps to prevent the practice of FGM/C/C

Governments' duty to take action against FGM/C has its foundation in the widely accepted principle that states must respect, protect and fulfill human rights. *Respect* for human rights requires states to refrain from taking direct action themselves to violate individuals' rights. The duty to *protect* human rights requires states to take action to prevent private individuals from violating the rights of other individuals. Finally, the duty to *fulfill* human rights requires governments to invest in programs and services that create the conditions under which rights may be fully realized.

What must governments do to *respect* women's right to be free from FGM/C?

What must governments do to *protect* women from violations of their right not to undergo FGM/C?

What must governments do to *fulfill* women's right to be free from FGM/C?

The duty to *respect* human rights requires governments to refrain from endorsing the practice of FGM/C. It also requires them not to permit the practice of FGM/C in public health care facilities or to in any way regulate the practice with a view to medicalizing it. In addition, governments may not interfere with the work of NGOs and other members of civil society who are working to stop the practice of FGM/C.

The duty to *protect* women's human rights requires governments to take action to prevent private individuals (not government actors) from causing women to undergo FGM/C. This usually means that governments must adopt and enforce legal measures that punish the practice of FGM/C. They must also conduct studies to be informed of the extent of the practice and develop a plan to protect girls and women from undergoing it.

Finally, the duty to *fulfill* human rights requires governments to allocate resources and invest in programs and mechanisms conducive to the enjoyment of women's rights. Measures to fulfill women's right to be free from FGM/C include outreach and training programs, women's empowerment programs and investments in girls' education and healthcare.

In addition to the general duties to respect, protect and fulfill human rights, international human rights instruments also impose some specific duties that provide direct guidance to governments.

At least four obligations pertain to FGM/C:

The duty to modify customs that discriminate against women is

affirmed in the Women's Convention (Articles 2 and 5) and in the documents adopted at certain United Nations conferences, such as the Vienna Declaration and Plan of Action, the Programme of Action of the International Conference on Population and Development, and the Beijing Declaration and Platform for Action.

The duty to abolish practices that are harmful to children is established in the Children's Rights Convention and the African Charter. The Children's Rights Convention recommends that states "take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children." In addition, the Children's Rights Committee, the body charged with monitoring compliance with the Children's Rights Convention, has consistently characterized FGM/C as a "harmful traditional practice" that governments must work to eliminate. The African Charter calls upon states to "abolish customs and practices harmful to the welfare, normal growth, and development of the child in particular: (a) those customs and practices prejudicial to the health or life of the child, and (b) those customs and practices discriminatory to the child on the grounds of sex or other status."

The duty to ensure health care and access to health information has been articulated in a number of international and regional conventions including the Economic, Social and Cultural Rights Covenant. Health education is a crucial strategy for eliminating FGM/C. Governments should undertake educational efforts at the community level to inform women of the health risks of FGM/C. In addition, women and children who have already been subjected to FGM/C and who are suffering from the complications of the procedure should have access to the care they need. Finally, governments themselves should take no action that compromises the right to health care. CEDAW, in its General Recommendations on Women and Health, characterizes governments' obligation to provide health care as the duty to respect, protect and fulfill that right. When a physician performs FGM/C in a public hospital upon a child or a woman, governments are implicated in a practice that interferes with women's right to health care, in violation of their duty to respect that right.

The duty to ensure an enabling environment in which rights can be realized is defined in the Universal Declaration, which states that "everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized." This provision implies that governments have a duty to identify and address the social and economic factors that may prevent some sectors of society from exercising their human rights. Preventing women from abandoning FGM/C is the fact that, in a number of communities, women and girls who do not undergo FGM/C may have difficulty entering into marriage. In societies in which there are cultural barriers to women's economic independence, a woman's inability to marry deprives her of basic economic security. Efforts to eliminate FGM/C, therefore, must include action to improve the status of women in every sector of society.

TABLE:
TREATY RATIFICATION BY COUNTRY

	Women's Convent.	Children's Convent.	Political Rights Conven.	Economic Rights Conven.	African Charter	European Convent.
Australia	X	X	X	X		
Belgium	X	X	X	X		X
Benin	X	X	X	X	X	
Burkina Faso	X	X	X	X	X	
Cameroon	X	X	X	X	X	
Canada	X	X	X	X	X	
Ctrl. African Rep.	X	X	X	X	X	
Chad	X	X	X	X	X	
Cote d'Ivoire	X	X	X	X	X	
Dem.Rep.Congo	X	X	X	X	X	
Denmark	X	X	X	X		X
Djibouti	X	X	X	X	X	
Egypt	X	X	X	X	X	
Eritrea	X	X	X	X	X	
Ethiopia	X	X	X	X	X	
France	X	X	X	X		X
The Gambia	X	X	X	X	X	
Germany	X	X	X	X		X
Ghana	X	X	X	X	X	
Guinea- Bissau	X	X		X	X	
Guinea	X	X	X	X	X	
Italy	X	X	X	X		X
Kenya	X	X	X	X	X	
Liberia	X	X	X	X	X	
Mali	X	X	X	X	X	
Mauritania	X	X	X	X	X	
The Netherlands	X	X	X	X		X

	Women's Convent.	Children's Convent.	Political Rights Conven.	Economic Rights Conven.	African Charter	European Convent.
New Zealand	X	X	X	X		
Niger	X	X	X	X	X	
Nigeria	X	X	X	X	X	
Norway	X	X	X	X		X
Senegal	X	X	X	X	X	
Sierra Leone	X	X	X	X	X	
Somalia			X	X	X	
Sudan		X	X	X	X	
Sweden	X	X	X	X		X
Tanzania	X	X	X	X	X	
Togo	X	X	X	X	X	
Uganda	X	X	X	X	X	
United Kingdom	X	X	X	X		X
United States			X			

MODULE 3

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Module objective

- To make participants aware that FGM/C is a violation of the reproductive and sexual rights of women and has a strong impact on their life and especially on their sexual and reproductive health.

Why this module?

In the previous module we have considered the women's and children's rights violated by FGM/C. There is the need now that people working for the abandonment of FGM/C understand without prejudices the concepts of reproductive and sexual rights - as defined in the Programme of Action approved at the Cairo 1994 Conference on Population and Development (ICPD) and in the Platform for Action of the Fourth World Conference on Women (FWCW) held in Beijing in 1995 – and the physical and psychological impact that FGM/C has on the health of women.

Activities:

Activity 1: Reproductive rights (1 hour and 50 minutes)
Activity 2: Sexual rights (1 hour)
Activity 3: FGM/C and reproductive health (1 hour and 25 minutes)

Total time: 4 hours and 25 minutes

Activity 1

REPRODUCTIVE RIGHTS

Time: 1 hour and 50 minutes

Why do this activity?

This activity shows that 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. This concept is in both the ICPD Programme of Action and the FWCW Platform of Action. Familiarity with this definition allows participants to draw on international agreements when motivating changes in their programming, as well as broader policy and programming changes in their countries.

Objectives:

- To identify the range of behaviours necessary to facilitate reproductive rights
- To know where to find reproductive rights in the ICPD Programme of Action
- To identify how international consensus agreements could be useful in national or local advocacy

How to do the activity:

Step 1: 50 minutes

Handout

Distribute Handout 1: Reproductive Rights, which provides the definition of reproductive rights and a series of questions.
If at this point the group is working comfortably as a group, you can use these questions to run an open discussion in plenary. If the group is big or some people in the groups are very quiet in plenary then divide into smaller groups and ask each group to have their own discussion on the questions

provided. In that case, the timing provided here will not allow for group report-backs and should be extended.

The following ideas should emerge from participants' discussions on each question.

Main points

Why is the issue of freedom from 'discrimination, coercion and violence' central to the concept of 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. Amongst young people in some countries, there is little clarity amongst young men about 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, while in the first instances breaches of 'sexual rights', which will be discussed in the next activity, 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 a woman 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.

Why are 'the needs of their living and future children and their responsibilities towards the community' relevant to individuals' reproductive decision-making?

Every child has rights. A child should be loved and cared for to enable him or her to grow up with a sense of self-esteem and the possibility of contributing positively to society. In addition, children have the right to basic necessities such as housing, food, clothing, education and health care (Convention on the Rights of the Child 1989). Before becoming pregnant, a woman should consider whether she wants a child and will give the child the love and care that the child requires. Likewise, before making a woman pregnant, a man should consider whether he wants a child and will give the child the love and care that the child requires. From this perspective, having a child needs to be considered in relation to responsibilities for existing children. The issue of 'future children' is a reference to the long-term sustainability of the world's consumption of resources. People and countries which consume disproportionate quantities of the world's resources and particularly of non-renewable resources are using up resources that will then not be available to future generations. While this is seldom in the minds of individuals making personal decisions about child-bearing, it is an important issue especially at the national level. Countries whose economies and populations are 'overconsuming' such as the United States of America should be promoting an awareness of this problem. It is important to promote people's responsibility in knowing that they can take care of their own children, and in promoting awareness of the problem of overconsumption of resources.

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 child-care, 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.

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

Reproductive rights are not only the rights not to have a child if you do not want to, but also to have a child if you want to.
As we will see better in Activity 3 , FGM/C may cause infertility, which prevents a woman from having the desired children and is very often the cause for her husband divorcing her, with all the negative effects on her life.
FGM/C causes difficulties in intercourse, pregnancy and delivery.

Step 2: 50 minutes

When the discussion is completed, tell the participants to take handouts from the previous module:

Handouts

Small Groups

The Universal Declaration of Human Rights and The Convention on the Elimination of All Forms of Discrimination Against Women.
Divide participants into groups of two or three each. Ask participants to skim through the two treaties that you have handed out (the Declaration of Human Rights and CEDAW) during the previous training activities and look for rights which are relevant to reproductive rights. Make clear that they do not have time to read again the treaties in detail. They should just try to pick up a few examples of rights that are necessary in order for people to enjoy reproductive rights. This step will help them to see how the enjoyment of reproductive rights requires a range of different rights which are agreed upon by the international community.

Walk around and listen to the groups. If they are battling then help them along by showing them one article in the Declaration that is relevant.

Note to facilitators

Examples of ideas that may come out of looking at the treaties:

The Universal Declaration of Human Rights Article 3 talks about 'security of the person' which links to the discussion participants had on the definition of reproductive rights. They discussed 'coercion and violence'. This article protects people from coercion and violence by committing to 'security of person'. Article 4 on slavery is relevant in the situation of trafficking in women where again they would have no control over whether or not to have children. Article 5 says that 'No one shall be subjected to – degrading treatment'. Participants may identify this as a right that can be interpreted as a right allowing the abandonment of FGM/C, It is also used to

promote a new approach to health service users- that they should be treated with dignity and respect. Article 6 can be linked to the issue of whether women are able to make their own reproductive choices, or whether their husbands make these decisions. If women are legal minors, they cannot have reproductive rights, since their lives are controlled by their fathers or husbands or sons. Article 7 says that 'All are equal before the law and are entitled without any discrimination to equal protection of the law'. This can be applied to the right of all people irrespective of ethnic group or sexual orientation to equal access to health services. Article 19 on 'the right to freedom of opinion and expression' may be important when developing information and education programmes that question cultural practices which discriminate against women, such as FGM/C

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) preamble notes that all people are entitled to all the rights and freedoms described, irrespective of their sex. Article 5 requires governments 'to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary 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 men and women'. This supports educational activities as well as advocacy for gender equality including in relation to reproductive decision-making. Article 10 ensures that there should be no discrimination in 'access to educational information to ensure the health and well-being of families, including information and advice on family planning' which may be particularly important where women are not allowed outside of the home.

When preparing for this activity, check whether your participants' countries have signed or ratified the Declaration of Human Rights and CEDAW. Also get some of the participants countries' reports so that you have copies with you for participants to look at during a break. It would also be useful to know about the constitution and key legislation and policies of their countries so that you can identify in which ways the countries are following the international treaties and conference agreements, and where they are not.

Step 3: 10 minutes

Plenary

Bring the group back to plenary. Ask them if they can imagine using any of these agreements to promote changes in their own country. Ask for examples. Remind participants how the definition of reproductive rights includes that government is responsible for policies and programmes on reproductive health. They can use this provision when advocating for government to improve its policies or programmes. In order to make their demands legally binding, they can link them to articles in the Universal Declaration of Human Rights or CEDAW.

Materials

- Copies of handouts for each participant.

Handouts

- Handout 1: Reproductive Rights
- Handout 2: Universal Declaration of Human Rights (from Module 2, Activity 1, Handout 2)
- Handout 3: CEDAW (from Module 2, Activity 3, Handout 2)

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 decision 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 commu8nity 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 eal 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".

QUESTIONS FOR DISCUSSION

The definition of reproductive rights includes freedom from "discrimination, coercion and violence": do people experience discrimination, coercion or violence in reproductive relationships? In what way? Why is it important for government and NGOs to address discrimination, coercion and violence?

Why are individuals expected to consider the needs of their living and future children and their responsibilities towards the community when making reproductive decisions? Do men usually do this? Do women usually do this?

The definition of reproductive rights includes "mutually respectful and equitable gender relations". Are most reproductive relationships mutually respectful and equitable? In what ways? Why is it necessary for government and NGOs to promote mutually respectful and equitable gender relations?

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

Activity 2

SEXUAL RIGHTS

Time: 1 hour

Why this activity?

Inequality within sexual relationships

Sexual relationships are a source of both pleasure and danger in most societies. 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 indeed, of death. But both men and women, can be endangered by the inability of individuals to communicate openly about sex and sexuality.
Lack of information about sexuality can undermine people's ability to understand their bodies and sexuality and hence to enjoy the sexual experience. 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 with their partners the need to practice safe sex. Women frequently describe how they will not suggest using a condom for fear that their partner will beat them up; they do not tell their partners that they have a sexually transmitted disease for fear that their partner will accuse them of being promiscuous. These difficulties indicate that HIV prevention activities cannot stop at telling people to 'abstain', 'be faithful', or 'use a condom', which is the current 'ABC' message in many countries. This is not enough, because people may not be able to implement these in a context of gender inequality. Hence it is important to challenge the underlying gender inequality within sexual relationships.

At the Fourth World Conference on Women 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. (paragraph 96)

Challenging unequal gender relations

This position is frequently referred to as 'sexual rights' although the actual words 'sexual rights' are not in the Beijing Platform. It reinforces that for women to control their sexuality, unequal gender relations have to be challenged even in the intimate terrain of sexual relations.

Many health issues, which are linked to sexuality, such as HIV/AIDS, require interventions which are different from reproductive health interventions, and even target different people. For this reason it is important for participants to be able to conceptualise sexual health separately from reproductive health, and sexual rights separately from reproductive rights.

Mobilising around sexual rights

While many NGOs are familiar with the concept of 'reproductive rights', they have seldom considered the meaning of 'sexual rights' or the reasons why it may be necessary to mobilise around sexual rights. This activity helps to consider why sexual rights are important and what sorts of activities can be undertaken to promote sexual rights.

Like the concept 'gender', the concept of 'sexual rights' may not be easy to translate into one word. You need to identify an appropriate word or group of words which capture the meaning of sexual rights, as agreed upon in Beijing. The concept of the right to decide if, when and how to have sexual relations is the key point - that is, women's right to control their own bodies and sexual relations; and men's right to control their own bodies and sexual relations.

Note to facilitator

Objectives

- To distinguish between reproductive rights and sexual rights
- To identify how lack of sexual rights leads to vulnerability towards HIV/AIDS and violence against women
- To identify actions that government, their own organisation and they as individuals could take to promote sexual rights

How to do the activity

Step 1: 10 minutes

Overhead
Handouts

Put up an overhead you have made showing newspaper articles that address issues of sexual rights, or give these out as handouts (see 'materials'). Remind participants about how common such occurrences are. Tell them that because so many human rights abuses are in the area of sexuality, the international community has developed a position on the right of individuals to control their own sexuality.

Overhead

Put up the Overhead: Sexual Rights.
Read the paragraph to participants. Tell them that the concept of sexual rights is being used to help people see how the underlying issues behind problems such as HIV/AIDS and violence against women are gender

inequality. You are going to give them a handout which is the text of a pamphlet that is being used in a Sexual Rights Campaign in South Africa.

Step 2: 10 minutes

Handout

Give out Handout: The Sexual Rights Pamphlet.
Ask participants to read the pamphlet individually, after which you will discuss it as a group.

Step 3: 40 minutes

Plenary

Ask the participants the following questions, and have a discussion after each question. If participants find any questions difficult to answer, give them a few seconds to discuss the question with a neighbour. You may want to write up the questions on a piece of paper so that participants can follow them easily.

Questions

1. Do similar conditions (AIDS; violence) exist in this country?

The likelihood is that most participants live in communities where there are social justice and health problems related to sexuality, such as sexual violence - whether incest or rape - and transmission of sexually transmitted diseases. There may be other problems such as trafficking in women - selling of women and children into sex work against their will.

2. What do you think that a sexual rights approach is aiming to achieve?

The sexual rights approach used in the pamphlet is aiming to identify how gender inequality makes sexual relationships dangerous for women, since they become vulnerable to abuse and disease. It argues for the need to promote equality so that both women and men can have control over their bodies and sexuality, as described under ‘what does sexual rights mean’ in the pamphlet. The campaign described in the pamphlet aims to involve both decision-makers and people at community level in building a culture of sexual rights both at the individual level and in social institutions such as the education, justice and health systems.

3. 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, whether or not they have children, whether or not they want children. Sexual rights are also relevant 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.

4. 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 sexual pleasure/activity of women, therefore represents a violation of their right to enjoy sexual life as naturally inscribed in their bodies.

5. What are the barriers to promoting sexual rights in your community?

In identifying barriers to promoting 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 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.

6. What could governments do to promote sexual rights?

Governments are responsible for providing laws and policies which promote sexual rights. They should put in place laws and by laws that prohibit traditions, practices and cultures that subject women to FGM/C wife inheritance, forced marriage, rituals that subject women/girls to forced sex, e.g. wife forced to have sex with a man she does not know when her husband dies, before the body is buried to avoid bad omen, or traditions that force girls to have sex with an older man after the first mestruation.

7. What could your organisation do to promote sexual rights?

Organisations can commit to incorporating the concept of sexual rights in the work they currently do. Organisations can do advocacy for government to change laws and policies so that they are in keeping with international agreements. They can do advocacy for governments to implement existing policies.

Organisations can build community awareness of the 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. While women tend to have more power in sexual relationships, organisations can also empower men in understanding and promoting sexual rights. For example, a man might feel that he has to pretend to be sexually experienced, because this is what society expects of men. This might prevent him from asking questions to learn about sexuality and safer sex. Organisations can offer health services which promote sexual rights.

8. What can you do to promote sexual rights?

Individuals can commit to talking more openly with their sexual partners about their sexual relationships. They can commit to using condoms or only having sex with one partner. They can commit to educating their family members about the importance of acknowledging and promoting sexual rights and the related responsibilities. They
can commit to challenging abuses of sexual rights as they come across them in their personal or working lives.

9. Has the fact that prevalence of HIV/ AIDS is so high in Africa opened the opportunity for talking about sexuality?

Participants may be uncomfortable with talking at this personal level. As the facilitator, it is important to point out that we cannot promote sexual rights in our organisation or community if we are not comfortable talking about it and practising it in our own lives.

Handout

After the discussion in plenary, give the participants Handout 2

Materials

- Flipchart paper
- Felt-tip pens
- Copies of handouts for each participant

Overheads

- Overhead 1: Sexual Rights

Prepare an Overhead or a handout of excerpts from articles from newspapers about issues relevant to sexual rights. This could include articles about rape, trafficking on women, discrimination on the basis of female genital mutilation, sexual harassment in the workplace or sexuality education in schools.
Alternatively the evening before this activity, or by lengthening the time for this activity, you could give participants newspapers and magazines and ask them to cut out relevant articles.
Another option, instead of newspaper clippings, would be to show participants a video that addresses issues related to sexual rights.
Or you could prepare an overhead of data from the participants' country on sexual rights issues.

Handouts

- Handout 1: The Sexual Rights Pamphlet
- Handout 2 : An Islamic perspective on Sexuality

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 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."

Platform for Action of the Fourth World Conference on Women, United Nations, Beijing 1995: paragraph 96.

The Sexual Rights Pamphlet

The sexual rights campaign: For mutual respect in sexual decision making

Together let's address:

- HIV/AIDS
- Violence against women
- Adolescent sexual health

The campaign is a joint effort of: The National Network on Violence Against Women (NNVAW); National AIDS Convention Of South Africa (NACOSA); National Association of People Living With AIDS (NAPWA); Planned Parenthood Association of South Africa (PPASA); The Joint Enrichment Project (JEP); Young Men's Christian Association (YMCA); Women's Health Project (WHP) and community based organisations throughout South Africa.

HIV / AIDS

Joyce (Linyenye village, 34 years): "For me contracting HIV/AIDS is not so far fetched. Before I received training on sexual rights, I couldn't negotiate for the use of the condom, even when my husband had penile discharges and sores. When I asked, he told me he had been pinched by the zip of his trousers. That is all the discussion we ever had about it. But I knew what was going on..... I knew what was the matter....."

Radio Mungana Lonene talk show respondent: "I understand all about sexual rights, but there's nothing I can do about it. My husband does not entertain the rights thing. He has 5 girlfriends. But I can't leave him. I'm terrified because I don't work. He feeds, clothes and gives me shelter. I can't even talk about the condom. He will ask me where I know it from. I'm trapped. Where will I go and what will I eat?"

South Africa is facing an AIDS epidemic.

- An estimated 4.2 million South Africans are infected with HIV/AIDS. In more practical terms, 1 in every 10 South Africans is infected with HIV.
- In 1999, it was estimated that there were 1,700 new infections per day.
- Young women less than 20 years and in their 20s are the most affected. They are twice as infected as other age groups over 30 years.

The problem in terms of Sexual Rights

Women often cannot negotiate for safer sex because of gender inequality, poverty and culture. These factors undermine their position is society and thus make them vulnerable to HIV/AIDS and unwanted pregnancies.

VIOLENCE

Maria (Katlehong 40, previously married to a priest): "He will beat me on a Friday to such an extent that I would be incapacitated. On Sunday he would dress up in his priestly regalia and go to deliver a sermon in church. When asked about my whereabouts, he would tell the church elders and the women that I was not at home. He lied because he feared that the church elders and the whole congregation would find out about his violent behaviour. When he wanted sex, he wanted it there and then. He would beat me when I happened not to be at home when he wanted to have sex. The violence lasted for 15 years. 3 years ago I got out of the abusive relationship. I spoke up and got support. That assisted me to divorce him."

Violence against women has reached epidemic levels in South Africa.

- South Africa has the highest ratio of reported rape cases per 100 000 people in the world.
- It is estimated that one in six women are in abusive relationships and one woman is killed by her partner every six days.
- Many young women report that men used violence when initiating sex with them.
- In 4 provinces in South Africa, abuse by a partner or ex-partner increased by more than 50% between 1998 and 1999. The range of abuse included sexual, physical, economic and emotional.

The problem in terms of Sexual Rights

As a result of unequal power relations between women and men, young women are vulnerable to coerced or unwanted sex, which places them at risk of unwanted pregnancy and sexually transmitted diseases, including HIV. Women also suffer from low self-esteem.

WHAT DOES "SEXUAL RIGHTS" MEAN?

"The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relationships and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences" (Fourth World Conference on Women, Beijing, 1995). The South African government committed to this agreement.

Sexual Rights means that women and men have a right to:

- Control over their bodies
- Only have sex when, with whom and how they want to
- Decide about their sexuality
- Not be forced to have sex through the use of violence or non-physical force
- Have sexual enjoyment
- Be protected from the risk of disease such as HIV and other sexually transmitted diseases
- Have access to responsive services that help them deal with concerns in relation to their sexual health

All these must be present, they are not mutually exclusive.

THE SEXUAL RIGHTS CAMPAIGN AIMS TO:

- Build a new vision of masculinity in which real men:
  - take responsibility for their sexual behaviour do not force women into sex
  - do not expose women to disease or unwanted pregnancy
- Build a new vision of femininity in which all women can:
  - claim their sexual rights
  - build a culture of equality and mutual respect in sexual relations between men and women
  - end women's and girls' vulnerability to violence, AIDS and unwanted pregnancy
  - reclaim sex as a positive and pleasurable experience

The Sexual Rights Campaign involves the following steps:

- Advocacy to national and provincial politicians and decision-makers
- Identification of priority actions to promote sexual rights amongst the police and justice sector, the health sector, the education sector and youth
- Training of trainers and running of sexual rights workshops in which individuals and groups identify and subsequently take up specific actions to promote sexual rights at community level
- Outreach to the public through print media, radio talk shows and posters
- Bringing together all of the findings of this process for the development of a Sexual Rights Charter (mid-2001)

DISSEMINATION OF THE CHARTER AND WINNING COMMITMENT OF DIFFERENT SECTORS TO IMPLEMENT THE CHARTER IN THEIR DAILY WORK AND LIVES

What your sector can do to make a difference:

Build a culture of sexual rights in your own sexual relationship.

Parliamentarians

- Make promoting sexual rights your business
- Talk about sexual rights in every talk you give
- Help to build a new culture of gender equality

Government managers

- Give talks and run workshops so that your staff embrace the concept of sexual rights and promote it in their lives and work
- Ensure that your sector's systems and rules promote gender equality

Government and civil society

Justice and Safety and Security

Train police and magistrates to:

- Respect and promote women's equality
- Implement all aspects of the Domestic Violence Act
- Target those who abuse sexual rights

Education

Build the commitment and competence of teachers to:

- Promote equality between girls and boys in the classroom
- Implement lifeskills and sex education in schools that promotes equality in sexual relations between girls and boys
- Identify and challenge all instances of sexual abuse by students or teachers

Health

- Run gender-sensitising workshops for all staff to enable them to provide supportive and effective care to women, men and adolescents to address violence, STDs/HIV/AIDS, unwanted pregnancies and other issues around sexuality
- Ensure all health managers and health workers use the protocol for implementing the Domestic Violence Act

Trade and industry and Labour

- Create the conditions for women's employment such that they are not reliant on men for income
- Help workers and management understand the impact of the absence of sexual rights on the workplace (sexual harassment, high levels of HIV, violence, absenteeism, etc.) and promote a culture of sexual rights

Women's Health Project,
University of Witwatersrand,
Johannesburg, South Africa.

AN ISLAMIC PERSPECTIVE ON SEXUALITY

In Islam, sexuality is considered part of our identity as human beings. In His creation of humankind, God distinguished us from other human beings by giving us reason and will such that we can control behaviour that, in other species, is governed solely by instinct. So, although sexual relations ultimately can result in the reproduction and survival of the human race, an instinctual concept, our capacity for self-control allows us to regulate this behaviour. Also, the mere fact that human beings are the only creatures who engage in sexual relations once they are beyond the physical capacity for reproduction, sets us apart from all other species which engage in sex for the sole purpose of reproduction.

For Muslims, based on an understanding of Qur'an and hadith, sexual relations are confined to marriage between a wife and husband. Within this context, the role of a healthy sexual relationship is extremely important. Having and raising children are encouraged among Muslims. Once a child is born, the parents are expected to care for, nurture and prepare the child for adulthood, with a goal of imparting Islam so that the individual is equipped with knowledge and willingness to accept and practice Islam and thus become a productive member of society.

Beyond childbearing, sexual relations assume a prominent role in the overall well-being of the marriage. In reading hadith, one is impressed with the Prophet's ability to discuss all issues including those dealing with human sexuality. The topics range from questions about menstruation to orgasm. He apparently was not embarrassed by such inquiries, but strove to adequately guide and inform the Muslims who asked. Both Qur'an and hadith allude to the nature of sexual relations as a means of attaining mutual satisfaction, closeness and compassion between a wife and husband. "Permitted to you on the night of the Fasts is the approach to your wives. They are your garments and you are their garments."(2:187) Also, Muslims are advised to avoid sexual intercourse during menses so as not to cause discomfort to the woman (2:222).

The goal of marriage is to create tenderness between two individuals and satisfy the very basic human need for companionship. "And among His signs is this, that He created for you mates from among yourselves, that you may dwell in tranquillity with them, and He has put love and mercy between you; in this are signs for those who think."(30:21) The hadith which address this issue are numerous. The Prophet himself, while not divulging all aspects of his own sexual life, was known for his nature as a loving husband who was sensitive and physically demonstrative. In several hadith, he speaks about the importance of foreplay and speaking in loving terms during sexual relations. Again, the concept of mutual satisfaction is elucidated in a hadith which advises husbands to engage in acts that enable a woman to achieve orgasm first. (see Ihya ulum-id-din (Revival of Religious Learning) by Imam Ghazzali, chapter on Marriage). Sexual dissatisfaction is considered legitimate grounds for divorce on the part of either wife or husband.

Clearly, from the above discussion, Islam is explicit about many aspects of human sexuality. Also, based on the numerous hadith showing the Prophet's willingness to discuss these matters openly, it should be obvious that education about matters related to sex is acceptable. Muslims may disagree about the age at which sex education begins; some don't discuss the subject at all. Explaining anatomy and the changes one's body experiences during puberty are essential for enabling young people to grow up with a healthy self-image. Also, in an age where sexual activity in many countries begins at an early age, Muslim adolescents must be informed to better enable them to deal with peer pressure. Sex education can be taught in a way that informs young people about sexuality in scientific and moral terms. Therefore, young people are given facts and information, and advised that when they marry they should take measures to prevent pregnancy and sexually transmitted diseases. The moral and religious aspects of sexuality can be incorporated either in schools of a particular religious denomination or in adjunctive coursework offered by religious institutions. Regardless of the challenges of each society, young people must be adequately informed. Also, in some Muslim communities, individuals are encouraged to marry at young ages. They need to be educated regarding sexuality prior to the marriage such that they know what to expect and can consider their options for birth control prior to consummating the marriage.

Activity 3

IMPACT OF FGM/C ON SEXUAL AND REPRODUCTIVE HEALTH

Time: 1 hour and 35 minutes

Why this activity?

After having considered the infringement of reproductive and sexual rights of women, there is the need to look more deeply at the impact that FGM/C has on the Sexual and Reproductive Health (SRH) of women.

Objective

- To better understand the negative effects that FGM/C has on SRH of women.

How to do the activity

Step 1: 10 minutes

Overhead

Showing the Overhead 1 on the definition of Reproductive Health contained in the Cairo Programme of Action, briefly explain the importance of ICPD in shaping a new concept of RH, shifting away from population control to "Freedom of choice". Tell participants to copy the definition.

Then explain them the various components of SRH writing them down on a flipchart.

Main points

Components of SRH

Safe Motherhood
Pre-natal care (antenatal examinations, vaccinations, follow-up of pregnancy, etc)
Assistance at delivery by skilled personnel

Emergency obstetric care
Post natal care
Prevention and control of miscarriages

Family planning
Contraceptive Counselling/Services
Pills
IUD
Injectables
Vasectomy
Tying of Fallopian tubes

Control/treatment of uro-genital apparatus illnesses
Control/treatment of sexually transmitted diseases, including HIV/AIDS
Control/treatment of genital cancer
Control/treatment of cases of infertility
Control/treatment of fistula
Control/treatment of uterus prolapse

Violence against women
Physical
Psychological
Economic
Rape
Rape in marriage

FGM/C and SRH
The range of health complications associated with FGM/C is wide and some are severely disabling. It is important to notice that the evidence on the frequency of the health complications is still very scanty. Also there is still no research on the economic cost of the practice which oblige girls/women to be hospitalised for short and long term complications and at delivery.

Often nurses, midwives and other health personnel in both health institutions and private facilities perform the practice. The justification given for "medicalisation" of the practice is that there is less risk to health if the operation is performed in a hygienic environment, with anaesthetics, and where pain and infection can be controlled.
"Medicalisation" of FGM/C encourages the less drastic forms of mutilation. But whether the procedure is performed in hospital or in the bush, the fact remains that FGM/C is the deliberate damage of healthy organs for no medical or scientific reasons.

Performing FGM/C violates the ethical principles "do no harm" and "do not kill".
WHO has expressed its unequivocal opposition to the medicalisation of FGM/C, advising that under no circumstances should it be performed by health professionals or in health institutions.
Professional bodies such as the International Confederation of Midwives (ICM), the International Council of Nurses (ICN) and the Federation of Gynaecologists and obstetricians (FIGO), have all declared their opposition to medicalisation of FGM/C and have advised that is should never, under any circumstances, be performed in health establishments or by health professionals.

Step 2: 5 minutes

Individual work

Show the actual performance of the practice from the video "The bleeding wound" filmed by AIDOS in Somalia or any other videos available.
Make no comments then give participants a copy of Handouts 1 and 2 and

tell them to go through them by themselves.

Step 3: 40 minutes

Group work

Divide participants into groups well balanced in number, gender and multi-disciplinary profiles.
Give participants Handout 3, Case study of FGM/C in Benin, and tell them to read it and answer the key questions on the case study in order to check whether the problems identified (consequences and complications) actually reflect the reality of women subjected to the practice in their country/community.
In each group a facilitator should lead the discussion until consensus is reached.
The group's findings are summarised on flipcharts or transparencies.

Step 5: 30 minutes

Plenary discusson

During the plenary session, the rapporteur appointed by each group will present the results of the discussion.
Observations enriching and evaluating the work of each group will be given at the end of the presentations.

Handout

Give them Handout 4. Who does my body belongs to? It will be used in plenary for a short discussion in order to verify if the message that a woman's body belongs to herself has got through.
At the end of the session give participants Handout 5 and tell them to read it by themselves.

Materials

- Flip chart or transparencies
- Video: The bleeding wound
- Handouts for each participant

Overhead

- Overhead 1: Definition of Reproductive Health

Handouts

- Handout 1: What is FGM/C
- Handout 2: Health Consequences of FGM/C
- Handout 3: Case Study of the health con sequences of FGM/C in Benin
- Handout 4: Poster "Who does my body belong to?"
- Handout 5: Millennium Development Goals

DEFINITION OF REPRODUCTIVE HEALTH ACCORDING TO THE ICPD PoA

According to the definition of the Cairo Programme of Action, Reproductive Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Reproductive Health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

WHAT IS FEMALE GENITAL MUTILATION/CUTTING?

According to WHO, Female genital mutilation (FGM), often referred to as 'female circumcision' comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons. There are different types of female genital mutilation known to be practised today. They include:

- Type I - Type I - excision of the prepuce, with or without excision of part or the entire clitoris:
- Type II - excision of the clitoris with partial or total excision of the labia minora;

- Type III - excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);
- Type IV - pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterisation by burning of the clitoris and surrounding tissue;
- Scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts);
- Introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above.

The most common type of female genital mutilation is excision of the clitoris and the labia minora, accounting for up to 80% of all cases; the most extreme form is infibulation, which constitutes about 15% of all procedures.

HEALTH CONSEQUENCES OF FGM/C

The immediate and long-term health consequences of FGM/C vary according to the type and severity of the procedure performed.

Short-term physical complications:
- Severe pain
- Injury to the adjacent tissue of urethra, vagina, perineum and rectum
- Haemorrhage
- Shock
- Acute urine retention
- Infection
- Failure to heal

Long-term physical complications:
- Difficulty in passing urine
- Recurrent urinary tract infection
- Pelvic infection
- Infertility
- Keloid scar
- Abscess
- Cysts and abscesses on the vulva
- Clitoral neuroma
- Difficulties in menstrual flow
- Calculus formation in the vagina
- Vesico-vaginal fistula (VVF), recto-vaginal fistula (RVF)
- Problems in child birth
- Failure to heal

Psychosocial consequences:
- For some girls, mutilation is an occasion marked by fear, submission, inhibition and the suppression of feelings. The experience is a vivid "landmark" in their mental development, the memory of which never leaves them.
- Long-term consequences include cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, dyspareunia (painful sexual intercourse) and sexual dysfunction and difficulties with childbirth.
- Some women have reported that they suffer pain during sexual intercourse and menstruation that is almost as bad as the initial experience of FGM/C. They suffer in silence.
- Some girls and women are ready to express the humiliation, inhibition and fear that have become part of their lives as a result of enduring FGM/C. Others find it difficult or impossible to talk about their personal experience, but their obvious anxiety and sometimes tearfulness reflect the depth of their emotional pain.
- Girls may suffer feelings of betrayal, bitterness and anger at being subjected to such an ordeal, even if they receive support from their families immediately following the procedure. This may cause a crisis of confidence and trust in family and friends that may have long term implications. It may affect the relationship between

the girl and her parents and may also affect her ability to form intimate relationships in the future, even perhaps with her own children.
- For some girls and women, the experience of FGM/C and its effect on them psychologically are comparable to the experience of rape.
- The experience of FGM/C has been associated with a range of mental and psychosomatic disorders. For example, girls have reported disturbances in their eating and sleeping habits, and in mood and cognition. Symptoms include sleeplessness, nightmares, loss of appetite, weight loss or excessive weight gain as well as panic attacks, difficulties in concentration and learning, and other symptoms of post-traumatic stress. As they grow older, women may develop feelings of incompleteness, loss of self-esteem, depression, chronic anxiety, phobias, panic or even psychotic disorders. Many women suffer in silence, unable to express their pain and fear.

Sexual complications of FGM/C
- Women who have undergone FGM/C may experience various forms and degrees of sexual dysfunction.
- Women who have undergone FGM/C may suffer painful sexual intercourse (dyspareunia) because of scarring, narrowing of the vaginal opening, obstruction of the vagina due to elongation of labia minora and complications such as infection. With the severe forms, vaginal penetration may be difficult or even impossible without tearing or re-cutting the scar.
- Vaginismus may result from injury to the vulva area and repeated vigorous sexual acts.

Source*: 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.

CASE STUDY OF EXCISION IN BENIN

The relationship between the consequences of FGM/C and RH problems

From a survey conducted in Benin

A Peul from Bagou stated: "Many women have lacerations that reach the anus at the moment of childbirth; a woman died of it. Non one doubts that excision could be the cause."
During an interview with Peul women, an old woman recalled with bitterness the case of some women with problems of urinary incontinence after their excision.
A question to a young excised woman: "Did you feel anything at the moment of the operation?" - "I had the impression that they wanted to kill me," she answered.
A young Bariba woman from Kouand stated that her sister lost one of her daughters following the operation.
"I lost a lovely daughter during excision," said one old woman form Segbana.
People interviewed in all localities confirm with certainty that excision kills girls and women.
A health agent in Segbana told us the story of two serious cases of haemorrhaging that she treated in November 1991. She was surprised at the first bleeding girl, lying on the sand, and giving her some medicine and the haemorrhaging stopped. A few days later, there was another case.
In the sub-prefecture of Bante, some people questioned stated that they had seen a pregnant woman haemorrhage.
A Bariba housewife remarked here. "The bleeding continued until the woman fainted."
The investigators from Segbana gave this testimony: "In all the areas we investigated, our information admitted the high number of serious tragedies due to haemorrhaging that often led to death."
A young man, aged 27, from Segbana narrated: "At least over 30 girls were operated that year. It was about 11 years ago. We watched the ceremony, hidden in the bushes. Three girls screamed and urinated from the shock of the pain, one of them bled a great deal and I later learned that she died. The elder women said that magicians ate the child because she was light-skinned and had too much blood. Afterwards, I learned that there are always cases of deaths in the surrounding villages."
Question asked of 27 women interviewed randomly in the sub-prefecture of Segbana: "Where there incidents when you were excised (haemorrhaging, deaths)?"
18 answered "no".
9 of them-33%-answered "yes".
"I almost died and my parents had to called the neighbours," said an Ichta housewife in the Bante region.
An old Boko man told researchers in Segbana that he was told of several cases of death by haemorrhaging. "When there were complications, everything was hidden without telling the nurses. There are frequently incidents, but no one ever goes to the health centre."
In the sub-prefecture of Toucountouna, cases of haemorrhaging are sometimes registered. Girls lose consciousness and to revive them, the oracle is consulted to deter-

mine the cause of haemorrhaging. People think that it was due to a sacrifice to a fetish or sacred site not performed, or performed improperly,.
In the region of Gognou, an investigator told of hearing of numerous cases of death, but he noticed however that some people are afraid to speak of it openly. In Boko and Bariba communities, girls are all young when they are excised and forget the pain and complications as adults, which might be why they do not frequently mention the pain and negative aspects of the practice. That might also explain their express desire to see the practice continue.
Moreover, it is very difficult to know exactly how many girls die or suffer serious medical consequences because there is no statistical data on the cases of death or hospitalisation due to excision; these cases are voluntarily ignored.

Key Questions for Discussion

1. What kinds of short-term and long-term health problems are mentioned in the reading?

2. Do you know of other long-term consequences that did not appear in the testimony? Give two frequent examples in your community and analyse the implied costs.

3. What is the relationship between each complication and reproductive health?

4. What are the social and economic costs caused by the practice?

5. Is the social and/or financial responsibility for costs of the consequences of FGM/C covered entirely by the families of the excised girls or is there any form of civil and/or social solidarity? Mention the different actors that could be involved and at what level.

Source:AIDOS/IAC/ITC ILO, *Mutilation genitales feminines. Une question de rapports entre hommes et femmes, droits humains et santé,* 2001.


Who does my body belong to?
my husband?
my doctor?
my boss?
the government?
my religion?
me?

MILLENNIUM DEVELOPMENT GOALS (MDGs)*

The signing of the Millennium Declaration at the United Nations Millennium Summit in September 2000, committed member countries to promoting gender equality and female empowerment as effective ways to promote sustainable development and combat poverty, hunger and disease. “Men and women have the right to live their lives and raise their children in dignity, free from hunger and from the fear of violence, oppression or injustice” (par. 6)...
“We resolve therefore: To promote gender equality and the equality and the empowerment of women as effective ways to combat poverty, hunger and disease and to stimulate development that is truly sustainable”.
(par. 20)
“We also resolve: To combat all forms of violence against women and to implement the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)”.
(par. 25).
The General Assembly recognised the MDGs as part of the road map for implementing the Millennium Declaration. The “Roadmap towards the Implementation of the United Nations Millennium Declaration: Report of the Secretary General” (2001/A/56/326) outlines potential strategies for action that are designed to meet the goals and commitments made in the Millennium Declaration.
The Report also encourages the further ratification and implementation of the CEDAW in Chapter V Human rights, democracy and good governance “Goal: To combat all forms of violence against women and to implement the Convention on the Elimination of All Forms of Discrimination against Women”.
“However, violence against women and girls continues to take place in the family and the community, while trafficking in women and girls, honour killings, and harmful traditional practices, such as female genital mutilation, remain common forms of abuse.” p. 38
The report contains specific references to FGM which establish clear links with gender equality and empowerment of women.
By 2002, this agenda had been refined into eight Millennium Development Goals, establishing measurable international targets and indicators of development. The MDGs set out an agenda for a global partnership to achieve a more equitable worldwide distribution of the benefits of progress, and a shared vision of a better world by 2015. The goals are broad-reaching in scope, aiming to cut extreme poverty by half, provide health and education for all children, end gender-discrimination, reduce maternal mortality, control deadly diseases (e.g. HIV/AIDS & Malaria) and manage environmental resources more efficiently. Ending FGM and improving sexual and reproductive health directly underpin goals 3 to 5, namely gender equality and empowerment of women, child mortality and maternal health.

Goal 3: Promote gender equality and empower women
Targets for 2005 and 2015: Eliminate gender disparities in primary and secondary education preferably by 2005, and at all levels by 2015.
Gender-based disadvantages in every area of life are the major cause for acts of vio-

lence committed against women and girls, including FGM.
Goal 3 challenges discrimination against women, and seeks to ensure that girls as well as boys have the chance to go to school. Indicators linked to this goal aim to measure progress towards ensuring that more women become literate, have more voice and representation in public policy and decision making, and have improved job prospects. But the issue of gender equality is not limited to a single goal - it applies to all of them.
It is widely recognised that undergoing FGM can have negative implications for girls and their families. However, for those living in societies where FGM is practiced the positiveimplications associated with it often determine the decision of the family - and especially the female members of it - to continue the practice. Indeed, girls undergoing FGM may receive rewards, increased social status, respect and positive public recognition. In essence, FGM is intimately linked to the overall gender inequalities present in the political, social, and economic structures of societies where it is practised. The practice not only reinforces, but is also enforced by, structural inequalities in social power relations.
Thus, addressing FGM is an important part of successfully achieving goal 3 in countries where the practice is widespread. The abandonment of FGM and the implementation of the relevant international and regional legislation in countries where FGM is practised can be seen as indicators for the achievement of this goal. In particular the Women's Convention (CEDAW) and its regional equivalent the Maputo Protocol are key documents shaping national action.

Goal 4: Reduce child mortality
Target for 2015: Reduce by two thirds the mortality rate among children under five
FGM is performed on female infants a few days old, children in their early years of life as well as adolescent girls. In a few countries we now see FGM being performed at an ever earlier age. Possible reasons for this are the attempt to avoid coming into conflict with existing legislation, or to avoid resistance on the part of (older) children, such as older girls refusing or running away.
There is substantial evidence to show that stillbirth or neonatal death occur as a complication of FGM during childbirth. Thus FGM is contributing to neonatal and child mortality.
The international community has generally regarded FGM as a violation of children's rights because FGM is commonly performed upon girls who are not in a position to give informed consent. The UN Convention on the Rights of the Child explicitly addresses harmful traditional practices as a human rights violation. It obliges governments to "take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence". Article 24 (3) of the Convention specifically requires governments to "take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children." The concern to stop traditional practices that are harmful to health is also evident in the African Charter on the Rights and Welfare of the Child.

Goal 5: Improve maternal health
Target for 2015: Reduce by three-quarters the ratio of women dying in childbirth.
Gender inequality and lack of empowerment, especially prevalent in rural areas, affectsaccess to information and services and leads to adverse reproductive health

outcomes,including high maternal mortality.
FGM is a threat to safe motherhood. Major health complications of FGM are associated with pregnancy, childbirth and the postpartum period. Therefore, FGM not only results in morbidity with regard to sexual and reproductive health, it is a significant contributory factor in many maternal deaths. Efforts to reduce the incidence of FGM should have the benefit of reducing maternal and child mortality ratios.

2. Poverty Reduction Strategy Papers (PRSPs)
While providing a broad framework for development, the MDGs are not a programmatic tool. They are intended to be closely linked to poverty reduction strategies, which 70 of the poorest countries develop assisted by the World Bank and the International Monetary Fund (IMF). A key vehicle to translate these long-term goals into practice are the Poverty Reduction Strategy Papers (PRSPs). They are medium term "national roadmaps" through which the governments of low-income countries set out country-tailored national policies and programmes needed to accelerate growth, improve service delivery and reduce poverty. In line with World Bank policy, the gender dimension should be taken into account when drafting PRSPs, and should be an important part of the PRS process itself.
The World Bank, the IMF and most donors have committed to aligning their assistance to PRSPs.
Many countries have already developed PRSPs which directly address FGM, e.g. Benin, Burkina Faso, Ethiopia, Ghana, Guinea, Mali and Niger. FGM 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 like violation of human rights, violence against women, human rights, gender, reproductive health, participation, empowerment and education. PRSPs are national plans which may offer a platform to anchor strategies to combat FGM. However, gendered poverty analysis in many of these PRSPs is still limited. The analysis on which a PRSP is based must fully demonstrate the gender dimensions of poverty, highlighting: the embedded gender biases in policies, and gender inequality as a cause of poverty, the different experiences of poverty for women and men, and the different effects of policy decisions on both. Although attention is paid to the qualitative dimensions of poverty (vulnerability, 'voicelessness' and powerlessness) these are poorly integrated with the rest of the poverty analysis. In order to make PRSPs gender sensitive and effective in reducing poverty, all stakeholders within the PRSP process must address the gender and human rights implications of FGM in a holistic manner, recognising that violence against women is indivisible from and interdependent with gender-based discrimination in all its forms.

Readings
- 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

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

MODULE 4

UNDERSTANDING FGM/C IN CHANGING SOCIETIES

Module objective:

- To define the cultural environment in which actions will take place by tracing back 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, at the conver gence of "modernity" on "tradition"

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 showed impressive high levels of prevalence: Egypt 97%, Guinea Conakry 99%, Mali 94%, Eritrea 90%, Burkina Faso and Ethiopia 73%. This despite in some of the surveyed countries prevention campaigns were conduced since the middle of the Eighties.
Why campaigns have been not so 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 5 years.
Behind the practice there seem to be profound reasons that prevention programs need to address, in order to be successful. This module aims at understanding these reasons in order to bring that knowledge into programming.

Activities:

Activity 1: Origins and evolution of FGM/C over time (2 hours and 10 minutes)
Activity 2: Myths and realities behind the practice (2 hours and 10 minutes)
Activity 3: A religious practice? An Islamic practice? (2 hours)
Activity 4: A Women's affair? (2 hours and 30 minutes)

Total time: 8 hours and 40 minutes

Activity 1

ORIGINS AND EVOLUTION OF FGM/C OVER TIME

Time: 2 hours

Why do this activity?

Anthropologists believe that FGM/C started approximately 2.000 years ago in what is now Southern Egypt or Northern Sudan. While conclusive evidence does not exist, experts have suggested that it was used to prevent female slaves from becoming pregnant. The practice did not become widespread until the 19th and 20th centuries, when it moved from Eastern Africa to Western Africa.

Female genital mutilation or circumcision or cutting (FGM/C) is currently found in 28 African countries, although it is also practiced in the Middle East (Yemen, Oman, minorities in Iran), in Asia (Indonesia, Malaysia) and among immigrant population in Europe, Canada and the United States, Australia. It is practiced among people of all education levels and social classes, and within various ethnic groups. It transcends religious beliefs, including Islam, Christianity, Judaism and traditional African religions. The World Health Organization (WHO) estimates that worldwide over 130 millions of women have undergone the practice, and an additional 2 million are at risk of being cut every year.

Generally speaking, many points of reference of African societies have changed over the last decades. Ethnic affiliation is no longer as visible as it once was due to scarification, food consumption and geographic regrouping. Most of localities have become a mingling of cultures which encourage even greater change in behaviour and attitude among different social groups. Thus, some relocated sub-groups renounce FGM/C while others embrace it under the influence of neighbours who practice it. Why it happens? Which are the reasons promoting the adoption of a practice that translates into pain and shock, at least emotional and psychological, for their daughters?

In order to better understand these processes and target prevention campaigns more appropriately, it is therefore useful to understand how the practice has originated and then spread. This activity is meant to bring planners closer to the sociological models that underlie historic evolution of FGM/C and, by a comparison with foot binding in China, also understand how it can eventually be brought to an end.

Objectives

- To understand how FGM/C became a prevalent practice in certain areas of Africa.
- To learn how the model can be applied to the countries/areas of inter vention to discover pattern of evolution of the practice over time and forecast possible trends.
- To be able to answer the question of origins and evolution which will inspire possible areas of intervention to speed up or start process of behavioural change towards the abandonment of the practice.

How to do the activity

Step 1: 1 hour

Individual reading

Distribute Handout "Origin and transmission of FGM/C. A comparative analysis with footbinding in China". Make a short introduction about the author and its theory.

Note to facilitator

In 1996 Jerry Mackie, a Researcher in Politics at St. Johns College in Oxford (UK), presented a complete, although condensed, "convention" theory of FGM/C, which attempted to account for the origins, distribution, maintenance and possible abandonment of the practice of FGM/C, that he defines "perplexing". Key element of his analysis are the role of intramarrying families, communities, villages and the possibility to form a "critical mass" that starts the process of behavioural change under specific conditions. He compared it with footbinding in China, and suggested that a strategy similar to the one adopted in China to end footbinding could be used in Africa.

Ask people to read carefully the excerpts of the article presented in the handout, in order the engage in a plenary discussion. Suggest to take notes on a piece of paper according to the points that strike them the most.

Step 2: 1 hour

Plenary discussion

Guide the discussion on the article. First invite all participants to quote the 3 most striking aspects of Jerry Mackie's theory according to their opinion. Ask a volunteer to write them on the flipchart. Confront results. Put particular attention in common choices, and explore them deeper. Use the following set of questions for guiding the discussion:

Note to facilitator

- Which are the main points of similarities among the 2 cases, footbinding in China and FGM/C in Africa?
- Which role do women play?
- Which role do men play?

- Which role do peers play?

- Which are the ground setting social relationships that promote FGM/C?

- Which role wealth and power play?

- Are there any changes noticeable in Africa today?

- What made FGM/C "fashionable" for an increasing majority of the population, so to have it spread over the continent?

- Many people in these days say they continue the practice to respect a tradition. What is the major shift happening in modern societies?

- Are there any indirect factors (changes in society, increase of education, better health knowledge) that can positively affect the process of change?

- Is the substitution of milder forms of FGM/C in areas where more severe ones are practiced a response to the same social evolution model?

- Which role can NGOs, local and national institutions play in the evolution of the practice according to this model?

Main Points

The main points that should come out of this discussion are:

Footbinding, by documentary evidence, and FGM/C by hypothesis, were first adopted at the top of the social stratification pyramid, in times when emperors and elites maintained many female consorts, as an instrument to control women's fidelity.
This behaviour was later adopted by families in lower strata in order to marry their daughters into higher strata.
Eventually the practice became an essential sign of marriageability: when a girl is circumcised, she enters adulthood/womanhood, and thus she can be married. Fathers/families decide upon her marriage, according to possible advantages by the relationship that will be created.
Peers pressure is the second element contributing to the persistence of the practice after bride price and marriageability: FGM/C is continued nowadays because "it is tradition" although other conditions that have contributed to its adoption are fading, and even the approach to marriage is changing.

Materials

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

Handouts

- Handout 1: Origin and transmission of FGM/C. A comparative analysis with foot binding in China

Readings

- 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

- Jerry Mackie, *"Ending Footbinding and Infibulation: A Convention Account"*, in American Sociological Review, vol. 61, n. 6, December 1996 (http://www.jstor.org)

ORIGIN AND TRASMISSION OF FGM/C. A COMPARATIVE ANALISYS WITH FOOTBINDING IN CHINA*

Footbinding and infibulation correspond as follows: Both customs are nearly universal where practiced, they are persistent and are practiced even by those who oppose them. Both control sexual access to females and ensure female chastity. Both are necessary for proper marriage and family honour. Both are believed to be sanctioned by tradition. Both are said to be ethnic markers, and distinct ethnic minorities may lack the practice. Both seem to have a past of contagious diffusion. Both are exaggerated over time and both increase with status. Both are supported and transmitted by women, are performed on girls about six to eight years old, and are generally not initiation rites. Both are believed to promote health and fertility. Both are defined as aesthetically pleasing compared with the natural alternative. Both are said to properly exaggerate the complementarity of the sexes, and both are claimed to make intercourse more pleasurable for the male. Important general differences between Imperial China and Sudanic Africa are elite concubinage in China versus commonplace polygyny (a marital practice in which a man has more than one wife simultaneously) in Africa, exogamy versus endogamy, and agrarian and commercial versus pastoral and horticultural production. Important similarities between Imperial China and Sudanic Africa are their histories of imperial female slavery and their rules of emancipation for the children of concubines.
[…]

Footbinding
Beginning at about age six to eight, the female child's four smaller toes were bent under the foot, the sole was forced to the heel, and then the foot was wrapped in a tight bandage day and night in order to mould a bowed and pointed four-inch-long appendage. Footbinding was extremely painful in the first 6 to 10 years of formative treatment. Complications included ulceration, paralysis, gangrene, and mortification of the lower limbs: perhaps 10 per cent of the girls did not survived the treatment. […] Bound feet were malodorous, and treated women were crippled and largely housebound. The custom was defended by women and was transmitted by them. Footbinding appeared in the Sung Dynasty (960-1279), a time of strong urbanization, expanding burocracy, commercialization of agriculture, monetization, and thriving trade. […] The practice effloresced along three dimensions over several centuries. First, its spread from the imperial palace, to court circles, to the larger upper classes, and then to the middle and lower classes. Second, it became more exaggerated over time. Third it radiated from the imperial capitals to the rest of the empire. Footbinding was clearly the normal practice among the Ming Dynasty (1368-1644). As measured in 1835, it prevailed in the whole empire among the Chinese, affecting 50 to 80 percent of women depending on the locale, the disgraceful exceptions only among the lowest classes, wherever women's work was needed in the fields or in the workshops.
[…] The Chinese offered various explanations for footbinding. It was said to distinguish the Chinese from the invading Mongols and other barbarians and to enhance

the difference between men and women. It was believed to promote good health and fertility. For Chinese men, bound feet were universally associated with higher-status love and sex, and so carried strong connotations of both, modesty and lasciviousness. Bound feet became a sexual fetish; they were said to be conducive to better intercourse, but this claim was medically false. […]

Infibulation

FGM occurs in Egypt and in what was formerly called the Sudanic Belt (the savannah lands between the desert to the north and the jungle to the south, or between the Tropic of Cancer to the north and the Equator to the south); from the Atlantic Coast fron Western Africa to Egypt in the northeast and Kenya in the southeast.
Infibulation, the harshest practice, occurs contiguously in Egyptian Nubia, the Sudan, Eritrea, Djibouti and Somalia, also known as Islamic Nnortheast Africa. […] For the sake of brevity. I concentrate on infibulation.
The origins of FGM are obscure. […] The geographic distribution of FGM suggests that it originated on the western coast of the Red Sea, where infibulation is most intense, diminishing to clitoridectomy in westward and southward radiation.
Whatever the earliest origin of FGM, there is certainly an association between infibulation ans slavery. The Egyptians raided and traded the Black south for slaves from dynastic to Byzantine times, and Sudanic slaves were exported through the Red Sea to the Persian Gulf before the rise of Islam. The Islamic slave trade delivered many Sudanic concubines and maids to Egypt and Arabia. […] Curiously, infibulation is called "Sudanese circumcision" by the Egyptians, but "Pharaonic circumcision" (i.e., Egyptian) by the Sudanese.
Infibulation is not only nearly universal and persistent where practiced, but is expanding its territory. It is spreading from Arabized northern Sudan further into indigenously populated areas od southern and western Sudan; as Arabized traders enter or as indigenous urbanize, the less advantaged adopt infibulation to make their daughters more marriageable to the high-status outsiders. […] Moreover, infibulation has been further exaggerated in the Sudan, beginning among educated urban dwellers and spreading to the uneducated in the villages, with the new practice of reinfibulation to pinhole size after each birth […].
[In Somalia] The most common explanation given is that infibulation is required for marriage and honour. Infibulation prepares for marriage, is a prerequisite for marriage, makes for better marriage prospects, makes possible the security available through marriage, and so on. It fosters virginity, first, because the physical barrier prevents rape, and second, because the physical barrier and the attenuation of sexual desire protect the supposedly oversexed and promiscuous woman from temptation. It is proof of virginity and secure fidelity by reduction of female desire and by reinfibulation upon the prolonged absence of the husband. Infibulation is closely associated with the modesty code. One explanation, sometimes neglected due to the inquisitive bias of intellectuals, is simply that "such is the custom or tradition here". […]
In Egypt, the Christian Copts follow the same practice of clitoridectomy as their Islamic neighbours; in the Sudan the tiny Coptic minority follows the same practice of infibulation as their Islamic neighbours.

Paternity Confidence

For the explanation [of the origin and spread of the practice] to succeed, one

assumption must be true: that humans strongly desire to successfully raise their biological children. The various forms of marriage and family serve this end. Females are certain of maternity, but males are not certain of paternity. In the standard pre-modern case, the female requires assurances of resource support for bearing and rearing children, and the male requires assurances that the children are his offspring. Because of the desire for children, each party prefers marriage to non-marriage. Marriage is a deeply interdependent choice and is a coordination equilibrium. Families advertise their male offspring as capable of providing both generous and sustained support, and their female offspring as both fertile and faithful.

Under conditions of resource equality, humans compete in conveying the many signs of trustworthiness to possible marriage partners. Under conditions of resource inequality, conventions of wealth and honour emerge as signs of higher rank. When the inequality of resource control reaches a certain extreme, polygyny and hypergyny (the phenomenon in which women tend to marry men that are of slightly higher social status) appear because a female is then more likely to raise children successfully as the second wife of a highranking man than as the first wife of a lowranking man. The richest families will also then prefer male children to female children because each polygynous son will generate more grandchildren than the equivalent daughter. The higher the male's rank, the greater the resource support he offers, the greater number of consorts he attracts, the greater his costs of fidelity control, and thus the greater the competition among female families to guarantee paternity confidence. Therefore, families will advertise the honour of their lines, the purity of their females, and their members' commitment to the values of chastity and fidelity, the so-called modesty code.

A highly polygynous apex induces an upward flow of women (hypergyny) and a downward flow of conjugal practices. If humans want to have their own children, then an emperor will take costly measures to ensure that the several thousand women he supports are sexually reserved for him, while the interests of his wives and concubines will be to seek clandestine insemination from men more available than he. It is then in the emperor's interest to inflict costly methods of fidelity control. The next lower stratum, competing to provide wives and concubines to the apex, will imitate and exaggerate the fidelity-control practice so as to gain economic, social, and reproductive access to the palace. The vacuum of women in the first lower stratum will be filled by women moving up from the second lower stratum, who in turn will adopt the fidelity-control convention, and so on, all the way down. Local conventions of modesty emerge: footbinding in one place, infibulation in another. Under extreme polygyny and hypergyny, the conventions are most intense at the highest rank but domino down to the lowest rank that can afford the practice. Female modesty in these circumstances is a positional good (valued not for attaining a standard, but for its rank; not "excellent," but "best") and thus is driven to maximum affordable values on the conventions: "One wrong word about his sister and he'll kill you"; "The errant daughter shall die"; "The smaller the foot, the better the family"; "The smaller the infibulation opening, the better the girl's reputation". Naive observation of runaway modesty practices gives rise to the folk belief, in honour cultures, that women must be excessively lustful to necessitate such scrupulous guarding - the "two-Marys" or "madonna whore" complex. The false belief in enlarged genitals as the rationale for FGM is based on similar reasoning.

[…] However the custom originated, as soon as women believed that men would not marry an unmutilated woman, and men believed that an unmutilated woman would

not be a faithful partner in marriage, and so forth, expectations were mutually concordant and a self-enforcing convention was locked in. A woman would not choose nonmarriage and not to have her own children; a man would not choose an unfaithful partner and not to have his own children.

Imperial Female Slavery

FGM is pre-Islamic but was exaggerated by its intersection with the Islamic modesty code of family honour, female purity, virginity, chastity, fidelity, and seclusion. I propose that imperial polygyny in Arabia and Egypt, and indirectly in Istanbul, induced an eastward flow of female slaves through the mainly polygynous Sudanic Belt into infibulating slave centers in Sudan and a westward flow of Islamization and FGM. Arabized pastoralists raided northeastern Africa for slaves, and, because Islam forbade the enslavement of Moslems, ventured further as closer sources converted. The Sudanic slaves were shipped down Nile Valley routes or through the Red Sea to Egyptian or Arabian markets. The distribution of infibulation in Sudan in the nineteenth century, by far the peak period of slaving (almost one-half million were exported by way of the Red Sea, follows the caravan routes. Slave raiding and slave concubinage continue in today's Sudan (U.S. Department of State 1994:285). The further radiation of clitoridectomy follows the channel of raiding and trading west to the Atlantic and southeast to Kenya. A practice associated with shameful female slavery came to stand for honour. Since defenders of infibulation regard the uninfibulated as no better than contemptible slaves, demonstrating its origin in the slave trade might contribute to its eradication.

Hereditary stratification decreased in "egalitarian" Sung China, but wealth stratification increased with strong urbanization. Commercialization probably decreased the relative price of female labour in agriculture, outdoor work, and increased its price in indoor work, such as commodity textile production, household services, and male entertainment. In the China of female infanticide, poor and middle-range families in the southern Sung capital preferred female children because of their bright prospects as concubines and maids for rich families. Perhaps footbinding arose as a slave traders' restraint on girl children; its obvious purpose was to keep them from running away. Then, nubile courtesans adapted dance performance to the restraint. […] ßThe imperial capitals contained not only the thousands of concubines, dancers, and servants of the emperor, but also an upper class serviced by additional legions of concubines, courtesans, and housemaids as well as government-owned brothels for lowranking officers and soldiers. The many women of the emperor and of other officials no doubt needed guarding against escape, trysts, rape, and bastardy. Initial adoption of footbinding by the imperial seraglio may have had a secondary aesthetic aspect, but the fidelity-control aspect must have been primary. Notice as well that footbinding made it harder for barbarian raiders to steal the palace women because they would have had to be carried rather than driven.

Belief Traps

The women who practice infibulation are caught in a belief trap. The Bambara of Mali believe that the clitoris will kill a man if it carries in contact with the penis during intercourse. In Nigeria, some groups believe that a baby will die if its head touches the clitoris during delivery I call these self-enforcing beliefs: a belief that cannot be revised because the believed costs of testing the belief are too high. KosoThomas (1987) interviewed 50 women in Sierra Leone who had known sexual

experience before clitoridectomy. All reported decreased sexual satisfaction after the operation, but they were unaware of the causal relationship until informed by the interviewer. Ironically, some of these women had become promiscuous in their search for lost satisfaction. Lightfoot Klein's (1989:22, 59) initial interviews with Sudanese women elicited the response, for example, that urination was "normal". She then switched to more descriptive questions such as "How long does it take you to urinate?" The answer then was "Normal about 15 minutes".

The painful surgery, prolonged urination and menstruation, traumatic penetration, and unbearable childbirth accompanying infibulation are all accepted as normal. Because it is inflicted on all girls before puberty they have no basis of comparison; the connection between cause and effect is remote; and the cost of testing pertinent beliefs is prohibitive to any one individual. Once in place, conventions regulating access to reproduction are deeply entrenched, in part because dissenters fail to have descendants. Adult-to-child transmission augments persistence.

*Source: Gerry Mackie, *"Ending footbinding and infibulation: a convention account",* in American Sociological Review, vol. 61, December: 999-1017), 1996.

Activity 2

MYTHS AND REALITIES BEHIND THE PRACTICE

Time: 2 hours and 10 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 standards over the life cycle, in particular when the worse forms are involved (FGM/C type III or infibulation, as well as type II including "sealing" as in several ethnic groups in Western Africa), and with increasing knowledge and information available on harmful consequences, the practice has not stopped.
Research instead is showing a progressive change, with age of performance reducing up to a few years or even a few months, an increasing involvement of health personnel in order to avoid immediate consequences such as infections and pain, and less invasive forms, with clitoridectomy and excision (type I and II) substituting type III.

Objectives

- To understand reasons for the persistence of the practice, con fronting what people say about why it should be done with findings and analysis from socio-anthropological research
- To define the cultural aspects that should be addressed in planning prevention campaigns and actions.
- To identify the different targets for planning.

How to do the activity

Step 1: 30 minutes

Small group exercise

This is a small group exercise where participants will discuss different statements about why FGM/C is practiced and should be practiced. Keep the groups small to facilitate coming to an agreement. If participants come from different areas/regions/countries, it is better to have people from same areas working together to speed up discussion.

Each group of 3/4 people has a certain number of statements and needs to answer the following questions:

- Is this statement made in the environment where the intervention will take place?

- Who makes this statements?

- Who takes advantage from the practice according to this statement?

- Is this statement based on real facts?

- What arguments can be opposed to this statement?

Step 2: 1 hour

Plenary discussion

Ask each group to present the statement and the considerations they have made about it. Write arguments on the flipchart. Ask other groups to verify if arguments to oppose the statement are efficient, or have loopholes. If loopholes are identified, ask the group to find new solutions.

In order to animate the discussion, ask one in the group to take the position of a specific stakeholder in society, such as an old woman, an old man, a young man/husband, and invite him/her to challenge the arguments from his/her point of view, inviting everybody to consider the position of "others" when planning activities.

The plenary discussion should cover some of the following:

Statement	Is this statement made?	By whom?	For the sake of?	Real fact behind the statement	Counter argument
Every human being is born with a double identity: excision is used as an instrument to define femininity, cutting off the male part.	YES NO… By some ethnic groups only…	Elder men/ women, traditional leaders, traditional healers/ practitioners	To make the practice accepted. To give women and men a defined gender identity and prevent madness.	Gender identity is the result of socio-cultural construction that has no need for physical alteration. Control of women's sexuality.	Other ethnic groups do not practice it. Education can contribute to gender identity definition.
Excised women are always in good health and rarely fall ill.	YES / NO… By some ethnic groups only…	Women Village elders	To make the practice accepted. Women's wellbeing / health.	Short and long term consequences of FGM/C.	FGM/C can be the cause of specific health problems, due to excessive scar tissue, difficulties with menstruation, obstructed labour.

Statement	Is this statement made?	By whom?	For the sake of?	Real fact behind the statement	Counter argument
The clitoris is removed for aesthetic reasons.	YES / NO… By some ethnic groups only…	Women Men	Men's pleasure, women's acceptance of their bodies, self-esteem and adherence to a beauty model.	Beauty is a matter of taste. In place where FGM/C has never been practiced other beauty criteria prevail.	Culture changes, so fashion and aesthetic values change also.
The clitoris will continue to grow and hang in an embarrassing way against the thighs, like the penis.	YES / NO… By some ethnic groups only…	Men Elders Women Non educated people	To make the practice accepted by women by scaring them.	Clitoris does not grow like this. Different dimensions are natural, as different sizes of penis, or bodies.	Scientific evidence of natural bodies.
It is a rite of passage to adulthood, to womanhood.	YES / NO In rural areas only.	Elders Village people Women	Give the woman an appropriate status in her community. Allow her to speak to adults. Mark her marriageability.	In some villages this still persists. But in urban setting and where education is accessible for girls, the need for a rite of passage to adulthood is not perceived so strongly.	The rite can stay, but with no cutting. The rite is already disappearing in urban areas. School education bridges the girls to adulthood.
It increases the bride price.	YES NO	Fathers, elders	Bride price is needed by the girls family, as with paid the money for the girl, her brothers will be able to "buy" a bride themselves.	Bride price is common. Its effects go beyond FGM/C and should be addressed in an overall women's empowerment perspective.	Target should be the men (grooms) as well as elder in the groom's family, so to make non circumcised women equally valued.

Statement	Is this statement made?	By whom?	For the sake of?	Real fact behind the statement	Counter argument
It preserves virginity until marriage and chastity during marriage.	YES	Everybody.	To reassure men, who want to be sure to marry a woman who is not pregnant of another man.	Sexual intercourse before marriage is common.	Women's sexual desire is not “caused” by the clitoris, but is a complex psycho physical status involving feelings and emotions. It is a matter of self-control.
The clitoris increases male excitation, leading to premature ejaculation. The vulva opening is reduced to increase male's pleasure.	YES NO	Some women/men. Elders.	FGM/C enhances men’s sexual performance.	Sexual intercourse duration is linked to many factors.	Men’s excitation is influenced by many factors, premature ejaculation cannot be responsibility of the woman. Sufferance of the woman spoils sexual pleasure for the couple.
It is necessary to be pure for being able to pray.	YES NO Some religious leaders	Parents. Religious leaders. Traditional leaders.	The women’s relation with God, her wellbeing from a spiritual point of view.	There is no mention of circumcising women in the Koran, nor in other religious texts. Traditional religion might have a role.	Use arguments pertinent to the faith embraced by the target population.
It is necessary for hygiene	YES NO	Women Men Elders Traditional birth attendants / healers	To make the practice accepted by women	Glandular secretion is natural to keep tissue smooth . If in healthy condition it does not have bad odours.	Explain reality. Blood and urinary retention can instead bring to infections.

Note that the discussion will depend on the statements distributed.
Explain that understanding the belief system which lies behind any society is essential in designing interventions aimed at changing behaviours. 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.
Use the handout on “The realities of myths and beliefs regarding FGM/C” as a reference for discussion.

Note to facilitator

Step 3: 30 minutes

Handout

Distribute the handout 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.

Step 4: 10 minutes

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

"When you see a river from afar, it may look like a blue (or green, or brown) line 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 its structure, it is entirely depending on 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

Handouts

- Handout 1: Questions
- Handout 2: Reasons behind the practice of FGM/C.
- Handout 3: The reality of myths and beliefs behind the practice of FGM/C.

Readings

- Carla Pasquinelli, *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.

QUESTIONS:

- Is this statement made in the environment where the intervention will take place?

- Who makes this statements?

- Who takes advantage from the practice according to this statement?

- Is this statement based on real facts?

- What arguments can be opposed to this statement?

REASONS BEHIND THE PRACTICE OF FGM/C:

It is suggested through the myth of "twin birth" (duality of the soul) that every human being has a double identity, and that excision 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, excision is conceived as a preliminary to marriage in those areas, believing that this protects the husband and progeny from the misfortunate that can assault a non-excised woman.

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 that 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.

According to certain social groups the clitoris is analogous to the penis and increases male excitation, 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 create 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 organism and ejaculation. In those types of excision 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.

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 and sub-areas). 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.

Excision practiced in puberty in group and with a period of reclusion for the excises girls used to be, and is still true in some rural areas, an important rite of initiation for girls. The decision for excision 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 excision 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.

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 excision, 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 excision, 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.

It is believed that excised women are always in good health and rarely fall ill; it is also believed that excision has healing powers. It has, people say, healed women suffering from depression, from melancholy, from hymphomania, from hysteria, from madness, from epilepsy and has the ability to stop women with kleptomania tendencies. Some supporters of excision 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 foods, water, clothes, etc. It is therefore deemed necessary that the glands and organs responsibility for these secretions be eliminated to avoid contamination and safeguard individual cleanliness.

Some Christians claim that they practice excision while keeping with Christian tradition. They explain excision with their affiliation to given ethnic groups. In contrast, the symbols and initiations that accompany excision adapt easily with animist believes and the tradition of blood sacrifice to their gods or fetishes.

There is an ambiguous relationship between affiliation to Islam and the justification of excision in western Africa. Some Moslems 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 country, most of the women who practice excision are Moslem, which some consider a de facto confirmation of the relationship between Islam and excision, 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 practices by a minority (e.g. Senegal, Mauritania and Niger), most of the Moslem population does not follow this practice. Moreover, the most fundamentalist subgroups of some countries (for example, Mali and Senegal) do not practice excision while some of their countrywomen submit to it, convinced that all good Moslem women must have their daughters undergo excision.

It is alleged that membership in 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 used 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, excision 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 undergo excision.

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 increase 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 health, 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 created 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 determined by genetic and hormonal influent. 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 stop 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 enlarge 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 later one), 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 harden scar and the stump that normally replace 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 pratiche excision, certain organs and certain bodily function 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 come on them 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 has 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 eliminat-

ing 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 responsibility 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 Moslem 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 Habits have been changed, others have a different point of view on this subject.

Activity 3

A RELIGIOUS PRACTICE? AN ISLAMIC PRACTICE?

Time: 2 hours

Why do this activity?

FGM/C is often defined as an Islamic practice. Why?

We know for sure that Islam was not responsible for introducing FGM/C in Africa and that the practice was already present on the continent well before the spread of this religion. It is a native practice, deeply rooted in the 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, among others.
Addressing the issue of Islam and its connection to FGM/C, in 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 the role of Islam in propagating the practice, as well as its potential in contributing to its abandonment.

How to do the activity

Step 1: 20 minutes

Plenary

Introduce the topic underlining that no revealed 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).

With the help of participants draw a table of the religious identity of their country/region/area, inviting to quote - as far as they can evaluate - percentages of followers for each religion present, and eventual crosscutting with local traditional cults.

Put on the Overhead with prevalence data from the DHS Surveys. Write the prevalence rate next to each country: it will be evident, as DHS Surveys have shown, that FGM/C prevalence is higher in countries where Islam is the prevailing religion, although it is very diffused also in countries with other religious compositions, such as Ethiopia (mainly Coptic Orthodox).

Step 2: 50 minutes

Small group activity

Handout

Divide participants in 4 small groups. People can be from different countries/regions. Each one will work with the scenario presented in one of the Handouts. Distribute also the Handout with the Outline for analysing the scenarios. Ask the group to choose one person to read the text out loudly, and then invite each group to analyse with particular attention to :

Note to facilitator

- 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?

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

Plenary discussion

Ask each reporter to summarize the content of the handout the small group has been working on, then to present their list of considerations and their evaluation about possible contribution to continuation or to 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.

Main Points

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, interpretation of Islamic scriptures has been done in order 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 under the name of sunna different types of FGM/C are meant, some of them only little less intrusive and damaging that infibulation itself.

Arguments from within 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 does support 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

Overheads

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

Handouts

- Handout 1: Outline for scenario analysis
- Handout 2: Egypt. The minister for Health, Islam and CNN
- Handout 3: Islam and Female Circumcision
- Handout 4: Becoming a Muslim: Female "Circumcision" and Religious Identity Among the Mandinga
- Handout 5: Sunnah: what form of FGM/C lies behind this name?

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 PREVELENCE RATES ACCORDING TO DEMOGRAPHIC AND HEALTH SURVEYS (DHS)

Country	Year of Survey	Overall Prevalence	Sample Size
Mali	1995-96	93.7%	9,704
Mali	2001	91.6%	12,849
Egypt*	1995	97.0%	14,779
Egypt*	2000	97.3%	15,573
Eritrea	1995	94.5%	5,054
Eritrea	2001-02	88.7%	8,754
Côte d'Ivoire	1994	42.7%	8,099
Côte d'Ivoire	1998-99	44.5%	3,040
Burkina Faso	1998-99	71.6%	6,445
Burkina Faso	2003	75.0%	12,477
Nigeria	1999	25.1%	8,206
Nigeria	2003-04	18.9%	7,620
Kenya	1998	37.6%	7,881
Kenya	2003	33.7%	8,195
Guinea	1999	98.6%	6,753
Northern Sudan*	1989-90	89.2%	5,860
Ethiopia	2000	79.9%	15,367
Mauritania	2000-01	71.3%	7,728
Central African Rep.	1994-95	43.4%	5,884
Yemen*	1997	22.6%	10,414
Tanzania	1996	17.9%	8,120
Benin	2001	16.8%	6,219
Ghana	2003	5.4%	5,691
Niger	1998	4.5%	7,577

Source: DHS, Macro International, www.measure-dhs.org.

OUTLINE FOR SCENARIO ANALYSIS

Consider the following points:

- Where the action takes place (urban/rural setting);
- The role played by different stakeholders (highlighting protagonists);
- Direct and indirect development issues that interfere;
- Role eventually played by foreign actors;
- Presentation of religious teachings;
- Strong or weak messages;
- Eventual reactions: positive? negative?
- Other relevant elements?

The facts presented in the Handout contributed to

- the continuation of the practice?
- the abandonment of the practice?

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. Further, 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.

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.6 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 sunnah 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 sunnah [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.19 Many scholars, though, seem to ignore this hadith, as it is considered weak. Some scholars are of the opinion that if female circumcision is to be performed - "there is no harm in not doing it, and there is some reward in doing it" - then only a mild operation, either a pricking or a removal of prepuce, is to take place. Removal of the whole clitoris in a woman can be compared to removing the penis of a man.

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 Muslims scholars' attitude is paradoxical, as they at the same time accept male circumcision-such a procedure also changes God's creation. But none of my informants, who claim that they are opposed to (harsher forms of) female circumcision with the argument that Islam forbids any harm to God's creation, have mentioned that they have a problem accepting male circumcision. The tradition of female circumcision has met with opposition among Muslim scholars also in historical times, e.g. in Imam Abu Hanifah in the eighth century, according to Anees. Abusharaf reports a later example: noted Muslim leaders in Sudan launched successful anti-circumcision efforts as early as in the middle of the nineteenth century. The stand taken by most Muslim scholars on the tradition of female circumcision seems to support mild or symbolic sunnah circumcision or no circumcision of girls. 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

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. As one elder woman from Bissau explained:

"The Pepel, the Mankanya, the Bijugus, many groups do not go to fanadu; just the Muslim groups, the Mandinga, the Biafada, and the Fula, because we have to pray. If you don't go to fanadu, you will have an odor there [in the genital region] and you will not be clean. If you cannot pray, then you are not a Mushm, and Mandingas are Muslims".

This need for cleansing or purification fits with Muslim ideas concerning .gender and the life cycle. As women progress through the life cycle, changes m 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. After discussing this issue with a medical doctor in Bissau leading the campaign against "excision" in Guinea Bissau, I decided to engage Mandinga men and women more actively on the connection between female "circumcision" and Islam.

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 Quran. 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 fall 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. The old woman was content. since she knew that the young girl would not sleep with her husband because of the pain she was feeling. Mohammed prayed to God. 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". Since the young girl was circumcised and God was content, the Mandinga put the idea of female circumcision into their heads, and that is how it all began".

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

SUNNAH: WHAT FORM OF FGM/C LIES BEHIND THIS NAME?

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 dby 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, Sunnah has been found to have al least four different meanings:

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

2. Sunnah, 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. Sunnah, as a descriptive religious term (noun) denoting Prophet Muhammad's sayings and doings, the tradition as it is described in the hadith.

4. Sunnah, 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.

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 to the “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 threat 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 full-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 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.

Activity 4

A WOMEN'S AFFAIR?

Time: 2 hours and 30 minutes

Why do this activity?

Why African women, often also with high education, 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 circumcise their girls and why even the educated of them 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 as well as in urban settings, in more "traditional" as well as in more "modern" contexts.
As abandoning the practice implies a fundamental change in behaviour, also hidden meanings and dynamics of its performance need to be understood and considered by program officers before planning activities. This concerns both, the ritual itself, which is on its progressive and apparently irreversible disappearance in many settings/countries, with increasing FGM/C performed on very young girls (up to babies of a few months), and by non-traditional practitioners, leaving girls deprived of the emotional and cultural surroundings that helps taking care of the pain endured and transmuting it into pride, dignity and force; and the values attached to the practice, today condensed in a simple word justifying the continuity of the performance: it's "tradition".
The disappearance of traditional rituals opens an entry point 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: 1 hour

Small group discussion

Handouts

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 look 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: 1 hour

Plenary discussion

Bring the group together. Ask each rapporteur to present the result of the discussion in small group, including a synthetic presentation of the content of the handout. Ask participants' comments. 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 and decision making within community, adult female identity.

Step 3: 30 minutes

Sharing personal stories / experiences

Note to facilitator

Bring the discussion on a more personal level. Ask participants, both women and men, which where their personal feelings / emotions in reading/listening to the handouts.
Ask a few participants, preferably women, to recall one personal experience, or the experience of a relative or beloved one, or a story they feel appropriate from their own direct life experience and contacts.
Allow two or three different stories to emerge from the group, possibly by people from different backgrounds and with different protagonists (i.e. not only recalling the moment of the practice, but also other experiences during lifetime).
Ask people in the group if they share the same feelings / emotions, and if similar or other memories have been evoked, or if they have additional comments.

This exercise is meant to put planners programme officers in the position of the women in their target groups, understanding also the emotional aspects of possible reactions by them.

Guide the conclusion of the discussion towards the question:

Can FGM/C be abandoned / replaced without setting women's condition back?

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 dressing 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?

Readings

- 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, Proceeding 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, Proceeding 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 FOR GUIDING THE DISCUSSION

1. Which is the attitude of women towards the practice in the case study?

2. Does the practice contribute to women's empowerment?

3. If yes, how?

4. Are eventual negative side effects perceived / recognized / accepted / contrasted?

5. Does the traditional and the modern socialization of women coincide or collide?

6. Does the role/position of women as described in the case studies can be found among women of practicing populations in your country/region/area?

7. Which are the changes in socialization of women already affecting the practice of FGM/C in your specific environment?

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. Gender is a process of the definition of self according to the connection to cultural models historically built on the difference between the sexes. 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 tights 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.

But there are two important relationships at play here: between the sexes and between the generations, mother and daughter in particular, which initiation rites make extremely visible and dramatic. The mother-daughter relationship is much more ambiguous and controversial than that between the sexes, basically an asymmetrical relationship of domination, based on the marital strategy linked to the bride price.

In the mother-daughter relationship, we find psychological rivalries and destructive instincts that are condensed, expressed and neutralized in the period of time required for the ritual performance. This is true from the point of view of the daughters who see in the rite a legitimization of their own sense of guilt at taking over their mothers' position, and from the point of view of the mothers who "betray" their daughters' trust, becoming persecutors and thus expressing their envy for their reproductive capacity. Then, all is forgotten, including torture and suffering, once the "passage" has taken place.

At the rite's end, only the bodies preserve the memory in the form of a scar appointed to represent the sign of membership in one's ethnic group.

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

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

The Kono are a Mande-speaking people who, according to oral historical accounts, migrated from Guinea savannah region toward the end of the Mali Empire to their current home in northeastern Sierra Leone. Kono is also the name of their geographic location and their common language. Most Kono uphold indigenous beliefs, although a minority proclaim Islam, and even fewer profess Christianity as their dominant faith. The subsistence economy is based on agriculture […]. Today intense civil war has driven out virtually all farmers from their villages as well as traditional chiefs, professionals, and businesspeople.

The two [most salient social organizations, who care for initiation and circumcisions] are Bundu, female "secrete 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 socioeconomic 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. However, cross-sex status comparisons would violate local dual-sex models, which emphasize complementarity and interdependence through sexual difference and autonomy. In the second instance, vis-à-vis their husbands and their male (and female) lineage representatives, young novices are taught to feign subservience - in verbal communication, body language and gestures, and the performance of domestic duties - in order to live anonymously among their affines. 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 their 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. If most women felt in some way oppressed by this aspect of culture - after all, they too were once initiates - why not then rise up individually or collectively and put an end to it? When the urgency is somewhat mitigated by distance and systematic disapproval of host countries, what are the reasons for continuation? 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. In short, I would be ridiculed and maligned as an arrogant puu moe [white person] or worse, an "uncircumcised woman", the ultimate insult against a woman. At the same time, these women do not necessarily believe that their Western-born or -bred daughters will care to be integrated in or accepted by Kono society. In fact, some admit that their daughters, if left to themselves, have no intention of visiting Kono or even Africa for that matter (given the negative image of war and poverty), let alone of marrying Kono men.

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.

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 circumcise their girls and why even the educated of them 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 FC/FGM 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 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 FC/FGM to take root and be sustained it must gather sufficient supported 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 FC/FGM is harmful to women. On the basis of objective logic and scientific criteria FC/FGM 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 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 FC/FGM 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, Proceeding from the Expert Consultation, Cairo 21-23 June 2003,* published by AIDOS and NPWJ, Rome, 2003.

MODULE 5

PROGRAMMING FOR THE PREVENTION OF FGM/C

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 inter vention for different target groups
- To recognize the important of research, monitoring and evaluation for programmes in the field of FGM/C
- 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 the 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.

The international attention to 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 to be created in 1982. It was followed by the IAC, Inter African Committee on Traditional Practices affecting the Health of Women and Children, composed originally by 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.

The international conferences of the Nineties

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 DHS surveys, 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 this 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 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 managed to have up to 1.300 villages in rural areas affirming through a Public Declaration their official decision to abandon FGM/C and early marriage. The “snow ball” effect, from the first villages to grouping of up to 300 villages declaring during the same ceremony, collectively, 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 to a definitive abandonment of the practice and if this model of intervention can be repeated elsewhere, where structure of society and culture are different.

This module aims at offering 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 promote creative programming in connection with the broader local and national development agendas.

Activities

Activity 1: Who? Target groups for preventing FGM/C (2 hours)
Activity 2: How? Different approaches for different settings (2 hours)
Activity 3: Steps in behavioural change: A case study (2 hours)
Activity 4: Abandoning FGM/C: interaction between women and the community (1 hour)
Activity 5: Prevention of FGM/C as a development issue (4 hours)

Total time: 11 hours

Activity 1

WHO? TARGET GROUPS FOR PREVENTING FGM/C

Time: 2 hours

Why do this activity?

FGM/C is multifaceted procedure involving individuals and the comumunity

This activity builds on the understanding of how women and men are socialised into their roles and of the multidimensional aspects of FGM/C gained through Module 4, in order to identify direct and indirect target groups involved in the decision making process about subjecting a girl to the practice.

Different aspects of FGM/C illustrated by scientific data

The DHS (Demographic and Health Surveys) data collected in 16 countries from 1989 to 2002 show substantial variations between and, more important, within countries: FGM/C prevalence rates, the manner in which FGM/C is performed, the importance attached to the ritual aspects of the circumcision event, the age at which the cutting is performed as well as the type of practice, differ significantly.
DHS indicate that the practice has changed in recent years, with girls circumcised at earlier ages, with less cutting then in the past, and with an increasing medicalization of the procedure. Sometimes data collected give a sharper picture, by including information on the role of residence (urban/rural), ethnicity, religion and level of education. It appears evident that families live in social environments of three kinds, with regard to FGM/C: 1) those in which nearly everyone has their girls cut, 2) those in which no one has their girls cut and 3) those in which some girls are cut and some others don't. The latter situation occurs in some urban areas and in regions of ethnic diversity.

Preventing FGM/C requires interaction with the decision making process

For prevention interventions to be effective it is important to understand who leads the discussion about how and when to circumcise a girl, what sort of person take the responsibility to make sure that FGM/C is carried out, and who participates in the action. In order to interact with the decision making process and direct it to a different outcome then the performance of FGM/C, it is also necessary to identify the social actors who might be best suited for this task.

Objectives

- To identify all actors involved in the decision making process concerning the performance of FGM/C
- To understand the interaction between individuals and the community concerning FGM/C
- To identify activities that can best interact with actors involved in the making process

How to do the activity

Step 1: 30 minutes

Plenary
Videoscreening

Invite participant 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 has learned that the problems she experienced in her reproductive life are caused by her circumcision, and wants to spare the same destiny to her daughter. In front of the growing pressure the relatives put on her, she finds a way to bring this issue up within the community and finds an alternative solution.

Note to facilitator

Step 2: 45 minutes

Debate in plenary: identify key actors

Make a first round of comments to the video: ask everybody to select and share ONE specific aspect that has impressed her/him the most.

Some points to bring forward are:

- The self esteem / awareness of Fatoumata : where does it comes from?
- The need to involve the whole community in the decision: who really takes the decision at the end?
- The personal commitment of the doctor: which role has personal experience?

Note to facilitator

Distribute the booklet “Fatoumata's story” to participants, for reference for the activity. Ask participants to list all actors, both individual and collective, involved in the story. For each actor, ask participants to define if it

- wants the practice to continue
- wants the practice to stop
- has a direct influence in the decision making process
- has an indirect influence in the decision making process

Invite one volunteer to the flip chart and ask him/her to divide the sheet in 4 columns:

FGM/C to continue / FGM/C to stop / Direct influence / Indirect influence

writing each actor in the appropriate column according to the indication of the group.

Invite participants to explain the reasons why they have chosen to put a certain actor in a certain category. Invite participant to broaden the picture including suggestions coming from their direct experience, naming also actors that do not appear in the video, but might play some role in the decision making process.

It will appear evident that some actors play both roles. The lists might look as follows:

FGM/C to continue	FGM/C to stop	Direct Influence	Indirect Influence
Mother	Mother	Elders	Medical doctor
Father	Father	Other girls (peers)	Teacher
Grandmother	Traditional birth attendant	Aunts	Religious leaders
Aunts	Husband	Other relatives	Parliamentarians
Elders	Circumciser	Neighbours	Media
	Grandmother	Traditional village leader	The judiciary
		Husband	
		The family of the groom	Priest
		Imam	Imam

Step 3: 45 minutes

Debate in plenary

Go back to “Fatoumata's story” and ask participants to reconstruct the fundamental steps of the decision making process leading to the decision of offering Efua and the other girls an Alternative rite of passage.

Note to facilitator

Steps might include

- the oat made by Fatoumata and the other girls after having been cut, not to subject their eventual daughters to the same procedure;
- the organisation of public meetings with all key actors of the village to discuss the isse over a month or so
- the help searched from external experts such as the medical doctor
- the support offered by religious leaders’ statement that FGM/C is not a religious requirement
- the role given to the circumciser in the new ceremony
- the old women who were convinced and supported the proposal

Invite participants to remark that the Alternative rite of passage was an

idea born within the village, a suggestion by a village member. But this idea came at the end of a process that involved lots of communication among village members, as well as with the participation of external supporters.

Now ask participants to act as a programme officer of an NGO or local/national institution that wants to promote the abandonment of FGM/C.

Given the actors listed above and bearing in mind the decision making process just described, ask participants to suggest one or more activities they deem appropriate for each actor, in order to move the actor from supporting the practice to supporting its abandonment. Invite them to bear on their own experience, on their intuition, on experiences they have heard about and not only on “Fatoumata's story”.

Ask the volunteer to divide a new flipchart sheet into 2 columns and list suggestions made by participants, which might include :

Actors	**Activities**
Mothers	Awareness raising meeting Literacy courses Reproductive health service
Daughters	Awareness raising activities Information on FGM/C included in school curricula Support to girls education (school fees etc.) Alternative rites of passage
Men (fathers, husbands, decision makers at village level)	Awareness raising meetings Reproductive health service with counselling including FGM/C
Circumcisers	Awareness raising meetings Alternative income generating activities Alternative rites of passage
Elders	Awareness raising meetings
Peers	Awareness raising meetings Special services to care for women with FGM/C Counselling of clients
Medical doctors	Awareness raising meeting Special services to care for women with FGM/C Counselling of clients
Traditional birth attendants, healers	Training on reproductive health including FGM/C health consequences

Religious leaders	Awareness raising meetings Debates within the communities lead by sensitized religious leaders
Village leaders	Awareness raising meetings Alternative rites of passages involving them
Government authorities	Advocacy for policy and resources Training of government officials on FGM/C
Teachers	Training on FGM/C Definition of new school curricula including FGM/C Debates with students Debates with parents

Note to facilitator

Invite the group to elaborate on the various suggestions. In the case of awareness raising activities, ask participants which topics, in their view, should be addressed during these meetings, and why they think these are the most appropriate for promoting the abandonment of FGM/C. Ask participants to explain why they deem a certain activity appropriate for the selected target group. Make participants notice that awareness raising alone is not enough as it might bring a change in attitude, but it does not automatically means abandonment of the practice, as the DHS surveys have shown. Put on Overhead 1 with the Table comparing attitude and prevalence rates and make participants remark that countries such as Mali, Sudan, Burkina Faso have had significant interventions aimed at preventing FGM/C, but still prevalence rates are very high.

To conclude, ask people to keep the list aside, as in dept analysis of approaches to FGM/C prevention activities will be the object of the next activity.

Materials

- Video “Fatoumata's story”
- TV and video recorder or DVD player to screen the video
- Flip chart
- Felt tip pens
- Overhead
- Booklet “Fatoumata’s Story” for each participant.

Overheads

- Overhead 1: Attitudes toward the abandonment of FGM/C and prevalence rates

in selected countries, according to DHS

Readings

- Yoder Stanley P., Abderrahim N., Zhuzhuni A., *Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis*, Macro International, Usa, September 2004.

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

- *Female circumcision. Strategies to bring about change, Proceedings of the International Seminar on Female Circumcision, Mogadishu, Somalia, 13-16 June 1988*, AIDOS, Italy, 1989

ATTITUDES TOWARD THE ABANDONEMENT OF FGM/C AND PREVALENCE RATES IN SELECTED COUNTRIES, ACCORDING TO DHS

Country and year of DHS	Attitudes toward FGM/C	Prevalence	Total percentage and number	
	Practice should not continue	Percentage of all woman who have undergone FGM/C	Total %	Number
Benin 2001	59.2	16.8	100.0	6219.0
Burkina Faso 1998/99	56.4	71.6	100.0	6445.0
CAR 1994/95	55.8	43.4	100.0	5884.0
Cote d'Ivoire 1998/99	60.0	44.5	100.0	3040.0
Eritrea 1995	38.4	94.5	100.0	5054.0
Ethiopia 2000	26.7	79.9	100.0	15367.0
Kenya 1998	73.3	37.6	100.0	7881.0
Mali 1995/96	12.7	93.7	100.0	9704.0
Mali 2001	12.4	91.6	100.0	12849.0
Mauritania 2000/01	20.8	71.3	100.0	7728.0
Niger 1998	13.8	4.5	100.0	7577.0
Nigeria 1999	47.0	25.1	100.0	8206.0
Sudan 1990	21.4	89.2	100.0	5860.0

Attitudes toward FGM/C
Percentage of all women who report the practice of female circumcision should continue, according to background characteristics

Prevalence of FGM/C
Percentage of all women who have undergone female genital cutting (FGC).

Source: ORC Macro, 2005. *MEASURE DHS STAT compiler.*
http://www.measuredhs.com

Activity 2

HOW? DIFFERENT APPROACHES FOR DIFFERENT SETTINGS

Time: 2 hours

Why do this activity?

Twenty years of interventions with little monitoring of impact

Since the 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 diverse approaches for the abandonment of the practice. Only recently has attention started to be given to objectively evaluating these approaches and their outcomes.

WHO: understanding what works and what doesn't

This process started after the publication of the results of the first Demographic and Health Surveys (DHS) including data on FGM/C, showing impressive high rates of prevalence also in countries where FGM/C prevention activities were carried out for a long period of time (such as Mali, for ex.). 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 identify 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 of 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 don't.
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.

How to do the activity

Step 1: 20 minutes

Plenary discussion

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

Note to facilitator

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 learned 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 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 to number of activists and researchers, the reason while the prevalence is still high, is that programmes implemented since 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 reflects opinions by all actors involved in the decision making process about subjecting a girl to FGM/C?

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

Step 2: 40 minutes

Small group activity

Divide participants into small groups. Distribute a copy of the Overhead 1 to each group and one or more of the different “Approaches to FGM/C prevention” contained in Handout 1: once photocopied, you might cut the

various approaches to distribute them. You might also decide to have different groups working on the same approach (just make extra copies for distribution) in order to compare evaluations.

Ask each group to analyze the approach considering

- the mental map
- the different target groups, both individual and collective, they have identified in Activity 1

Distribute the “Evaluation form” photocopied on trasparencies - one per approach - to each group, and ask them to put an X according to the answer for each of the following questions:

Each question can be answered by a YES, a NO, or by PARTIALLY.

1. does the approach include all actors involved in the decision making process about subjecting a girl to FGM/C?
2. does the approach help women's empowerment?
3. does the approach address the marriageability issue?
4. does the approach address peer pressure?
5. does the approach address the psycho/sexual reasons (control of women's sexuality)?
6. does the approach address the religious reasons (including traditional religion)?
7. does the approach address the passing of age and of status (to adulthood and womanhood)?
8. does the approach address the hygiene/health reasons?
9. does the approach foresee some monitoring over time?

At the end, each approach should be evaluated according to efficiency in preventing the practice:

1. Insufficient (F)
2. Sufficient (D)
3. Good (C)
4. Very good (B)
5. Excellent (A)

Ask each group to summarize the reasons for their evaluation and for their rating in the appropriate space of the “Evaluation form”. Each group needs also to choose a rapporteur for presentation in plenary.

Step 3: 1 hour

Plenary discussion

Invite each group to present their evaluation in plenary, putting the appropriate transparent on, so that participants can read the description of the approach. Ask rapporteur and group members to elaborate on the reasons for their answers and grading.

Ask if among participants there is somebody who has been part of an activity including the presented approach and likes to share his/her experience. Does the experience confirm evaluation by the working group?

To conclude, note that the last questions has introduced the concept of monitoring. In fact the lack of monitoring procedures and tools has been identified as one of the major weaknesses of a large number of programs, and a call for more appropriate measures for monitoring and evaluation has translated into increasing research and emphasis on this aspects of programming, in order to really understand, and continue, what works and avoid or stop what does not.

Materials

- Overhead projector
- Overheads
- Handouts
- “Evaluation form” copied on overhead sheets in sufficient copies for approaches distributed
- Flip chart paper
- Felt tipped pens

Overheads

- Overhead 1: “Why the Practice of FGM/C Continues: A Mental Map”
- Overhead 2: “Evaluation form”

Handouts

- Handout 1: Approaches to FGM/C preven tion

Readings

- 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.

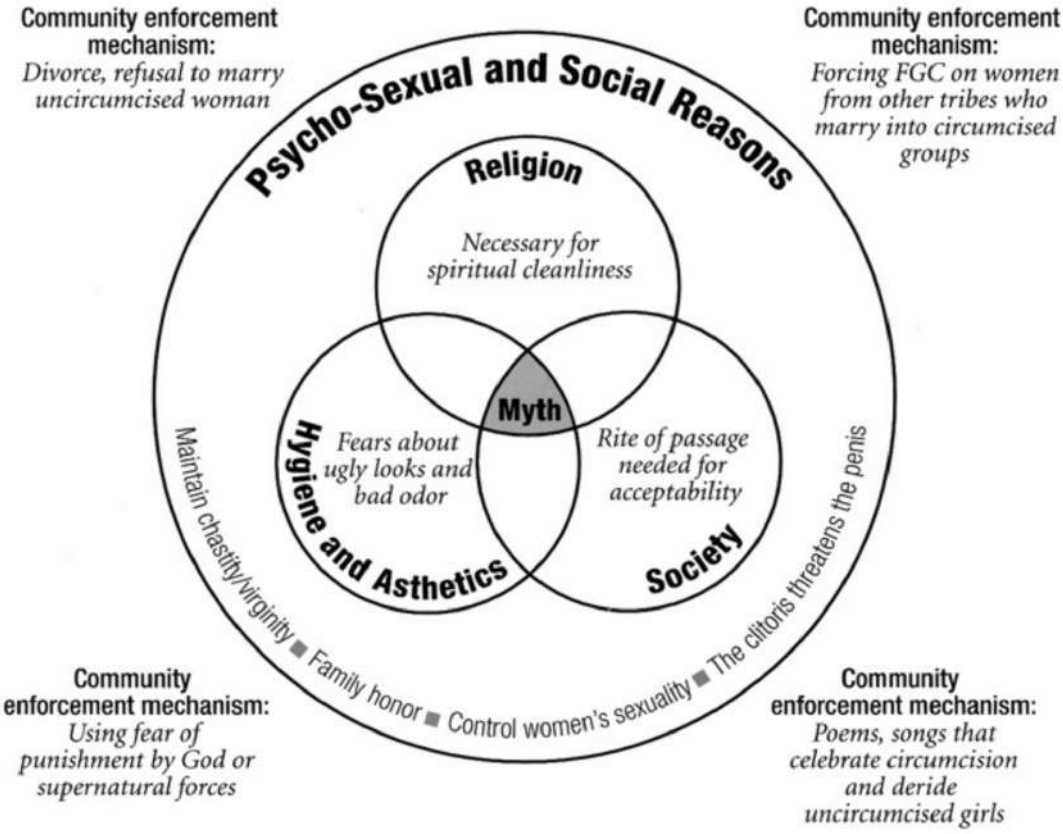
Fotheringham Megan, *"Culture Clashes: Balancing Local and International Interests in Ending Female Genital Cutting Practices"*, in LBJ Journal Of Public Affairs, Vol XVI

• 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



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

Approach:	Questions:	Answers:
	1. does the approach include all actors involved in the decision making process about subjecting a girl to FGM/C?	☐ YES ☐ NO ☐ PARTIALLY
	2. does the approach help women's empowerment?	☐ YES ☐ NO ☐ PARTIALLY
	3. does the approach address the marriageability issue?	☐ YES ☐ NO ☐ PARTIALLY
	4. does the approach address peer pressure?	☐ YES ☐ NO ☐ PARTIALLY
	5. does the approach address the psycho/sexual reasons (control of women's sexuality)?	☐ YES ☐ NO ☐ PARTIALLY
	6. does the approach address the religious reasons (including traditional religion)?	☐ YES ☐ NO ☐ PARTIALLY
	7. does the approach address the passing of age and of status (to adulthood and womanhood)?	☐ YES ☐ NO ☐ PARTIALLY
	8. does the approach address the hygiene/health reasons?	☐ YES ☐ NO ☐ PARTIALLY
	9. does the approach forsee some monitoring over time?	☐ YES ☐ NO ☐ PARTIALLY

Rating: A B C D F

Explain reasons for rating: _____

APPROACHES TO FGM/C PREVENTION

The Harmful Practices 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 actions 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 decides 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 years 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 table 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

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 Quran 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 the 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 actually an integral part of all those programmes that intervene at the village level, first engaging a few individual 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 governments 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 rights 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 but 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 practitioners, 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 circumcisers (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.

Activity 3

STEPS IN BEHAVIOURAL CHANGE: A CASE STUDY

Time: 2 hours

Why do this activity?

Over the last years “behavioural change” has become in the jargon of those working in the field almost a synonym of abandonment of FGM/C. Abandoning FGM/C is a major change in behaviour: it involves women first of all, as women play a key role in the practice, and it has to take place in the deepest recesses of their hearts, minds and souls. But it can only become manifest, consolidated and long lasting when it becomes a change for the entire society: family, in particular elders, community, ethnic and religious groups, official institutions of all kinds, the laws, the culture.

Sustained change in behaviour is only seen at the end of a lengthy process involving many individuals and numerous social dynamics following a variety of inputs at individual and collective level. Such a process does not have a simple and clear-cut beginning or end: the age of circumcision might only shift, or the decision to abandon the practice might be reversed if pressure from relevant actors intervenes at a later stage.
But, as ultimately abandoning FGM/C is truly a major change in behaviour, it is of utmost importance to understand the pattern of this process, which affects all moments and events of life, when applied to the particular field of FGM/C. In recent years increasing attention has been addressed by international organisations as well as donors, to understand and define those interventions who had the best possible outcome in terms of “behavioural change”, in order to privilege these interventions as best practices and eventually adapt and expand them.

This activity uses the experience of TOSTAN, an NGO of Senegal, with its nowadays-famous Public Declarations, to disclose key elements for programming in the field of FGM/C prevention in order to achieve a long lasting “behavioural change”.

Objectives

- To understand the overall mechanisms of behavioural change
- To identify the key elements for a successful program to prevent FGM/C.

How to do the activity:

Step 1: 20 minutes

Plenary presentation

Put up Overhead 1 "The road to individual behavioural change" and introduce it to participants.

Note to facilitator

This model has been taken from *Learning about social change. A Research and Evaluation Guidebook Using Female Circumcision as a Case Study*, developed by RAINBO. It is based on comparative analysis of major systems of therapy for behavioural change. The description of the journey toward abandonment of FGM/C is an attempt to deconstruct this process using the stages of change as reference model.
In adapting this model for the case study of FGM/C, program officers need to find out what will encourage people to move forward - towards the abandonment of FGM/C - and what can be a potential obstacle which can block this process or even reverse it.

Note that this is a model that describes individual behavioural change using the route of a bus a metaphor.

The "behavioural change process" goes through 5 stages:

1) **precontemplation**. At this stage an individual is not thinking about abandoning FGM/C and may not have given much thought to the practice. The beliefs and attitudes she/he holds about it are primarily acquired through social conditioning (adherence to a prevalent social model), and the decision weather or not circumcise is based on these existing views. *The bus is parked*.
2) **contemplation**, where interest/curiosity in and awareness of a certain problem/phenomenon start to grow, and the first doubts of the person's system of thought are born. Anecdotal evidence suggests that the shift is generally precipitated by significant event, such as a direct experience, new knowledge or societal changes. These might include: the death of a girl after circumcision; an interview in the radio with a passionate advocate; passing of a law prohibiting FGM/C etc. While these events might instigate a process of change, continued progress down the road might depend on the other influences that intervene, including those attempting to dissuade the person from changing. *The bus is set in motion*.
3) **preparation**, where attitudes change and the person takes the decision to act differently: she has decided the FGM/C is not an acceptable practice for her daughter and intends to act to avoid or prevent it. Potential barriers might include pressure from peers, from elders in the family, from any other source of information she perceives more reliable or influential than the sources consulted up to this moment. *The bus is confronted with the first crossroads and possible diversion of the route*.
4) **action**, where the decision made becomes visible, declaring it publicly and sharing it with others, avoiding to take the daughter to the village during school holidays, or looking for an alternative rite of passage. The route is shared and made public; t*he bus might face possible resistances and interference*s.
5) **maintenance**, where the person faces the opposition to the new behaviour from the dominating context and keeps his/her commitment, handling the conflict. Criticism might come from spouse, parents-in-law, other elders in the community; peers (her own, and the ones of the girls); local religious authorities. But there might also be positive welco-

me and support from the same actors, and from others as well, including own family. *Despite opposition and resistances, the new route is not abandoned*.

Looking back at the "Mental map" (if needed, put on the Overhead 1 from Activity 2), remind participants of the specificity of FGM/C: although individuals take the ultimate decision about FGM/C, decision is always taken with clear reference to a socio-cultural system involving directly or indirectly other actors (grandmothers, aunts, future husband and family of the groom, religious leaders, peers).

While each individual might go through his/her own process of behavioural change, in order for the practice to be abandoned there is evident need for a similar change to involve also the other actors in society, in particular those who put pressure on the parents (the mother) to make sure that the girl is circumcised and the tradition respected.

If this does not happen, the "route of the bus" used as a metaphor for the behavioural change process can always be diverted, as the model has shown, and the process of behavioural change be stopped or at least slowed down.

Step 2: 20 minutes

Overhead

Put on Overhead 2 "Stages for Behaviour Adoption" developed by WHO and analyse it in the light of the last considerations.

Note to facilitator

This model is meant to visualize the interaction between the behavioural change process and interventions to promote it. As changing behaviour is not an easy task in societies where the value attached to "tradition" is very strong, it describes the process as the climbing of a staircase, where the person

1. **becomes aware of a problem**, or starts looking at an event with a different approach;
2. **seeks information** and depending on the information received she/he will or not climb the staircase further;
3. **process information**, personalising it according to her/his experience and appropriating it in a way that allows her the further step;
4. examining options: to subject the daughter to FGM/C or not? Pro and contra elements are weighed;
5. **reaches a response/decides** (in favour of the new behaviour);
6. **tries new behaviour**: this exposes her/him to the appreciation or critic of others. She/He needs to appeal to the information processed in order to withstand possible negative pressure by peers, elders or other stakeholders;
7. **receives positive reinforcement:** this might include adoption of national policy or law, launching of awareness raising campaigns, as well as support from relatives such as the mother, grandmother or mother-in-law, or from religious leaders, professional staff such as medical doctors etc.
8. **shares information** and becomes a multiplier of the action. Once the decision is maintained over a consistent period of time, for ex. until after marriage of the daughter, it can be considered as a permanent change in behaviour.

This model has been used in particular to understand how some people in a given society have already achieved abandonment of FGM/C, in order to replicate the process within the framework of specific programs and projects (it lies at the basis of the "Positive deviance" approach used in Egypt).
The assumption is that a significant increase of people who change behaviour will then lead to what social scientists have defined as the "tipping point", applying the theory of epidemics to the study of behavioural changes. In epidemiology the term "tipping point" is used to refer to the point at which a low level outbreak of a disease turns into an epidemic. In the case of FGM/C it indicates the number of people needed for the new behaviour to stop being matter of a minority and being adopted by the majority, quickly leading to complete abandonment.

Plenary discussion

Now invite participants to share their understanding of the two models. Facilitate the discussion using the following set of questions:

- Is the sequencing of the behavioural change process described in the two models appropriate for FGM/C abandonment according to your experience?
- Which are the common points of the two models?
- Which are the differences?
- When the intervention of a prevention program is absolutely necessary in order to keep up or speed up the behavioural change process?

In particular bring to the attention of the participants to:

- the need for a behavioural change to happen **at the same moment** among different actors in society, including not only those who take direct decision about FGM/C, but also those who influence the decision making process;

- the need to **consider FGM/C within a broad set of interventions**, addressing interests and priorities of all actors involved directly and indirectly, in order to reduce the risks of resistances and obstacles to the behavioural change process.

Step 3: 30 minutes

Individual reading

Distribute Handout 1 "Convention shift in Senegal" and Handout 2 "The Community Based Education Model" which describe the approach developed by TOSTAN. The first text recalls the first Declarations of abandonment of FGM/C, in 1997, while the second one describes in detail recent implementation of activities.

Introduce the case study briefly to participants.

Note to facilitator

In Senegal, TOSTAN, a local NGO, has implemented a non formal learner-centred education programme, with a strong emphasis on human rights, women's rights, program solving skills. This has lead to the first collective decisions to abandon the practice, starting with a group of 13 intramarrying villages and lead by a local Islamic religious leader. This process has the been expanded and at present, more the 1.300 villages have participated in a "Public Declaration" ceremony, stating their decision to abandon FGM/C and, in many cases, early marriage. Not all villages have been through the whole "empowerment program" of TOSTAN, but they have decided to join the Declaration, in order to keep marriage relationships possible on an equal basis.

Ask participants to read it carefully, keeping in mind the “behavioural change” process they have just be familiarized with, in order to be prepared to discuss it in plenary.

Step 4: 30 minutes

Invite participants to share their consideration about the case study according to the “behavioural change” model just presented. Ask one volunteer to come to the flipchart and write down considerations by participants, dividing the into “strong” and “weak”.

Guide the discussion using the following questions:

- how the Tostan methodology responds to the different phases of change in behaviour?
- which are the key elements of the TOSTAN approach that have contributed to the connection between an individual decision making and a collective decision making against tradition?
- which is the element the prompts the “tipping point”?
- Malicounda Bambara, the first village to abandon the practice, has not changed its decision for the moment. Why?
- which areas might need improvement?
- are there external factors that have contributed to the programme?

Main points

Main points include

- the decision making process about the programme involves the village leaders and representatives from the beginning in all activities;
- great attention is given to use of local languages and local idioms, in order to make concepts clear and bring them close to everyday life of target population;
- women are the main target group, but the whole community is involved;
- the decision to stop FGM/C is the result of a deeper understanding of reproductive health life as well as practical translation of human rights understanding gained through the programme;
- the public declaration helps in holding all participants accountable in front of the community, of other villages and over time;
- the public declaration is an instruments that resounds with traditional village management mechanisms;
- the expansion of the programme within intra-marrying communities reinforces decision of stopping the practice and casts out one main reason for perpetuation of FGM/C, namely the need to guarantee marrying of daughters, in societies heavily relying on marriage for recognition of women's role and socio-economic support;
- follow up to make sure that the decision is kept over time needs to be strengthened;
- the needs emerging from a better understanding of their rights, in particular by women, have to be addressed.

At the end share with the group the results of the evaluation of the intervention of TOSTAN in the region of Kolda (Senegal), carried out by Population Council, GTZ and TOSTAN over a period of 2 and a half years (published in August 2004). Check considerations by participants with results of evalutation.

Step 5: 20 minutes

Lecture with overheads

Put on one by one Overheads 3- 8 on “Evaluation of the TOSTAN Programme”

Explain what has been tested, also to give an idea of the technical aspects of monitoring and evalutation activities.

Implementation of the TOSTAN programme in 90 villages in the region of Kolda, in Senegal, a region where 2 previous programmes were conducted:
- research in 20 experimental villages with 20 matched comparison villages
- women and men attended the programme trainings, both as separate and mixed classes.

Methodology: 3 rounds of questionnaires were submitted to the sample population, which in the experimental villages included women and men who both, participated and do not participated in the programme, in order to have
- a baseline survey with data describing the situation at the beginning of the action;
- an intermediate evaluation (Immediate post intervention evaluation), with results to be analysed against data from the Baseline Survey;
- an endline evaluation to document new attitudes and changes in behaviour.

The research has permitted to understand the “diffusion model” of the behavioural change process from a core group of trained participants,
- to the immediate neighbours whit whom knowledge and information are shared (exposure by adoption),
- to the whole village as a collective subject taking decisions affecting all individuals,
- and finally to a larger number of villages, those with intra-marrying relationships.

Read out data from the tables concerning:

- Sample size in Senegal

and impact of the TOSTAN programme in experimental group not only on FGM/C abandonment, but also on other issues considered as a priority by target group/villages:

- Significant increase in awareness of human rights
- Significant increase in knowledge of contraceptive methods
- Significant increase in knowledge of STIs
- Significant increase of awareness of at least 2 consequences of FGM/C
- Significant decrease of women who think that FGM/C is necessary
- Significant decrease of women who approve FGM/C
- Significant decrease of women who will cut their daughters in the future
- Significant increase of discussion about FGM/C in the experimental villages during the past 12 months
- Significant increase of women that share information on FGM/C with others

Note to facilitator

To conclude distribute to all participants Handout 3, with final analysis by Prof. Jerry Mackie on the TOSTAN approach to end FGM/C.

Materials

- Handouts for each group
- Overheads
- Overhead projector
- Flip chart paper
- Felt tip pens

Overheads

- Overhead 1: The road to individual behavioural change
- Overhead 2: Stages for Behaviour Adoption
- Overhead 3: Evaluation of the TOSTAN Programme - 1
- Overhead 4: Evaluation of the TOSTAN Programme - 2
- Overhead 5: Evaluation of the TOSTAN Programme - 3
- Overhead 6: Evaluation of the TOSTAN Programme" - 4
- Overhead 7: Evaluation of the TOSTAN Programme - 5
- Overhead 8: Evaluation of the TOSTAN Programme - 6

Handouts

- Handout 1: Convention shift in Senegal
- Handout 2: The Community Based Education Programme
- Handout 3: Final consideration on the TOSTAN programme

Readings

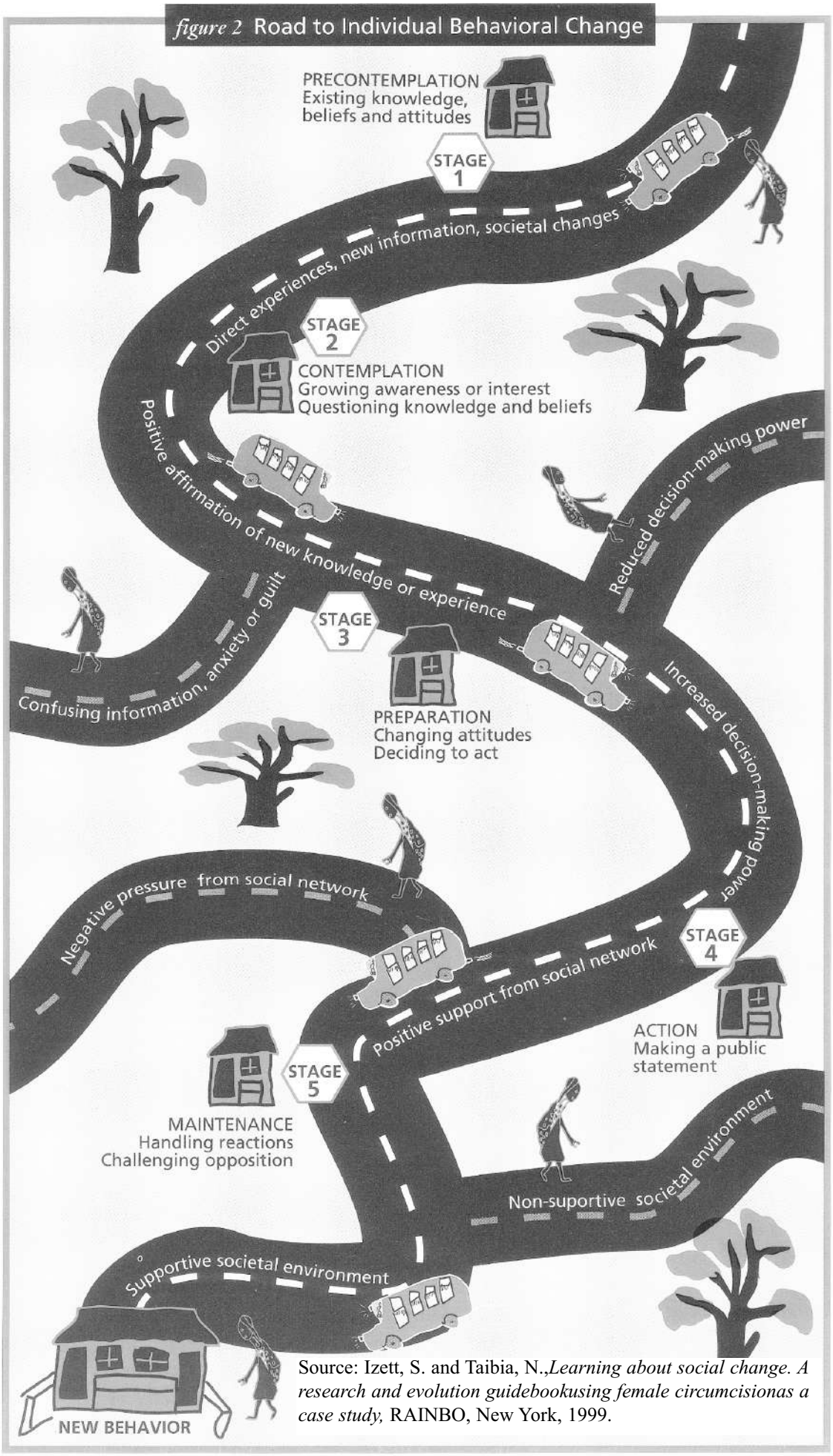
- WHO - PATH, *Female Genital Mutilation. Programs to date: What Works and What Doesn't,* WHO - PATH, Geneva, 1999

- Izett, Susan and Nahid Toubia, *Learning about social change. A Research and Evaluation Guidebook Using Female Circumcision as a Case Study*, RAINBO, New York, 1999.

• Gerry 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

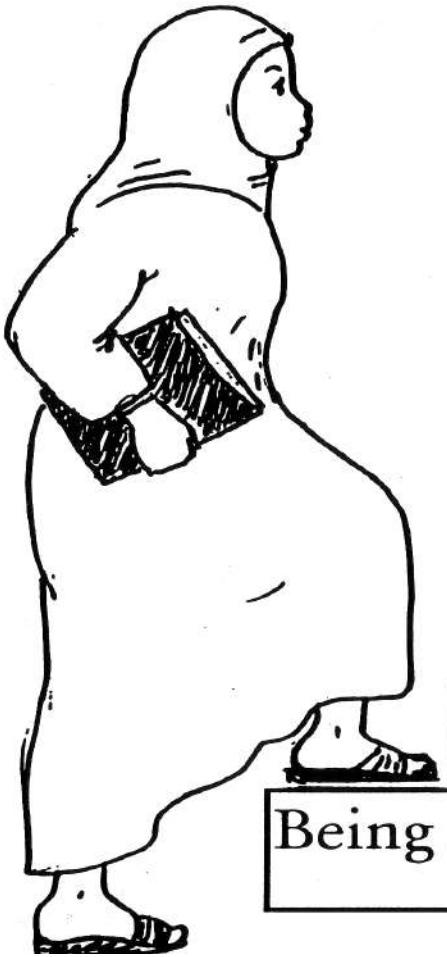
• Diop, Nafissatou and others, *The TOSTAN Program. Evaluation of a Community Base Education Program in Senegal,* Population Council - GTZ - Tostan, August 2004

figure 2 Road to Individual Behavioral Change



Source: Izett, S. and Taibia, N.,*Learning about social change. A research and evolution guidebookusing female circumcisionas a case study,* RAINBO, New York, 1999.

STAGES OF BEHAVIOUR ADOPTION



Being Aware of the Problem

Seeking Information

Processing Information/ Personalizing

Examining Options

Reaching a Response/ Deciding

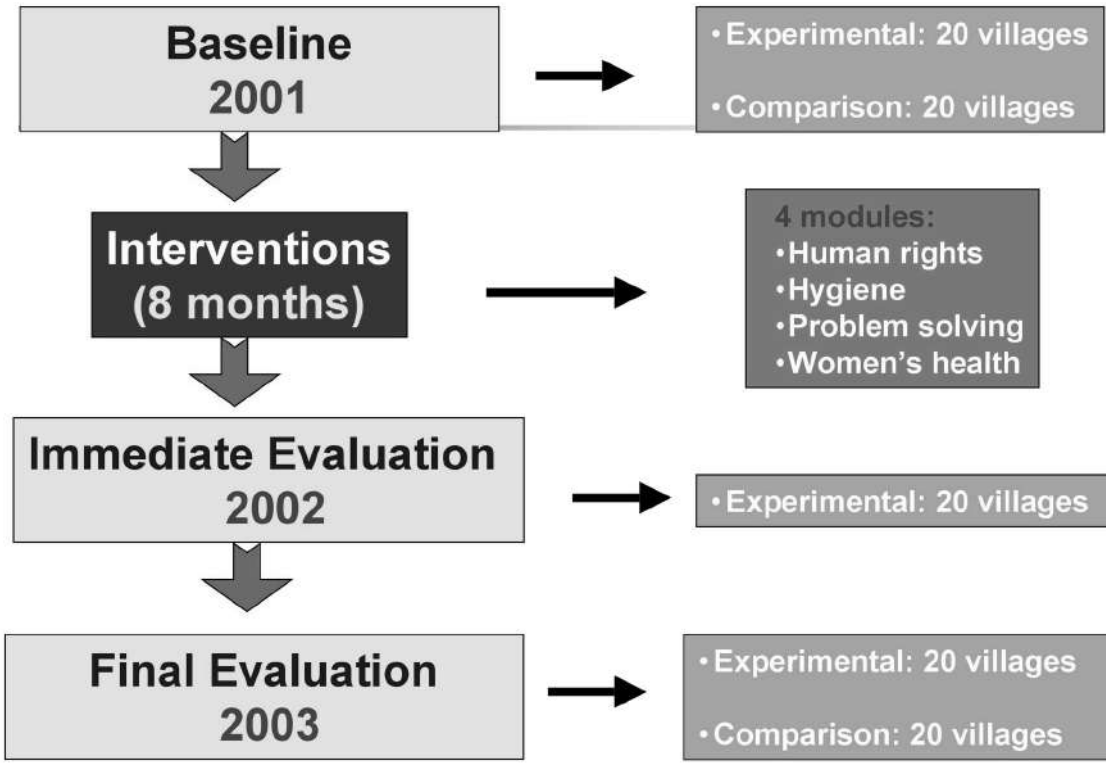
Trying New Behavior

Receiving Positive Reinforcement

Sharing Information/Multiplier

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

EVALUATION OF THE TOSTAN PROGRAM - 1



Population Council
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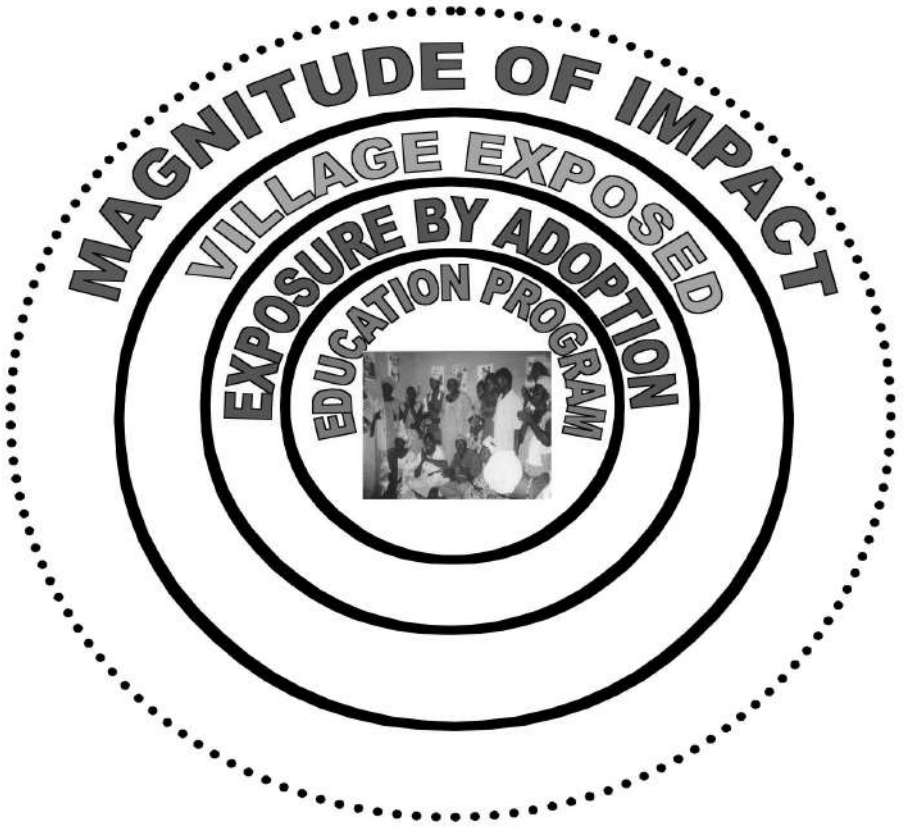
Sample Sizes - Senegal

	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

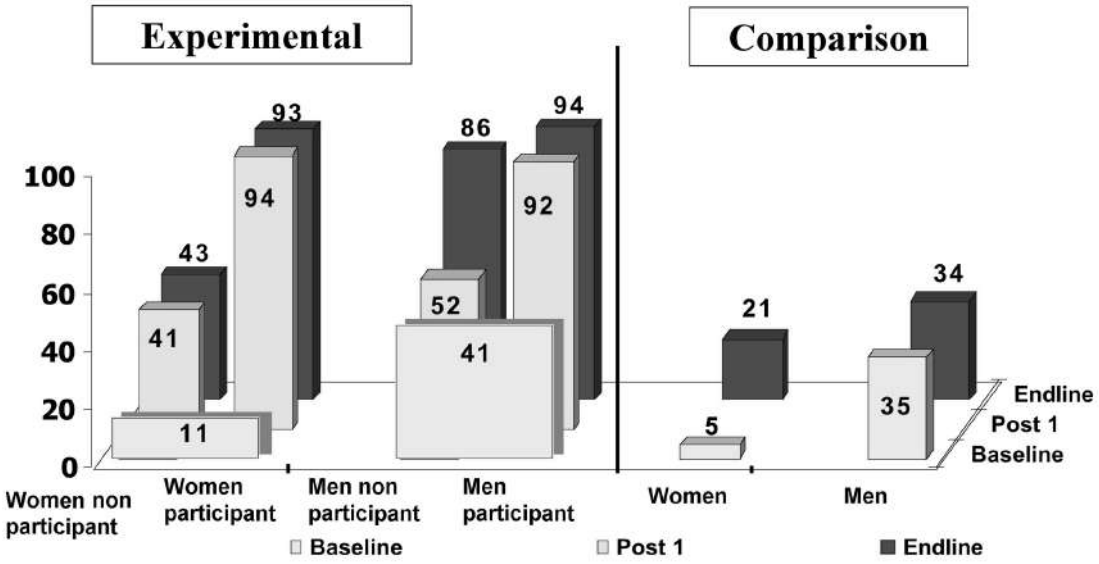
EVALUATION OF THE TOSTAN PROGRAM - 2

The Diffusion Model



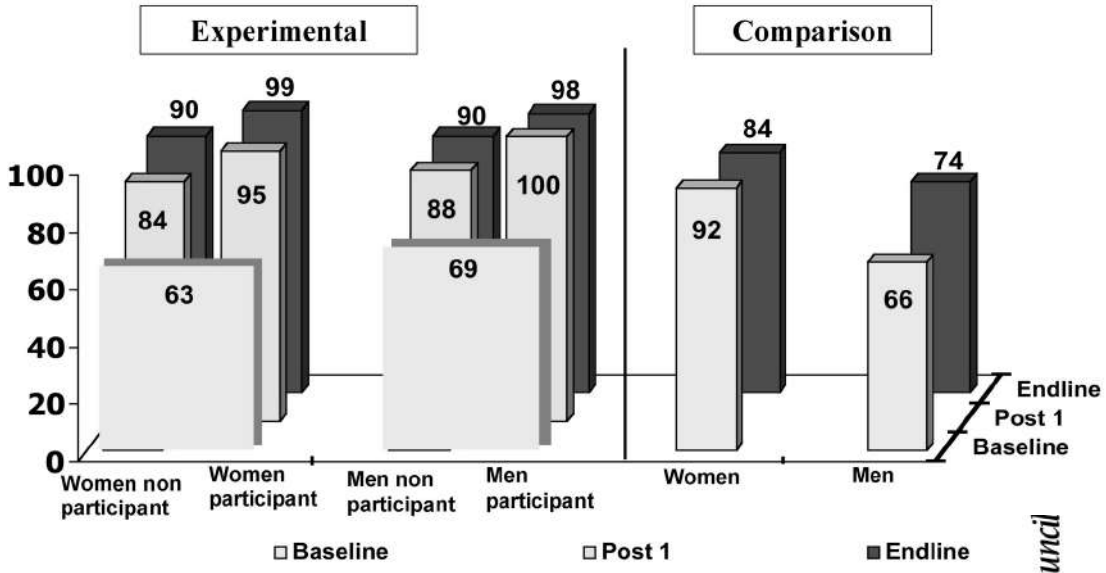
Population Council
FRONTIERS IN REPRODUCTIVE HEALTH

Significant increase in awareness of human rights in experimental group



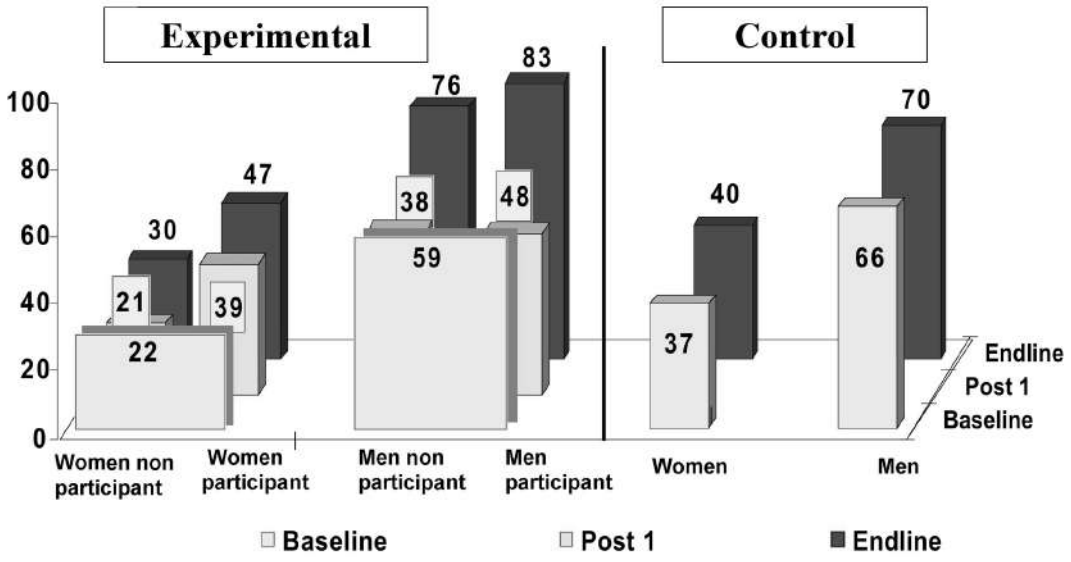
EVALUATION OF THE TOSTAN PROGRAM - 3

Significant increase in knowledge of contraceptive methods in experimental group



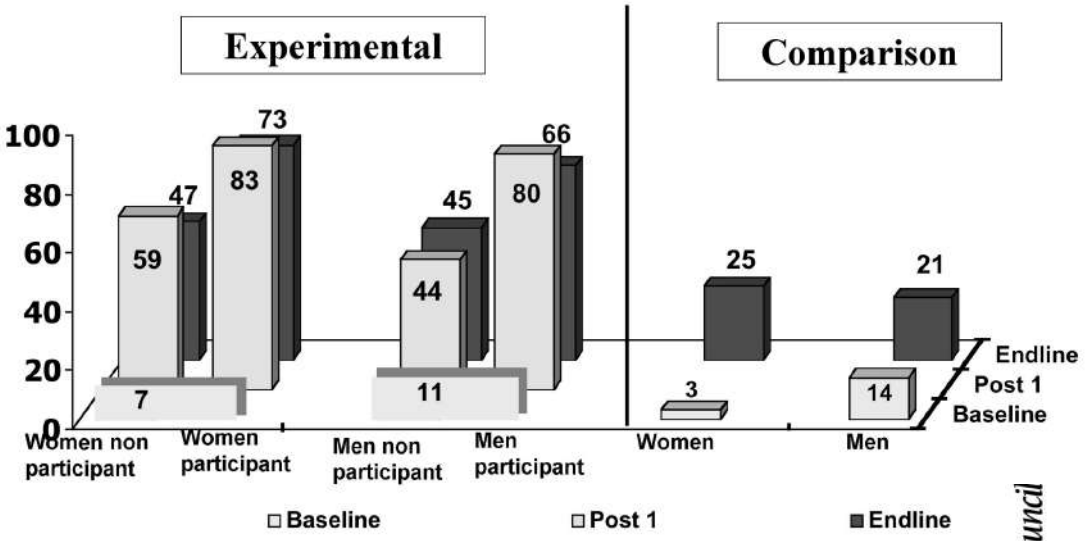
Population Council FRONTIERS IN REPRODUCTIVE HEALTH

Significant increase in knowledge of STIs in experimental group



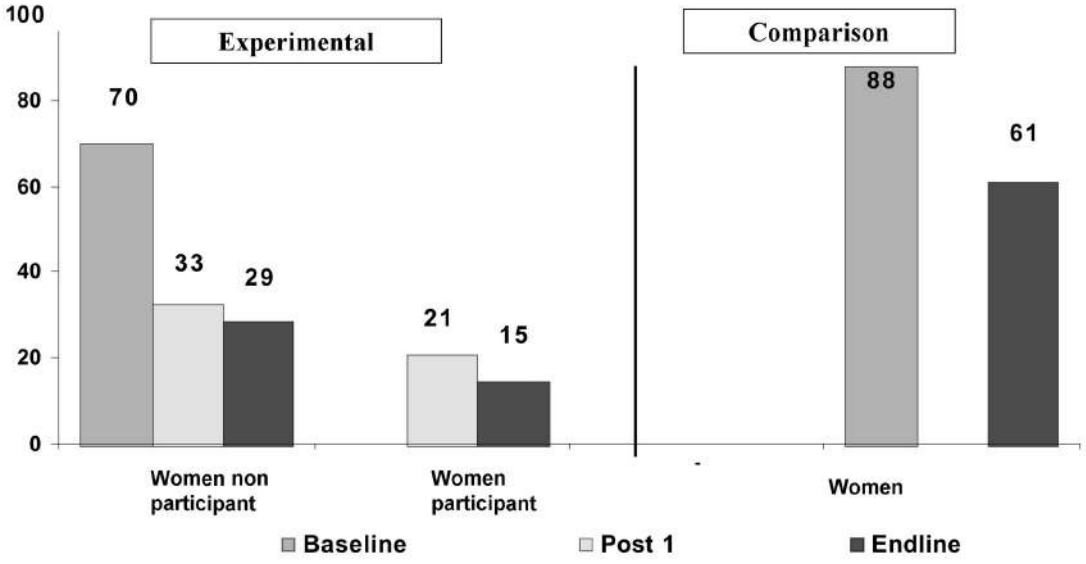
EVALUATION OF THE TOSTAN PROGRAM - 4

Significant increase of awareness of at least two consequences of Female Genital Cutting in experimental group



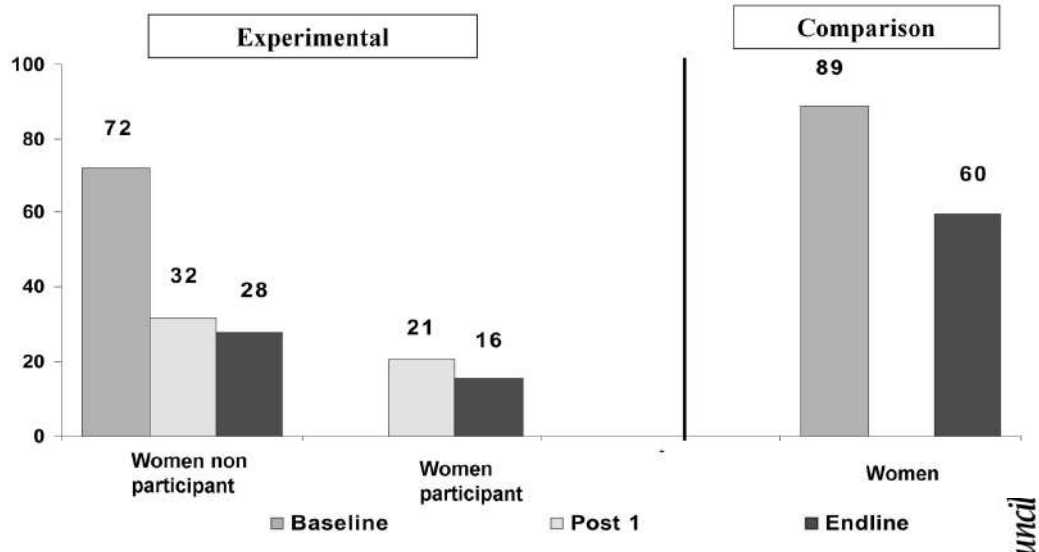
Population Council
FRONTIERS IN REPRODUCTIVE HEALTH

Significant decrease of women who think that FGC is necessary in experimental group



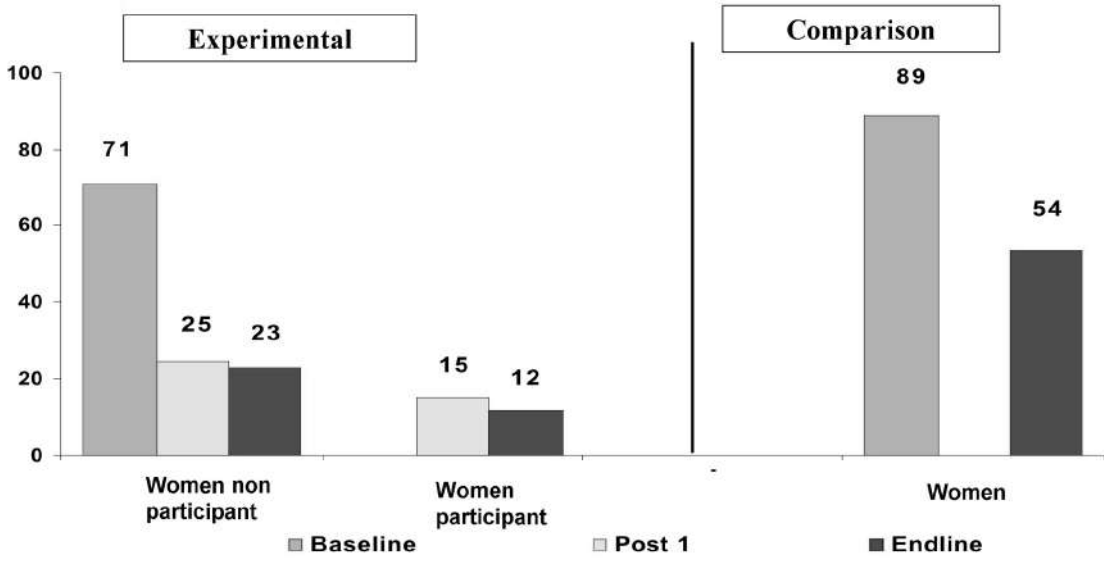
EVALUATION OF THE TOSTAN PROGRAM - 5

Significant decrease of women who approve FGC in experimental group



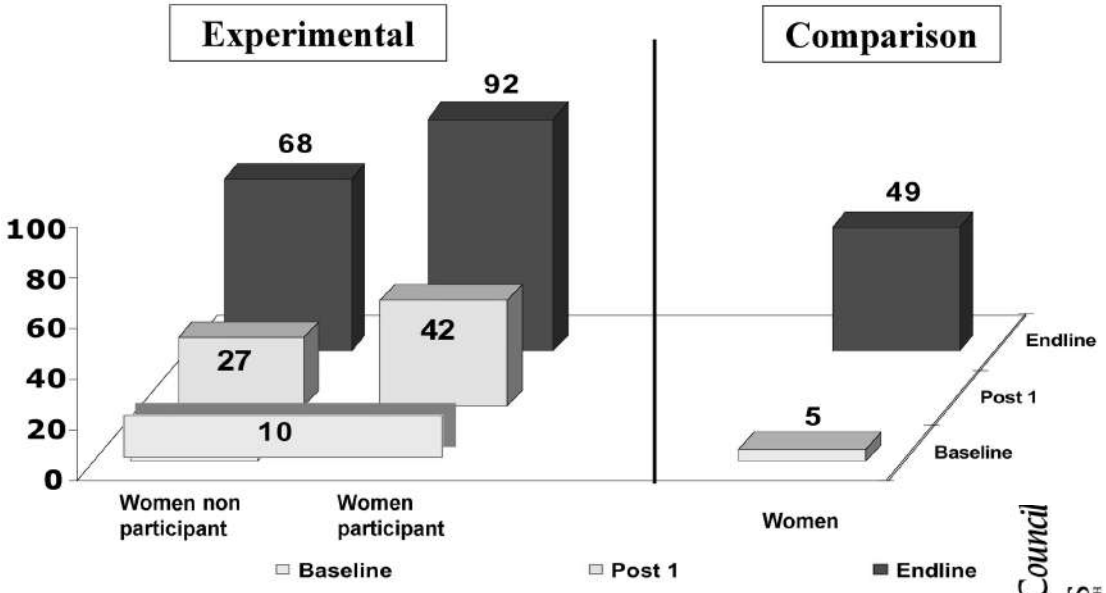
Population Council
FRONTIERS IN REPRODUCTIVE HEALTH

Significant decrease of women who wi cut their daughters in the future in experimental group



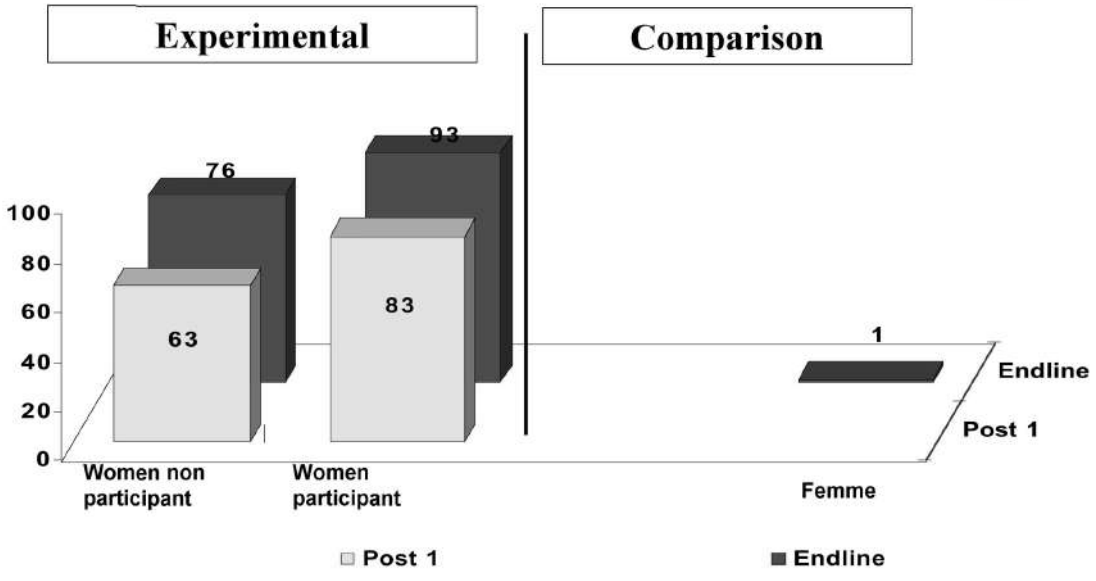
EVALUATION OF THE TOSTAN PROGRAM - 6

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



CONVENTION SHIFT IN SENEGAL*

In September of 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 intermarried. 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 fact of 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 assure 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 PROGRAMME*

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 FGC 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 FGC 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 learned 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 FGC. 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 PROGRAMME*

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 nondirective. 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 influentials, local political and religious leaders with genuine authority. Obviously, it is desirable to expand as rapidly as possible the declarations in Senegal. If the Senegalese process continues to deliver dramatic results, then proven techniques should be extended to coethnics in neighboring countries. Further, 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). Further, an urban suitor may not consider that many more partners than a rural suitor, but in the urban area there are many overlapping marriage markets as 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

Activity 4

ABANDONING FGM/C: INTERACTION BETWEEN WOMEN AND THE COMMUNITY

Time: 1 hour

Why do this activity?

Using theoretical models improves planning of activities

In the past, in most cases FGM/C interventions have not been designed with reference to a theoretical model, such as the “stages of behaviour change” just seen in previous activities. They have been developed in response to a particular situation, e.g. caring for women with fistula, preserving the ritual part of the practice but not the cutting, or as a result of programmatic experience, e.g. functional literacy program leading to discuss about sensitive issues, such as family planning, adapted to target FGM/C. Some times they have been intuitive attempts, such as converting traditional practitioners to other income generating activities.

Defining appropriate indicators to monitor change.

However, to foster behaviour change, in particular in such a complex area as FGM/C, it is also critical to understand the process through which project and programmes are implemented. Assess the challenges encountered at each stage and the lessons learnt, how individuals and families reach decisions about changing their beliefs and behaviours, and especially which messages or information most influenced them, is essential to avoid possible backlashes, and to disguise possible models to be adapted and replicated elsewhere. Monitoring programme implementation requires appropriate indicators. Much effort was put in recent years by international NGOs including RAINBO and by international organisations such as WHO and UNICEF, in developing better indicators to understand and impact of interventions.

FGM/C abandonment means women's empowerment. And vice versa.

Looking to success stories, it appears evident that women play an essential role in continuation - thus in ending - of FGM/C. The abandonment of FGM/C can happen only if women's empowerment is addressed with a truly holistic approach, working at the same time on the construction of a socio-cultural environment where changes in behaviour are not only reluctantly tolerated, but permitted and even supported.
This module bears on this ongoing process and is aimed at making programme officers familiar with some basic requirements of efficient designing of FGM/C prevention intervention, inviting to experiment their use in developing an appropriate intervention for a specific area.

Objectives

- To recognize key elements for designing programmes in the area of FGM/C prevention
- To understand the role of women within community as the essential target group for programmes to prevent FGM/C
- To use a specific “Model for social change to stop FGM/C” for programming ·

How to do the activity

Step 1: 1 hour

Plenary presentation and discussion

Introduce the subject by reminding the audience of the specificity of FGM/C: practiced in some African countries for centuries, but also recent custom of other particular ethnic groups; element of a rite of passage preparing girls for adulthood and marriage among some communities, or merely a “tradition” repeated for various, often unspoken, reasons, including curbing women's sexual desire, preserving virginity prior to and fidelity during marriage; perpetuated by women on girls, with the full consent, approval and often pressure by the rest of the community, in particular the elders. Abandoning the practice is therefore the matter of a great **change in behaviour** that must follow a **change in attitude** towards FGM/C and a **transformation of the value attached to the practice.**

Overhead

Put on the Overhead 1 “Members of community at different stages of behavioural change”

Make reference to the previously analysed stages an individual goes through in order to acquire a new behaviour. From the point of view of the target groups, invite participants to remark that they might be among the

1. Innovators and pioneers
2. Early adopters
3. Early Majority
4. Late Majority
5. Resistors and oppositors

Ask participants to think about abandoning FGM/C and identify who falls in the 5 categories, reminding them that this reflects current situation in most African countries.

Write the proposed actors in the available space on the overhead and put it again on the projector for discussion by the group.

Possible outcome could include

1. **Innovators and pioneers**
- first African activists to speak against the practice,
- first government to prohibit it,
- first religious leaders to state that it is not a religious requirement

Note to facilitator

2. Early adopters
- those who have stopped FGM/C while the whole community continues, for various personal reasons (e.g. death of a daughter)
- educated families who have decided not to submit their daughters to the practice, but have done this secretly

3. Early majority
- those who have joined the first to abandon the practice, as the new behaviour acquires more value in the social environment, thus reaching the so called "tipping point" where the new behaviours expands at large

4. Late majority
- those who enter the new behaviour by simple emulation of "what everybody does", conforming to the majority

5. Resistors and oppositors
- traditional and religious leaders
- elders
- some women
- some men

Overhead

Put on the Overhead 2: "The relation between FGM/C, social change and women's empowerment". Go though its content and invite participants' considerations, based upon what has been learned through out the whole module.
Ask participant's comments and invite to debate:

Note to facilitator

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.*

Plenary discussion

What is the impact of such an hypothesis?

Does it influence project design?

If yes, how? What is required?

Put on the Overhead 3 “Women and gatekeepers”, which has been developed by RAINBO for a meeting on Indicators organised by Unicef (November 2003). Explain the graphics:

Overhead

Note to facilitator

- 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 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 Map” from Module 4) 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.

Put on the last Overhead 4: “The WECC - Women's Empowerment Community Consensus model for social change do stop FGM/C”

Overhead

Explain that this model was developed by RAINBO at the end of a 2 years long revision of all possible documentation concerning programmes implemented, with the aim at identifying a set of indicators that would contribute to better monitor and evaluate the impact of FGM/C prevention actions at the field level.

Note to facilitator

The model describes the steps that need to be accomplished in order to develop efficient prevention actions. As Nahid Toubia writes:

- At the heart of the framework is prioritizing and promoting women's and girls self-empowerment through investment in their awareness, as well as increasing decision making abilities, including economic empowerment.

- The other half of the formula is building community consensus for protection of women's and children's rights through negotiating support from the hierarchy of power-holders such as men, religious and civic leaders, health professionals and others”.

Note that a key element is the Public Declaration to abandon FGM/C, which involves the whole community, and might also take the shape of an Alternative right of passage, or other forms of public declarations.

- Ethnographic studies of FGM/C and other sexually related practices (such as public defloration) show that women have complied with and adopted these socially dictated behaviours as a means of negotiating a

degree of power in the face of overwhelming disempowerment.

- In an unspoken social pact, women trade their sexual organs in return for free mobility, survival through marriage, and a degree of power and respect as sexually pure mothers.

- Older women who have experienced the cutting and have become beneficiaries of the social order become the “gatekeepers” of the culture by incorporating FGM/C as essential to their own identity and ensure that their daughters experience the same social markers and retain the same benefits.

- Questioning a painful and deeply entrenched psychological experience and contemplating rebelling against it is fraught with tremendous fear and insecurity for women.

- Reversing the psychological imprint of the experience of FGM/C and providing women with the means to redefine their identities and their position in society is key to truly overcoming the forces that perpetuate the practice.

- The WECC Model proposes that the investment in women's self-empowerment though health and rights information, literacy training, problem solving and organizing skills coupled with improvement in their economic status and altering the legal conditions will result in altered individual and group consciousness that is self-sustaining.

This process is clearly demonstrated by a project such as the TOSTAN programme in Senegal reviewed in the previous activity.

Invite participants to recognize:

- the fundamental role of Step 1: data are collected in order **to identify indicators** which are essential to monitor behavioural change over time;
- a detailed analysis of socio-cultural environment helps **to recognise the stages of behavioural change** the target groups are in, and plan accordingly, choosing the most appropriate activities and messages;
- primary and secondary target groups are those who play **a direct and indirect role in decision making** about submitting a girl to the practice: all have to be reached at the same time and go through a process of change in behaviour.

Finally, drive the attention of the audience to the fact that the Model shows clearly that **FGM/C cannot be addressed as a self standing topic**, detached from all other aspects of personal and collective life. In order to lead the whole community to state the decision to abandon the practice, and later on to keep up with the taken decision, practical and strategic gender needs have to be addressed.

As the next Activity will show, this means that other aspects of development might provide a precious entry point to address FGM/C, targeting both women, and the community at large.

Materials

- Overheads
- Overheads projector
- Handout for small group work
- Flip chart paper

- Felt tipped pens

Overheads

- Overhead 1: Members of community at different stages of behavioural change
- Overhead 2: The relation between FGM/C, social change and women's empowerment
- Overhead 3: Women and gatekeepers
- Overhead 4: The WECC - Women's Empowerment Community Consensus model for social change to stop FGM/C

References

- *Frontiers in reproductive health/Population Council, Using Operations Research to Strengthen Programmes for Encouraging Abandonment of Female Genital Cutting*, Report of the Consultative Meeting on Methodological Issues for FGC Research, April 9-11, 2002, Nairobi, Kenya,

- Beckmann Sabine, *Baseline Data Collection for FGM programmes: a review of selective approaches and methods*, GTZ, Eschborn, 2003.

- Abdel-Tawab Nahla and Hegazi, Sahar, *Critical Analysis of Interventions Against FGC in Egypt*, Frontiers for reproductive health - Population Council, June, 2000.

- Toubia N.F. and E.H. Sharief, *"Female genital mutilation: have we made progress?",* in International Journal of Gynecology and Obstetrics", 82 (2003), pagg. 251-261.

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

•RAINBO, *Accelerating social change,* Beta version 1.0, Rainbo 2004

MEMBERS OF COMMUNITY AT DIFFERENT STAGES OF BEHAVIOURAL CHANGE

1. Innovators and pioneers

2. Early adopters

3. Early majority

4. Late majority

5. Resistors and oppositors

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.

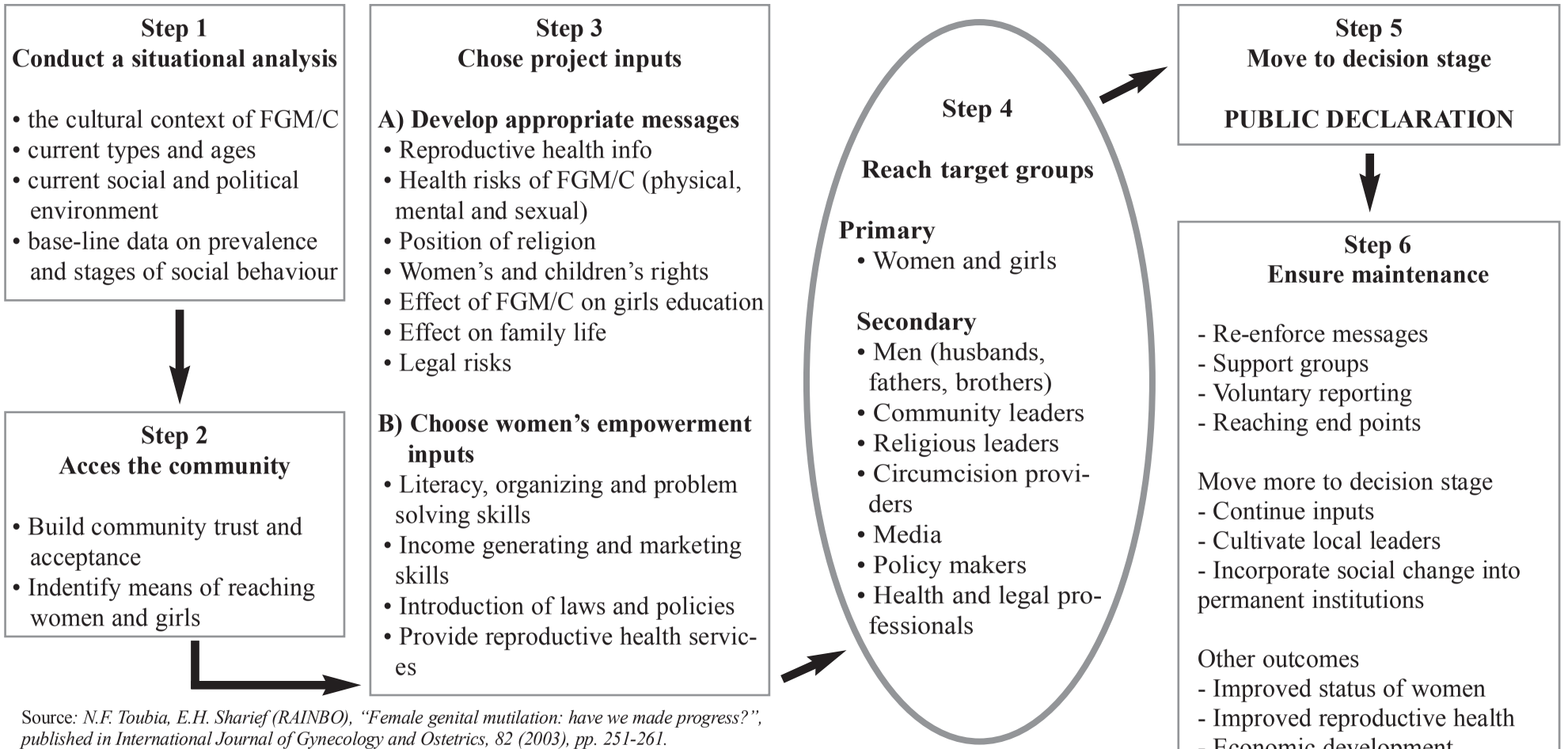
Hypothesis 4
- Behavioural and social change is a cumulative non-linear process
- To catalyse and sustain it requires supportive inputs over the longer term (laws, policies, investment in education, etc).

Overhead 3

Activity 4

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

The WECC – WOMEN'S EMPOWERMENT COMMUNITY CONSENSUS MODEL FOR SOCIAL CHANGE TO STOP FGM/C developed by RAINBO



Source: *N.F. Toubia, E.H. Sharief (RAINBO), "Female genital mutilation: have we made progress?", published in International Journal of Gynecology and Ostetrics, 82 (2003), pp. 251-261.*

Activity 5

PREVENTION OF FGM/C AS A DEVELOPMENT ISSUE

Time: 4 hours

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.
In fact, the analysis carried out during the previous modules has brought to the conclusion that FGM/C will come to an end when women themselves feel that they can abandon the practice without loosing what the practice guarantees to 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 spectales” 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 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 “Declaration”, as we have seen with the TOSTAN programme.
The programme should be designed in order to build the supportive social and cultural environment that is 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 in order 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 change” and the “WECC model”

- To identify the linkages between women's empowerment pro grammes and FGM/C prevention programmes.
- 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: 30 minutes

First step is to learn where the two basic programming models crosscut. Therefore put on Overhead 1 “Steps to follow in gender planning”.

Plenary presentation

Note to facilitator

Steps include:

1. **Gender consultation**

including all social actors, directly and indirectly involved in the decision making process about FGM/C.

2. **Gender analysis**

This should include:
· desegregation of target groups within a community
· look at household structure
· look at different roles played by women and men, both in the household and in the community
· level of education
· collect data on FGM/C. Essential indicators include:
- FGM/C prevalence in women / girls
- type of FGM/C performed
- practitioner (traditional / medical staff)
- age at FGM/C
- main reasons given by women / community for performing FGM/C
- attitudes towards its eventual abandonment

3. **Build a hierarchy of unmet practical / strategic needs**

In order to understand why these are unmet and identify the role played by FGM/C:
- when FGM/C enters in the picture?
- how does it develop into a cause for specific unmet needs for women?

In particular look at FGM/C :

a) as a key to access some goods / values (through marriage)
b) as a cause of specific needs (sexual and reproductive health, etc.)

Consider the possible changes in behaviour, looking at women

a) from the point of view of their own experience of FGM/C
b) from the point of view of the choice women have to make when it comes to submit their daughters to FGM/C.

4. **Determine programme objectives and outputs**

Design the intervention, with clear objectives (remember the easy acronym used to describe objectives: SMART, Specific, Measurable, Appropriate, Realistic and Time-bound) for each target group. Objectives should be conceived as changes in behaviour. Identify appropriate indicators to monitor activities.

5. **Identify an entry strategy - room for manoevre**

· What is possible to do?
· What is not possible to do?
· What will elicit a negative, closing counter reaction by community, damaging the attainment of objectives?
· Which are the constraints?
· Which are the assets (all kind of resources)?

6. **Define the working objectives**

Define which are the gender specific results that will progressively facilitate the programme's implementation you want to reach: these are results in terms of overall women's empowerment and not in terms of FGM/C prevention.

7. **Conduct progressive monitoring**

In order to cope with all possible outcomes, foreseen and unforeseen, positive and negative (in particular the latter).

Ask for comments by participants, and include practical examples from previous activities to support the explanation.

Step 2: 30 minutes

Overhead

Put on the Overhead “The WECC model for social change to stop FGM/C” from Activity 4. Go quickly with participants through the different steps, and look where the “gender planning” methods can be used to implement the foreseen WECC steps.

Note to facilitator

Cross-cutting elements of the 2 methodologies are:

Step 1. Conduct a situational analysis

The elements necessary for a good situational analysis have to be gathered through the gender consultation and include both **assets** and **constraints**. Another useful element contributing to a complete situational analysis is the **hierarchy of practical / strategical gender needs**.

Step 2. Access the community

Defining the entry strategy is exactly about this: building community trust is necessary to open up the room for manoevre that permits both women's self empowerment and FGM/C prevention activities to be put in place.

Step 3. Choose project inputs

As we have seen in Activity 2 of this module, there is a whole list of

activities that can be implemented to prevent FGM/C. At the same time, there is a whole range of other development issues that need to be addressed in order to fulfil both, the practical gender needs as well as the strategic gender needs.

Ask participant to name some of them. These might include:

· education,
· sexual and reproductive health and rights,
· prevention of violence against women,
· economic empowerment and access to formal labour,
· access to decision making roles within the community,
· control over resources,
· improvement of legal measures to promote equal rights...

But there are also overall development issues affecting the whole community (again ask participants to name them):

· food security and agricultural development
· water and sanitation
· general healthcare
· management of environmental emergencies (droughts, floods, etc.)
· prevention of sexually transmittable infections + HIV/AIDS
· prevention of other diseases such as malaria
· improvement of the transport system (road and rail building)
· participation in political life (ability to stand as a candidate for elections and to participate in the voting)
· assistance to refugees and victims of war...

Ask participants if they can recognize specific differences in addressing these “general” issues, when it comes to women and men, girls and boys. Take the examples of

· HIV/AIDS prevention
· access to education (using data from previous activities)
· assistance to refugees and victims of war

Then ask participants: is prevention of FGM/C relevant to these activities?

It will become immediately clear that mainstreaming FGM/C prevention is almost a matter of awareness raising, in other words, it is a matter of developing appropriate messages (WECC Step 3A).

Step 4. Reach target groups

To effectively reach both target groups, women and girls (primary/direct) and all other actors in the community (secondary/indirect), working objectives are essential as they permit to open up a progressively larger room for monoevre, allowing the consolidation of results reached and fostering changes in behaviour acceptable to all actors involved.

Step 5. Move to decision making stage

The **public declaration** stating the abandonment of FGM/C by the whole community should be seen as a catalyst for the empowerment of women, as it states that - from that moment on - women's social recognition (through marriage which is essential for survival, dignity, reproduction, etc.) will not pass any longer through FGM/C, but will be the result of other social processes / activities, including education, equal rights, access to reproductive health services and income generating activities etc. that will be targeted at women and girls as well as at all

other social actors in order to build the community consensus.

Empowering women and girls will be a contribution in itself to the empowerment and wellbeing of the community.

Step 6. Ensure maintenance - Move to decision stage - Other outcomes

Again, the possibility of **constantly redefining working objectives** in order to include new assets and adjust strategy to overcome constraints is a particularly useful tool, in order to maintain decision taken and foster behavioural change.

The **monitoring and evaluation process** is also very important: therefore the definition of indicators is essential. These must reflect both the empowerment of women as well as the abandonment of FGM/C specifically.

Step 3: 2 hours

Small group activity

Distribute Handout 1 “Tools for gender / FGM/C programming” to each participant to keep as a reference. Divide participants in groups, and distribute a Scenario from Handout 2/1, 2/2, 2/3 to each small group, together with the “Reminder” included in Handout 3.

Ask each group to design a FGM/C prevention programme/ project according to the new strategy. The approach in choosing and designing activities should:

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. Write on the flipchart the form the presentation to plenary of each working group should take (see list below).

Ask each group to present their project/program according to following model (also included in Handout 3):

1. Situational / gender analysis
2. Practical / strategic needs identified / chosen
3. Access to community
4. Program objectives
5. Project inputs / activities according to target group
6. Messages selected
7. Working objectives / entry points to different target groups
8. Move to decision stage (“public declaration”)
9. Indicators for monitoring activities
10. Activities to ensure maintenance of decision taken and reinforce behavioural change process (empowerment of women).

Step 4: 1 hour

Plenary presentation

Ask each group to present their programme/ project. Invite comments and appreciation by other participants.

Materials

- Flipchart paper
- Felt-tip pens
- Overheads
- Copies of handouts for participants and small groups

Overheads

- Overhead 1: Steps to follow in gender planning
- Overhead 2: The WECC model for social change to stop FGM/C (from Activity 4)

Handouts

- Handout 1: Tools for gender / FGM/C pro gramming
- Handout 2: Scenarios for project design (3 separate handouts)
- Handout 3: Reminder for project design

Readings

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

- Gruenbaum Ellen, *FGM in Sudan: Knowledge, attitudes and practices,* UNICEF Khartoum, August 2004

- Abdel Tawab Nahla and Hegazi Sarah, *Critical Analysis of Interventions Against FGC in Egypt,* Frontiers - Population Concern, June 2000

STEPS TO FOLLOW IN GENDER PLANNING

1. Gender consultation

2. Gender analysis

3. Build hierarchy of unmet practical / strategic needs

4. Determine programme objectives and outputs (activities)

5. Identify an entry strategy / room for manoevre

6. Define working objectives

7. Conduct progressive monitoring

TOOLS FOR GENDER/ FGM/C PROGRAMMING

WEECC - Women's Empowerment Community Consensus Model for social change to stop FGM/C	**Gender planning**
1. Conduct a situational analisys	Conduct a gender analysis of the target environment where the action will take place: - disaggregate community members to define target groups - who does what, where - data on FGM/C (age,type,performer, attitudes) Use gender consultation, including also interviews with women in baseline research.
2. Access the community	Define the entry strategy to build the consensus of the community and open up the room for manoevre that permits both women's self empowerment and FGM/C prevention activities to be put in place.
3. Choose project inputs	Prioritise problems: which are the practical/strategic gender needs that are not met? Build a hierarchy. Then identify activities: 1. General development activities benefitting the whole community with a gender perspective 2. Women's empowerment activities 3. FGM/C prevention activities Finally identify appropriate messages.
4. Reach target groups	Establish workling objectives, i.e. specific results for women's empowerment to be reached within any foreseen development activity and progressively expand the room for manoevre, allowing the consolidation of results towards behavioural change.
5. Move to decision making stage	Identify constraints and assets (all kind of resources) is another essential element of the room for manoevre leading to the "Public declaration" confirming community consensus to a new form of women's empowerment (without FGM/C)
6. Ensure mantainance **- Move more to decision stage** **- Other outcomes**	Programme objectives should be defined in order to have a clear set of indicators to monitor progressive implementation of activities, evaluate impact and define appropriate interventions for maintenance and fostering of behavioural change process and addressing other outcomes.

SCENARIO 1

Wad Sharifae is a large settlement with good transportation to nearby city of Kassala, in Sudan. The settlement has an unofficial subdivision in a East and West zones, roughly corresponding to the ethnic division of people of West African origins and others. The division among the 2 settlement is quite invisible, as both make use of the same market. The Eritrean border is at 35 km, and recently a refugee camp has been located in the surroundings. Around 14.000 people live in Wad Sharifae. Ethnic composition includes the Beni Amer, one of the nomadic populario on of eastern Sudan, Hadendawa and House, mainly concentrated in West Was Sharief. Many Eritrean or people pf Eritrean origin also live here.
Economic situation is quite good, with irrigated orchards, herding, brick making, urban employment and day labour. There are 7 basic schools for boys and 7 for girls (grade 1-8), there is one high school for boys only. There are also 10 Coranic schools. Although illiteracy remains high among women, it is estimated that 60 per cent of the population has some degree of education. Schools are in a very deplorable state, and teachers complain the lack of government support for education.
The most prominent groups of Muslims are the Khatmiyya, a traditional Sufi group quite numerous in Eastern Sudan, and the Ansar Sunna, a Wahhabist oriented religious movement with close ties to Saudi Arabia. Pharaonic circumcision is quite diffuse, 57 per cent of girls aged 5-11 years have already been submitted to infibulation. Political and religious leaders from the Ansar Sunna movement often criticize Sudanese traditions, including girls circumcision and parts of the traditional wedding celebration. A wedding now consists of just a contract signing and a large, segregated gathering for a meal, after which the groom takes the bride home. They also restrict the movement of women requiring them to be accompanied by others and wearing black veils when moving beyond family's compound.

Source: Gruenbaum Ellen, *FGM in Sudan: Knowledge, attitudes and practices,* UNICEF Khartoum, August 2004

SCENARIO 2

Hameshkoreib akìl Jadida, in Sudan, is a community that is spread over a fairly large area located about 15 km est of Aroma by dirt track and 75 km from Kassala, with a paved road between Aroma and Kassala. Wind blows all the time. Nearly all the people identify as Hadendawa, an ethnic group that is considered on of the Beja people of eastern Sudan. The Hadendawa speak their own language among themselves, men also know Arabic well, but women don't, so that one woman has always to translate for the others. The children learn Arabic when they get older, at school. The village is composed by different “gabila” (tribes), each with its own sheikh. Housing is mostly mud brick round with straw shaded shelters. But a consistent number of houses consist of the traditional nomadic structures that can be relocated easily. There is a relevant problem with supply of clean water as well as with sanitation, with no latrines near a large number of houses and people simply using the bushes. Poverty is widespread, in particular in the dry season. Agriculture is the mains source of revenue, but many women revealed that their husband and brothers have migrated to Port Sudan.

Women have almost none incoming generating activities. The Hadendawa people of this community strongly adhere to cultural values and traditions of its previous pastoral life, with close proximity among families, endogamous marriages (close intramarriage, preferably with paternal first cousin). Patriarchal power is manifested in well defined gender roles, including women's segregation, rigid assigned workloads, deference and obedience to male relatives. However women are not powerless, exerting a great deal of influence in the family and community contributing to reputation of community members.

All the community, men and women, is very supportive of pharaonic circumcision, and until a few years ago never heard about “sunna”. This is considered a topic that should not be discussed in public. Not being infibulated is considered shameful by women, although they know/remember the pain associated with it.

Source: Gruenbaum Ellen, *FGM in Sudan: Knowledge, attitudes and practices,* UNICEF Khartoum, August 2004

SCENARIO 3

Tuwaifra is a large community in West Kardofan in Sudan, of about 6.000 people, founded originally in 1906 by Hammar people. It expanded in 1956 when the deep bore hole and pumping station were established at the end of the colonial period, transforming the village in a major water point for the area. The Ma'alia were the first group to be settled here. Actual ethnic composition includes Ma'alia, Berti and Hammar, with a smaller minority of Dinka. Each community has its own sheikh, who cooperate together.

Local authorities comprehend also the director of the school, a village council, and a committee under the Community development committee organized as part of a development project by a local NGO. Tuwaifra has no medical facility. There is a licensed midwife in the community, but the lack of regular healthcare is a major problem for the community. There are a few traditional healers, although not an herbalist but only a "boonsetter" and people who threat using the Qu'ran. The nearest hospital is at a 2 hours long drive.

There are no statistics concerning maternal and infant mortality, but these seem lower then in the past. The local school serves grades 1-8, with one book for every student only, no library, not convenient supply of drinkable water. Many girls drop out of school very early because of marriage: in grade 8 there are at present 15 boys and only 4 girls. Only a few girls in the story of the village have had higher education than grade 8.

FGM/C is performed in town, although there are no quantitative data available. People seem to have an open position towards the abandonment of the practice after some awareness raising interventions, in particular the men and some younger women, such the trained midwife. Another relevant change, according to one of the ethnic sheikh, is substitution of infibulation (pharaonic excision) with sunna. What is meant really in practice by "sunna" is not clear.

Source: Gruenbaum Ellen, *FGM in Sudan: Knowledge, attitudes and practices,* UNICEF Khartoum, August 2004

REMINDER FOR PROJECT DESIGN

1. Address gender practical / strategical needs, thus contributing to women's self empowerment.
2. Address 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.
5. Choose one specific development issue as an entry point.
6. List minimum 3 messages you deem appropriate for each activity/target group.

PRESENTATION OF PROJECT

Present the project on the flip chart according to following points:

Ask each group to present their project, starting from:

1. Situational / gender analysis
2. Practical / strategic needs identified / chosen
3. Access to community
4. Program objectives
5. Project inputs / activities according to target group
6. Messages selected
7. Working objectives / entry points to different target groups
8. Move to decision stage (“public declaration”)
9. Indicators for monitoring activities
10. Activities to ensure maintenance of decision taken and reinforce behavioural change process (empowerment of women).

MODULE 6

LEGAL AND POLICY MEASURES TO STOP FGM/C

Module objective

- To have a common understanding of the role of laws and policies in preventing FGM/C.
- To consider the options available to lawyers, judges, law enforcement officials, medical providers and members of civil society who can use legal mechanisms to prevent FGM/C
- To have a rights based approach to programming for the prevention of FGM/C

Why this module?

In many countries, government commitment to stopping the practice of FGM/C has translated into concrete laws and policies. Of the 28 African countries where FGM/C is prevalent, 15 have at least one specific law or regulation addressing the practice. It is significant that few of these measure pre-date 1994, the year of the International Conference on Population and Development in Cairo. At that conference, FGM/C received a great deal of attention and governments agreed to take action to stop the practice.
Legal measures to stop FGM/C include: constitutional protections, reproductive health laws, criminal laws, civil remedies, regulation of the medical profession and child protection laws. Laws and policies provide a tool for advocates to protect individual women, promote greater awareness of women's rights, seek greater governmental accountability for widespread tolerance of FGM/C, and guide the behaviour of governmental representatives. However, advocates may face some challenges in using the law: Institutions for law enforcement may be under-equipped, knowledge of the law may be limited, or legal proceedings may be carried out in an inconsistent or arbitrary manner. It is up to judges, lawyers, law enforcement officials, medical personnel and members of civil society to give force to the laws and policies on paper. This module encourages participants to think about how they may use law to support efforts to stop FGM/C.

Activities

Activity 1: What role can law play in preventing FGM/C? (1 hour and 30 minutes)
Activity 2: What does the law say about FGM/C in your country? (45 minutes)
Activity 3: Who can use the law to stop FGM/C? (1 hour and 30 minutes)

Activity 4: How can the law be used to stop FGM/C?
Looking at Criminal Law (1 hour and 10 minutes)
Activity 5: How can the law be used to stop FGM/C?
Considering other Legal Measures (2 hours)

Total time: 6 hours and 55 minutes

Activity 1

WHAT ROLE CAN LAW PLAY IN STOPPING FGM/C?

Time: 1 hour and 30 minutes

Why do this activity?

Legal measures can strengthen the position of those advocating for the abandonment of FGM/C.

Few advocates for legislation prohibiting FGM/C would argue that law alone could change individual behaviour. The effectiveness of any law will depend upon a number of factors, including the strength of enforcement mechanisms, the importance of formal law in norm-setting and social control, and the extent to which legal measures are accompanied by other manifestations of government commitment to stopping a particular practice. Nevertheless, legal measures specifically condemning and prohibiting FGM/C can help strengthen the position of those advocating for change. This activity encourages participants to consider the manner in which legislation addressing FGM/C can contribute to efforts to prevent the practice. It also considers barriers to successful implementation of such legislation.

Objectives

- To consider the benefits of using law to stop FGM/C.
- To identify the major obstacles to using law to stop FGM/C and consider strategies for governments and civil society to overcome those obstacles.

How to do the activity

Step 1: 15 minutes

Plenary The facilitator stands at the flipchart and asks the group first how laws against FGM/C contribute to efforts to stop the practice?

The benefits of a legal approach are listed and summarized for the group.

Points that may come out during the discussion, as developed in the book by Anika Rahman and Nahid Toubia, Female Genital Mutilation: A Guide to Laws and Policies (Zed Book), include:

BENEFITS of a legal approach to FGM/C	Explanation
1.Where measures are enforced, they may create incentives for change in individual or collective behaviour.	The most obvious of such incentives is the avoidance of punishment - in the forms of imprisonment, fines, social stigma or professional sanctions. Practitioners of FGM/C who learn that their actions may be punishable under the law may cease their activities for fear of being prosecuted. Parents may dread the potential consequences of being prosecuted for having their daughters circumcised illegally. In addition, under certain conditions, law may have a moral force that is persuasive to members of society. The sheer desire to be law-abiding may be enough to induce some individuals to abandon a practice that has been criminalized by the state.
2.Legal measures may also act as educational tools, publicizing information about the risks associated with the practice of FGM/C.	The passage of a law criminalizing FGM/C creates an opportunity for media coverage of the issue and opens the door for wider discussion of the harmful nature of the practice. Likewise, a government's condemnation of the act may lead some individuals to seek out more information themselves.
3.The passage of legislation may facilitate communication within families across generations.	The passage of legislation provides an occasion for those who oppose the practice to broach the subject with more traditional members of the family.
4. Where a prohibition against FGM/C is placed within a broader bill on, for example, women's human rights or women's reproductive and sexual rights, the law can help shape people's perception of the practice.	Such bills send the message that the right to be free from FGM/C is an essential human right, with its foundation in women's basic right to reproductive and sexual autonomy.

Note to facilitator

Step 2: 15 minutes

The participants are asked to name the major challenges of using law to prevent FGM/C. Challenges are listed on the flipchart.

Plenary

Note to facilitator

Points that may come out during the discussion:

CHALLENGES in using law to prevent FGM/C	Explanation
1. Legislation targeting FGM/C is likely to have little positive effect in a legal context in which women's rights are not recognized or are explicitly undermined.	Women cannot abandon the practice of FGM/C until they have the information, material conditions, and skills to enable them to do so. In countries in which FGM/C is seen as a prerequisite for marriage, women and girls whose economic security depends upon their ability to be married have little choice but to undergo FGM/C.
2. Efforts to stop FGM/C can face resistance at the community level.	A law condemning FGM/C can only have weight where the practice harmful effects are understood and recognized at the community level. In many societies, behavioural change at the individual level is difficult to achieve without the approval of the community. In such a context, using the law to subvert the demands of one's own relatives or community members may cause graver social and economic repercussions for the person resisting FGM/C than for the person trying to impose it.
3. When FGM/C is common among one ethnic group or community and not the majority, enacting and applying a criminal law could fuel ethnic tensions.	In countries in which primarily a minority ethnic group practices FGM/C, criminal laws prohibiting FGM/C may be perceived as a pretext for harassing or persecuting members of that group. This may particularly be the case when criminal legislation is enacted in the absence of concerted governmental efforts to reach women and girls through outreach and empowerment programmes.
4. In some countries, law enforcement mechanisms are weak and lack resources.	Where FGM/C is widely practiced and approved by most members of society, there are likely to be few cases brought to the attention of the authorities. The burden thus falls on law enforcement officials to investigate and uncover evidence of the practice. The logistical difficulties of performing such investigations, particularly in rural areas, are obvious. Adopting criminal legislation with no means of enforcing the law risks engendering disrespect not only for that measure, but also for the rule of law generally. In the context of FGM/C, some have argued that criminalizing the practice will do no more than drive it further underground.

CHALLENGES in using law to prevent FGM/C	Explanation
5. The practice of FGM/C is connected to the lack of reproductive health services for all women.	First, where such services are lacking, women have less information about their own reproductive health. Women who understand the harmful health consequences of FGM/C may be less likely to undergo the procedure or encourage their daughters to do so. Second, women who have already undergone FGM/C have the greatest need for medical attention, particularly during pregnancy, childbirth, and the post-partum period.

Step 3: 40 minutes

Once the list is complete, go through each challenge identified and ask participants to recommend strategies for governments and civil society to address and, hopefully, overcome those challenges. Write the suggestions by participants on the flipchart.

Note to facilitator

Guide the group to identify the possible strategies also making use of the examples from different African laws included below:

1. Legislation targeting FGM/C is likely to have little positive effect in a legal context in which women's rights are not recognized or are explicitly undermined.

Ways of addressing this challenge:

- Governments should ensure that they have **ratified the major human rights treaties** guaranteeing women's rights, including CEDAW, the Convention on the Elimination of All Forms of Discrimination against Women and the Maputo Protocol (Additional Protocol to the African Charter of Human and People's Rights on the Rights of Women).

-They should then **bring all national-level laws into conformity with the rights guaranteed in these treaties**. In reforming national-level laws, it is critical that governments modify laws that discriminate against women.

- **Constitutions should be unambiguous in securing the equality of women** and men under the law in all matters, protecting the rights of children and guaranteeing women and children protection against harmful practices. The constitutions of several African countries, including those of **Kenya** and The **Gambia**, explicitly declare that guarantees of non-discrimination are not applicable in matters governed by customary law. The term “customary law,” as used here, refers to the legal systems that are applicable to particular communities. The term does not necessarily encompass practices that may be viewed as obligatory as a matter of culture, but are not mandated by “law”. Because customary law frequently governs such matters as marriage and inheritance in Africa, a government's refusal to enforce women's equality when customary law is at issue may result in a perpetuation of conditions that lead to women's subordination. Women's weak social standing, in turn, reinforces their inability to reject FGM/C.
In matters affecting individual rights, constitutions of all countries should declare their supremacy over customary and religious law. Such explicit

statements upholding the primacy of the constitution and guarantees of individual rights are found in several constitutions, including those of **Eritrea**, **Ethiopia**, **Ghana**, **Niger**, **Nigeria**, and **Uganda**. In **South Africa**, the constitution permits application of customary law only when it is not "opposed to principles of public policy and natural justice".

- In addition to removing formal discrimination from the constitution and other national laws, **governments should adopt affirmative measures aimed at promoting women's rights**. Governments should adopt measures enabling women to raise their economic, social and political status, including ensuring that both women and men have the right to work and the right to equal pay for equal work. Governments also have a responsibility and obligation to support women and encourage their participation in all aspects of community life. Barriers to women's ability to access credit and training should therefore be addressed. Governments should ensure girl's equal access to education by allocating sufficient resources and adopting gender appropriate policies. Governments should also work to ensure women's participation in public office and decision-making.

- Finally, where popular knowledge of the law and government is limited due to high levels of illiteracy and remoteness from urban areas, **national campaigns should be instituted to disseminate information about the legal protections that do exist**, particularly those aimed at upholding women's rights.

2. Efforts to stop FGM/C can face resistance at the community level.

Ways to address this challenge:

- It is critical to ensure that a **broader governmental strategy that includes outreach and awareness-raising programs aimed at individual behaviour and social norms** is in place prior to any national-level criminalization of the practice. Governments should devote resources to reaching out to those communities that practice FGM/C. This outreach should aim to: promote human rights and demonstrate the connection between human rights and FGM/C; focus on the needs of women and girls while involving the entire community; and emphasize the impact of FGM/C on the lives of women, girls, and members of the community-at-large.

- Governments should rely on the assistance of NGOs, local leaders, and health care professionals to create and to provide this information in an effort to generate social dialogue.

- Moreover, government resources should support the **dissemination of accurate information about FGM/C and women's health and rights, enable people to access services, and support skills development and other training programs**. At the same time, as noted above, specific legislation that is appropriately and effectively publicized can itself serve as an educational tool to inform communities, individuals, members of the judiciary and law enforcement about the practice, its consequences, and available recourse. Well-disseminated laws not only inform potential perpetrators about what behaviour is considered criminal (putting them on "notice"), but they also communicate that the government has taken a stance against the practice.

3. When FGM/C is common among one ethnic group or community and not the majority, enacting and applying a criminal law could fuel ethnic tensions.

Ways to address this challenge:

- Governments should **show a consistent pattern of interest in eliminating FGM/C as a means of improving the lives of women and girls**. In countries in which minority rights are vulnerable, governments should take steps to show that their actions are not motivated by an interest in disrupting the lives of members of a minority ethnic group. Such steps may involve increased consultations with minority organizations and enhanced appropriate outreach programs, as well as allocating resources to community groups - particularly women's groups.

- It is advisable that lawmakers specify within legislation that efforts to prevent FGM/C should **comport with guarantees of minority rights and general protections against discrimination.**

4. In some countries, law enforcement mechanisms are weak and lack resources.

Ways to address this challenge:

- Even **occasional enforcement, if highly publicized**, may be sufficient to send the message that those who practice FGM/C incur criminal liability.

- In all cases, it is important that enforcement of any kind be accompanied by **public education informing people that a law criminalizing FGM/C has been adopted**. To date, while enforcement of legal measures aimed at stopping the practice of FGM/C has been uneven, news reports of arrests in several countries with legislation criminalizing FGM/C, including Senegal and **Ghana**, have received international attention. There have also been scattered prosecutions for FGM/C in cases where the girl undergoing the procedure died as a result, as in **Egypt** and **Sierra Leone**.

5. The practice of FGM/C is connected to the lack of reproductive health services for all women.

Ways to address this challenge:

- Legislation addressing FGM/C should be accompanied by **measures to ensure women's access to sexual and reproductive health care**. An example of such an effort is Togo's legislation prohibiting FGM/C, which takes special note of these health needs and directs public and private health facilities "to ensure the most appropriate medical care to the victims of female genital mutilations arriving in their centres or establishments".

Step 4: 20 minutes

Handout

At the end distribute to participants the Handout 1 "Cairo Declaration on Legal Tools for Preventing FGM/C". Allow 10 minutes to participants for reading it, and use the remaining 10 minutes for a last round of comments by participants.

Note to facilitator

The "Cairo Declaration on Legal Tools for Preventing FGM/C" is the result of a 3 days long Expert consultation organised in Cairo in 2003 by AIDOS (Italian Association for Women in Development) and NPWJ (No Peace Without Justice) in the framework of the "Stop FGM" campaign supported by the European Commission. The event saw the participation of legal experts, human rights and FGM/C prevention advocates from both governmental institutions and civil society, as well as

representatives of international organisations and NGOs active in this area. RAINBO and CRR, Centre for Reproductive Rights, as well as group of experts from various African countries, provided the background papers and case studies to lay the basis of the discussion in the working groups. The resulting final Declaration was adopted by the plenary and later used by all partners as a tool to advocate for a renewed approach to legal measures for the prevention of FGM(C (info: www.stopfgm.org).

Materials

- Flipchart paper
- Felt-tip pens
- Handout for each participant

Handouts

- Handout 1: Cairo Declaration on Legal Tools for Preventing FGM/C

Readings

- *Center for Reproductive Rights, Women of the World: Laws and Policies Affecting their Reproductive Lives*, Anglophone Africa Progress Report 153, New York, 2001

- *Cairo Declaration on Legal Tools to prevent FGM/C*, in *STOP FGM. Proceedings of the Expert Consultation on Legal Tools for preventing FGM, Cairo 21-23 June 2003*, AIDOS - NPWJ, Rome, 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 states 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 information 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 2

WHAT DOES THE LAW SAY ABOUT FGM/C IN YOUR COUNTRY?

Time: 45 minutes

Why do this activity?

Is there a law against FGM/C in your country? So often, the question is answered with a “yes” or a “no”. In fact, almost every country has a law or policy that supports action to stop FGM/C. This activity is aimed at encouraging participants to think expansively about the law and the legal instruments that can be used to stop FGM/C.

Objectives

- To identify the various types of laws and policies that can be used to stop FGM/C.
- To alert participants to areas of the law with which they may be unfamiliar, setting the stage for Activity 3.

How to do the activity

Step 1: 15 minutes

Plenary

Ask the group if there is a law on FGM/C in their country. If participants come from different countries, invite a volunteer to the flipchart and create columns for each country and record responses.

Step 2: 15 minutes

Individual work

Distribute handout 1: Questionnaire on National FGM/C Laws. Give participants 10 minutes to fill it out individually.

Step 3: 15 minutes

Plenary

Ask the group whether the questionnaire reminded them of additional legal measures addressing FGM/C. If so, what are they? Ask the group whether there were any types of legal measures with which they are unfamiliar.

Materials

- Flip chart
- Felt-tip pens
- Handout for each participant

Handouts

- Handout 1: Questionnaire on National FGM/C Laws

Readings

- Anika Rahman and Nahid Toubia, *Female genital mutilation. A guide to laws and policies worldwide*, CRLP (now CRR), RAINBO, Zed Books, New York, 2000

QUESTIONNAIRE ON NATIONAL FGM/C LAWS

1. Has your country ratified

CEDAW Children's Rights Convention

ICCPR ICESCR Banjul Charter African Charter on the Rights

of the child Maputo Protocol on the Rights of women

2. Does your country have a constitutional provision ensuring womens's equal rights?
YES NO _____

3. Does the constitution say anything more explicit about FGM/C?
YES NO _____

4. Does a national reproductive health law condemn FGM/C?
YES NO _____

5. Is there a criminal law prohibiting FGM/C?
YES NO _____

6. If yes, has this law been enforced?
YES NO _____

7. Is there a criminal law prohibiting assault or abuse of minors?
YES NO _____

8. Has a judge ever issued an order preventing a girl from undergoing FGM/C or else requiring an FGM/C practitioner to pay compensation to a girl or woman upon whom FGM/C was performed?
YES NO _____

9. Are medical providers prohibited from performing FGM/C though specific regulations?
YES NO _____

9. Are there other child protection laws that allow the state to intervene to prevent FGM/C?
YES NO _____

Activity 3

WHO CAN USE THE LAW TO STOP FGM/C?

Time: 1 hour and 30 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 a government's powers to control the behaviour of people living in 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 assumption that often creates uncertainty about whether law is an appropriate response to a practice as deeply engrained 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 the 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: 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 judges, a lawyer, a public official responsible for law enforcement (police 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 daughter.

Distribute Handout 1 How to use the law to prevent FGM/C. Task for the working group discussion.

Note to facilitator

Each small group will decide the legal framework for its interaction, based upon Questionnaire compiled out during Activity 2:

- 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 2: 45 minutes

Plenary

Group is called back together. 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.

Note to facilitator

Points that might come out in discussion

There are 2 main scenarios that can be envisaged by the working groups:

1. **there is** specific legislation addressing FGM/C
2. **there is no** legislation specific to FGM/C

1. In a country where THERE IS specific legislation addressing FGM/C

Category	**Haw can its member use the law to prevent FGM/C**
Legal community	**Judge**: apply the law, issue arrest order, 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 Supervision body for preventing members of the medical community from performing FGM/C. They might also raise questions about duties to report cases of FGM/C. Sensitize patients about FGM/C and existing laws. Play role model. Keep records of FGM/C related medical consequences to be used as evidence for law enforcement.
Institutional/political community	**Government representative** 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. Play a 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	Seek help from lawyers. Seek assistance from NGOs or other organisation to support costs of legal action, as well as to sensitize their community about the law prohibiting FGM/C and thus facilitating the adoption of their decision.

2. In a country where THERE IS NO legislation specific to FGM/C	
Category	**Haw can its member use the law to prevent FGM/C**
Legal community	**Judge**: apply the law, issue arrest order, and prosecute. **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 Supervision body for preventing members of the medical community from performing FGM/C. Sensitize patients about FGM/C and its consequences on health. Play role model. 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 on FGM/C. 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	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.

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

Readings

- 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

HOW TO USE THE LAW TO PREVENT FGM/C

Tasks for working group discussion

Each participant chooses a role among the following five categories:

1. Representative of the **legal community**: a judges, a lawyer, a public official responsible for law enforcement (police 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 daughter.

Each small group will decide the legal framework for its interaction, based upon Questionnaire compiled during Activity 2:

- 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.

Activity 4

HOW CAN THE LAW BE USED TO STOP FGM/C? LOOKING AT CRIMINAL LAW

Time: 1 hour and 10 minutes

Why do this activity?

Criminal law should be part of a broader strategy to prevent FGM/C.

While, as noted earlier, numerous legal responses to FGM/C are available to governments, by far the most common response has been to criminalize the practice. Fifteen African countries (including Benin, Côte d'Ivoire, Ghana and Kenya) and eleven receiving countries (including Sweden, Norway, the United Kingdom, and the United States) have adopted laws specifically criminalizing FGM/C. In addition, in most countries, criminal or penal provisions ban intentional injury, wounding or mutilation, often increasing penalties when the crime is committed against minors. Such provisions may be applied to prosecute the practice of FGM/C. In the absence of specific legislation, however, criminal laws against bodily injury are rarely invoked or interpreted to cover FGM/C.
Because criminalization of FGM/C is happening around the world, advocates need to be aware of the elements of criminal FGM/C laws (what is prohibited, who may be punished, etc.), as well as the policy considerations and potential consequences of each element.

Objectives

- To become familiar with the elements of criminal legislation banning FGM/C.
- To consider some of the policy implications and potential conse quences of each of these elements.

How to do the activity:

Step 1: 40 minutes

Plenary The facilitator explains the elements of criminal laws addressing FGM/C, posing questions along the way.

Handout 1 “African legislation on FGM/C: a comparative overview” is distributed to participants to consult along debate as different measures are analysed.

Handout

Understanding the elements of a criminal FGM/C law

Criminal laws prohibiting FGM/C vary around the world, but they have several common elements. Each law defines an offence that gives rise to punishment, states or implies who may be subjected to punishment, and provides a set of penalties.
The text of a law only tells part of a story. It is only when we consider how laws are applied (or should be applied) to concrete, factual situations that we begin to see the law's capacity to change facts on the ground. Enforcement of laws criminalising FGM/C occurs sporadically in African countries and is rare in receiving countries.
The challenge for advocates is to determine how criminal laws may serve efforts to stop FGM/C, without unnecessarily drawing girls and their families into the criminal justice system. Ideally, criminalization of FGM/C by itself will deter the practice. In reality, the law will have little deterrent effect without at least sporadic enforcement. Law enforcement officials and judges should therefore use their discretion to ensure that in those cases in which they enforce the law, the best interests of the child are taken into account.

Note to facilitator

The following subsections go through some common elements of FGM/C laws, as well as some variations. The definition of FGM/C, the set of persons who may be prosecuted, and the relevance of the age and capacity to consent of the victim are all issues that affect the manner in which FGM/C legislation will be impact the practice.
The definition of FGM/C, the set of persons who may be prosecuted, and the relevance of the age and capacity to consent of the victim are all issues that affect the manner in which FGM/C legislation will be impact the practice.

1. How is FGM/C defined?

Question

FGM/C occurs in several different forms. Penal laws should therefore state clearly whether all procedures commonly referred to as FGM/C are prohibited under the law. Legislation can achieve such clarity in one of two ways. Drafters may adopt an **"inventory" approach**, listing the various types of FGM/C that are prohibited. Alternatively, they may adopt a **“blanket” approach**, prohibiting all forms of FGM/C.
Both approaches risk some degree of ambiguity. The former creates a possibility that one form of FGM/C will be left unnamed, thereby creating a loophole for some practitioners. The latter, on the other hand, leaves open the possibility of disagreement over which practices constitute FGM/C. For example, some practices of FGM/C do not involve cutting, including a custom in **Nigeria** of “deadening feeling and retarding growth” of the clitoris by use of hot compresses on female infant's genitals. Whether or not this practice would commonly be understood to be prohibited under a general ban on FGM/C is open to speculation.
Among the laws that have been enacted to address FGM/C in African countries, the degree of specificity varies substantially. The laws enacted prior to 1990, namely those of **Central African Republic** and **Guinea**, merely state that the practice is prohibited and assign a penalty. Among the more recently enacted laws, those of **Djibouti** and **Tanzania** follow a similar model, stating only that FGM/C is prohibited and subject to penalties. The laws of **Burkina Faso** and **Ghana** are more complex. Both attempt to define precisely the behaviour that is prohibited. Ghana's Criminal Code, for example, specifically prohibits the excision or infibulation of any part of the labia minora, labia majora

and the clitoris and the terms “excise” and “infibulate” are explicitly defined.

Question

2. Who may be punished?

A number of laws, such as that of **Senegal**, assign criminal penalties to one who incites or instructs another to perform FGM/C. **Canada**, **New Zealand**, and **Sweden** also prohibit arranging for the illegal practice of FGM/C in a country in which the procedure is not prohibited.
Benin and **Burkina Faso** explicitly make it a crime for a person with knowledge that FGM/C has occurred to fail to report the act to the proper authorities. Benin's law, which requires that supervisors of health care facilities provide appropriate care to women who have undergone FGM/C, expressly demands that such personnel report FGM/C cases to law enforcement authorities.
All laws providing a basis for prosecution in cases of FGM/C potentially impose liability upon parents who procure FGM/C for their daughters. The laws of several African countries, including those of **Burkina Faso**, **Senegal**, and **Togo**, explicitly apply to parents and family members, as well as to practitioners of FGM/C. The law in **Côte d'Ivoire** punishes the relatives “by blood or marriage” (to the fourth degree) of the victim who have solicited FGM/C or who did not report a known imminent case to the authorities. Other laws render parents and family members guilty under general legal principles of accomplice liability, according to which anyone who procures the procedure or otherwise cooperates with the practitioner could be prosecuted.
Where laws do potentially subject parents to prison sentences, **judges may, in their discretion, elect not to impose such penalties on parents** who have been convicted in cases of FGM/C. In **France**, one of the few countries to have prosecuted parents for procuring FGM/C for their daughters, the result of most prosecutions has been that convicted parents have not been assigned criminal penalties. In the most recent case of this type, for example, a practitioner of FGM/C was sentenced to eight years in prison for performing the procedure on 48 girls. The 27 parents who were tried as accomplices received suspended sentences from three to five years.

Question

3. What do you think the penalty for FGM/C should be?

Countries that have addressed FGM/C in criminal legislation have assigned widely varying penalties to punish the practice. **Kenya's** law calls for a relatively light maximum sentence of 12 months in prison, while **Tanzania's** law imposes a minimum prison sentence of five years.
The severity of sentences may **reflect governments' view of the degree to which FGM/C is accepted by society at large**. In national contexts in which FGM/C is widely practiced and not viewed as a serious infraction, legislators may anticipate courts' unwillingness to convict practitioners of a crime carrying severe punishments. On the other hand, where only a minority of the population practices FGM/C, popular sentiment against the practice may be sufficiently negative that courts will be willing to convict practitioners and impose severe minimum sentences.

Question

4. When considering punishments for parents for seeking FGM/C for their daughters, how should the principle of the “best interests of the child” be applied?

In keeping with the requirements of the Child's Rights Convention, “the best interests of the child” should be the guiding principle in formulating the law.
Laws that provide criminal sanctions for parents who procure FGM/C for their daughters may create undue hardship for the girls

who have undergone the procedure. Long prison terms for parents of young children, involving separation of members of a family, can have severe effects on the emotional lives of the children involved. Governments should consider either assigning criminal sanctions only to the practitioners of FGM/C themselves or assigning lighter penalties to parents than to practitioners.

5. Should governments treat women and children differently in criminal FGM/C laws? Should the punishment be greater for performing FGM/C on a young girl than for doing so on an adult woman?

Question

A number of laws note **aggravating circumstances** that give rise to elevated penalties. When the practice results in death, the prison sentence provided for in **Togo**'s law, for example, goes from a maximum of five years to a maximum of ten.
It is also not uncommon for laws to assign greater penalties to members of the medical or paramedical professions. In **Burkina Faso** and **Senegal**, such individuals are assigned the "maximum" penalty for performing FGM/C. Provisions such as these reflect governments' **condemnation of the "medicalization"** of FGM/C, that is, the practice of FGM/C in hospital or clinical settings by trained members of the medical profession. While medicalization of FGM/C reduces many of the health risks associated with the practice, the underlying violations of women's rights - their rights to the highest attainable standard of health, bodily integrity, and non-discrimination - are no less undermined.
Finally, a number of laws punish **recidivists** more severely. Under **Togo**'s criminal law, for example, penalties are doubled for repeat offenders. **Nigeria's Cross Rivers State** law prescribes imprisonment of two years for a first-time offender and up to three years for each subsequent offence. Such provisions have the effect of punishing regular practitioners of FGM/C more severely than, for example, individuals implicated in a one-time circumcision of a daughter or granddaughter.

6. What if a woman asks/accepts consents to be submitted toundergo FGM/C? Which What are the consequences of the victim's consent to FGM/C according to criminal law?

Question

Criminal laws addressing FGM/C have generally not recognized circumstances in which a woman is deemed to have capacity to consent to undergoing the procedure. Only **Canada**, **Kenya**, **Tanzania**, and the **United States** have limited their prohibitions of FGM/C to procedures performed upon a child under the age of 18. The Kenyan and Tanzanian prohibitions of FGM/C are incorporated into criminal provisions pertaining to children, which both laws define as persons under the age of 18. Implicit in these laws is an assumption that by attaining the age of 18, a woman is in a position to consent to FGM/C in the absence of coercion and with full understanding of the procedure's consequences. What remains in question is whether women will be given the information and life choices necessary to abandon FGM/C or will the force of cultural norms and lack of economic and legal autonomy prove stronger.
On the extreme end of this debate are **two Nigerian states**, **Edo** and **Cross River states**, that have passed anti-FGM/C laws that punish the "female who offers herself" for circumcision or genital mutilation, the practitioners, and parents and guardians, regardless of whether the woman consents to the procedure. Thus, not only does an adult woman's consent not exempt the perpetrators of FGM/C from criminal liability, the consenting woman herself is subject to prosecution.
The Expert Consultation on Legal Tools to prevent FGM/C held in Cairo in 2003 concluded that "That age of a girl or woman or her consent to undergoing FGM/C should not, under any conditions, affect the criminality of the act".

Question

7. What is the impact of reporting requirements in the healthcare context?

In the healthcare context, mandatory reporting requirements may raise ethical concerns and may also prove to undermine broader government objectives. The ethical concern raised by such requirements relates to patients' **right to confidentiality** in the use of health care services. Requiring health care providers to violate their basic duty to maintain provider-patient confidentiality is a breach of universally recognized principles of medical ethics.
The practical effect of such a provision is likely to be **greater hesitation on the part of parents and other individuals to seek care for girls who are suffering from complications related to FGM/C. To do so would be to make oneself vulnerable to criminal prosecution**. Girls and young women themselves may avoid seeking care for fear of subjecting parents or loved ones to arrest and prosecution

Step 2: 30 minutes

Buzzing according to handout

Participants will work in couples. Distribute Handout 2 with the Scenario to each couple. The scenario reveals some of the challenges of determining what punishment is just and in the best interests of the child. Invite participants to discuss the answers among themselves for 10 minutes.

Then reconvene the plenary and guide a discussion among the group around the proposed case.

Note to facilitator

Scenario

A 32-year-old woman is reported to police for having arranged with a traditional FGM/C practitioner to have her 9-year-old daughter undergo FGM/C. The law provides that anyone who seeks to procure FGM/C for a girl under 18 can be sentenced from six months to 3 years in prison. The accused woman has one older daughter who has also been circumcised and three younger children under the age of nine, two of them girls who have not been circumcised. The woman is put on trial and found guilty of conspiring to perform FGM/C, in violation of the criminal law.

Questions for discussion:

1. What sentence should the judge impose?
2. How should the judge seek to promote the “best interests of the child” involved? What about her siblings?
3. Should the sentence be different if the perpetrator were a girl's grandmother or non-custodial uncleaunt? Is it realistic that it would be an uncle?
4. Which role can an organisation advocating for the abandonment of FGM/C play? This is changing the subject and might be confusing. Maybe include this question: hHow can an NGO sensitize judges and prosecutors on the importance of asking these questions?

Main points

Points to bring out in discussion:

Here, participants may consider how the mother's punishment will affect the nine-year old girl. They may also fear that if the mother is not seriously punished, her younger daughters will be at risk of undergoing FGM/C. Whether or not the accused has primary custody of the child may be a fac-

tor in determining the sentence. NGOs advocating for the abandonment of FGM/C can use the case to sensitize communities about the risks involved in breaking the law, once it is in place. They may also provide support to the woman's family while she is under trial. They may work sith the traditional practitioner to promote the abandonment of the practice.

Materials

- Handouts for participants

Handouts

- Handout 1: African legislation on FGM/C: a comparative overview
- Handout 2: Scenario

Readings

- Laura Katzive/CRR, *"Using the Law to Promote Women's Rights: Considerations in Drafting and Implementing Legislation to Prevent FC/FGM"*, in *STOP FGM. Legal tools to prevent FGM, Proceedings of the Expert Consultation, Cairo 21-23 June 2003*, AIDOS-NPWJ, Rome, 2003

- Legal measures to prevent FGM/C from all over the world are compiled in www.stopfgm.org.

AFRICAN LEGISLATION ON FGM/C: A COMPARATIVE OVERVIEW

Prepared by the Center for Reproductive Rights

COUNTRY (prevalence)	TYPE OF LAW	DEFINITION OF FC/FGM	WHO IS COVERED	PENALTY	CIVIL REMEDIES AVAILABLE?	EFFECT OF ADULT STATUS
Benin (50%)	- Criminal legislation adopted in 2003 - General provision in reproductive health law declaring FGM/C a violation of the rights to sexual/ reproductive health	Criminal law: "All forms" of FGM/C, performed by any person, are prohibited. Medically necessary procedures excluded.	Criminal law: Any person who performs FGM/C, aids and abets, who has knowledge of and fails to prevent an act of FGM/C, and who fails to report an act of FGM/C	Criminal law: Prison for 6 months to 3 years and fine of 100,000 to 2,000,000 francs; increased penalties when girl is under 18, when the cutting results in death, and in cases of recidivism.	N/A	Criminal law: Penalty is higher for FC/FGM performed upon a girl under the age of 18
Burkina Faso (70%)	Criminal legislation adopted in 1996	Law prohibits "violation of the physical integrity of female genital organ," by "total ablation, excision, infibulation, desensitization, or by any other means." Attempt is punishable.	"Any person who violates or attempts to violate the physical integrity of the female genital organ," including medical personnel, and those who fail to report an act of FGM/C	Prison for 6 months to 3 years &/or fine of 150,000-900,000 francs; increased penalty when cutting results in death and when practiced by medical personnel (who may also have their licenses suspended for 5 years)	N/A	None
Central African Republic (43%)	1966 Presidential Ordinance with force of criminal law	"The practice of excision is abolished"; no definition.	Does not specify. "Any violation" shall be punishable	Prison for 1 month & 1 day to 2 years &/or fine of 5,001-100,000 francs	N/A	None
Chad (60%)	Reproductive Health Law adopted in 2003	Female genital mutilation is prohibited; no definition.	Does not specify.	Does not specify.	N/A	None

Activity 4 Handout 1

COUNTRY (prevalence)	TYPE OF LAW	DEFINITION OF FC/FGM	WHO IS COVERED	PENALTY	CIVIL REMEDIES AVAILABLE?	EFFECT OF ADULT STATUS
Côte d'Ivoire (43%)	Criminal legislation adopted in 1998	Genital mutilation is the "violation of the integrity of the female genital organ, by total or partial ablation, infibulation, desensitization or by any other procedure." Medically necessary procedures excluded. Attempt is punishable.	"Any person" who commits a mutilation; medical/paramedical personnel; victim's mother, father, relatives by blood & marriage (to 4th degree) who solicited FGM/C or, knowing it was imminent, did not report. Perpetrator's spouse and relation by blood/ marriage to 4th degree (minors of victim's or perpetrator's family are exempt).	Prison for 1 to 5 years and a fine of 360,000 to 2 million francs. Penalties are doubled for medical/ paramedical personnel (who may also have licenses suspended for up to 5 years) and increased when cutting results in death.	N/A	None
Djibouti (98%)	Criminal legislation adopted in 1995.	"Acts of violence resulting in a genital mutilation;" No definition provided	N/A	Prison for 5 years and a fine of 1 million DJF	N/A	None
Egypt (97%)	1996 MOH decree upheld by highest administrative court	FGM/C in hospitals or public or private clinics is forbidden; medically necessary procedures excluded.	Members of the medical profession and non-physicians	"Criminal & administrative punishment"	N/A	None
Ethiopia (90%)	Criminal legislation adopted 1994 Constitutional provision adopted in 1994 on "harmful customs"	Criminal law: not available Constitution: "Women have the right to protection by the state from harmful customs. Laws, customs and practices that oppress women or cause bodily or mental harm to them are prohibited	N/A	N/A	N/A	N/A

Handout 1

Activity 4

COUNTRY (prevalence)	TYPE OF LAW	DEFINITION OF FC/FGM	WHO IS COVERED	PENALTY	CIVIL REMEDIES AVAILABLE?	EFFECT OF ADULT STATUS
Ghana (30%)	- Criminal legislation adopted in 1994. - Constitutional amendment adopted in 1992.	Criminal Code: "Whoever excises, infibulates or otherwise mutilates the whole or any part of the labia minora, labia majora and the clitoris of another person" violates the law. To "excise" is to "remove the prepuce, the clitoris and all or part of the labia minora." "Infibulate" includes excision and removal of the labia majora. Constitution: "All customary practices which dehumanize or are injurious to the physical and mental well-being of a person are prohibited."	Any practitioner; accomplices not defined in legislation.	A minimum of 3 years in prison.	N/A	None
Guinea (50%)	- Existing 1965 Penal Code provision - General provision in 2000 reproductive health law declaring FC/FGM a violation of the rights to sexual/ reproductive health	Penal Code: "castration" includes "Ablation or the mutilation of the genital organs of either man or women". Reproductive health law: every person has the right not to be subjected to torture or cruel or degrading treatment, "particularly on one's reproductive organs."	Penal Code: "any person guilty of the crime"	Penal Code: Hard labor for life or, if cutting results in death, a death sentenc	N/A	Penal Code: None
Kenya (50%)	Children Act adopted in 2001	Female circumcision means the "cutting and removal of part or all of the female genitalia and includes the practice of clitoridectomy, excision, infibulation or other practices involving the removal of part, or of the entire clitoris or labia minora of a female person."	"No person shall subject a child to female circumcision"	Prison for a maximum of 12 months and / or a maximum fine of 50,000 Shillings	Judicial orders of protection Any person that alleges that a protection provided under the act "has been, is being, or is likely to be contravened in relation to a child… may apply to the High Court for redress on behalf of the child." (Art 22) Children's courts have jurisdiction over "children in need of care and protection" which includes females, "subjected or likely to be subjected to" FGM/C. (Art. 118(h))	No crime when cutting is performed upon a woman over the age of 18

COUNTRY (prevalence)	TYPE OF LAW	DEFINITION OF FC/FGM	WHO IS COVERED	PENALTY	CIVIL REMEDIES AVAILABLE?	EFFECT OF ADULT STATUS
Mali (94%)	2001 ordinance establishes a national program to stop FGM/C					
Niger (20%)	Criminal legislation adopted 2003	Information not available				
Nigeria (60%) State criminal laws	**Edo**, criminal legislation adopted 1999	Prohibits circumcision ("cutting off of the clitoris") and mutilation ("cutting, incision, damage, removal of any or all of female sex organs.")	Practitioner ("any person who performs C / GM"); "person who offers herself for C or GM"; anyone who "coerces, entices, induces" a person to undergo FGM/C; parent/ guardian who allows it	Prison for 6 months &/or a fine of N1,000	N/A	None. No circumstance for consent allowed: "irrelevant whether consent is obtained or not"
	Cross River, criminal legislation adopted 2000	Prohibits circumcision ("cutting off of the clitoris of a female") and genital mutilation ("cutting, incision, damage, removal of any or all of the female sex organs")	Practitioner ("any person who performs C/ GM"); person who offers herself for FC or GM; anyone who "coerces, entices, induces" person to undergo FGM/C; parent/guardian who allows it	Prison for a maximum of 2 years or a fine for a minimum of N10,000 For repeat offenders, prison for a maximum of 3 years	N/A	None. No circumstance for consent allowed: "whether or not her (the female) consent is obtained"
Senegal (20%)	Criminal legislation adopted in 1999	Prohibits the violation of "the integrity of the genital organs of a female person by total or partial ablation of one or several of the organ's parts, by infibulation, by desensitization or by any other means;" attempt is punishable	Anyone "who violates or attempts to violate" the prohibition; anyone who through "gifts, promises, influences, threats, intimidation, or abuse of authority or of power, provokes these sexual mutilations or gives instructions for their commission"	Prison for 6 months to 5 years; maximum penalty for medical personnel; where cutting results in death, penalty is hard labor for life	N/A	None.

COUNTRY (prevalence)	TYPE OF LAW	DEFINITION OF FC/FGM	WHO IS COVERED	PENALTY	CIVIL REMEDIES AVAILABLE?	EFFECT OF ADULT STATUS
Tanzania (18%)	Criminal legislation adopted in 1998	causing "female circumcision or procur[ing] that person to [be treated] in a manner likely to cause suffering or injury to health, including…injury to…[an] organ of the body"	Anyone with custody, charge or care of a person under 18 who causes prohibited act	Prison for 5 to 15 years and/or a fine of up to 300,000 Shillings	Compensation determined by court for person injured	No crime when cutting is performed upon a woman over the age of 18.
Togo (50%)	Criminal legislation adopted in 1998	All forms of FGM/C "understood to mean any partial or total removal (ablation) of the external genital organs of little girls, young girls, or women and/or any other operations affecting these organs." Medically necessary procedures excluded.	Any person who practices FGM/C, whatever his position and anyone who participates in prohibited acts; "anyone with knowledge of an excision already planned, attempted or practiced," who fails to tell authorities when denunciation would have prevented future acts of FGM/C. Exemption for relatives by blood/ marriage of perpetrator and accomplice (up to 4th degree)	Prison for 2 months to 5 years and/or a fine of 100,000-1 million francs; increased penalties in cases of recidivism and when the cutting results in death	N/A	None. Law covers "little girls, young girls, or women"
Uganda (5%)	1996 Children Statute Constitutional prohibition against cultural customs contrary to dignity and welfare of women	Children Statute: "Unlawful to subject a child to social or customary practices that are harmful to the child's health." Constitution: "Laws, cultures, customs or traditions which are against the dignity, welfare or interest of women or which undermine their status are prohibited…"	N/A	N/A (No criminal penalties)	N/A	Children Statute addresses only the rights of the child.

SCENARIO

A 32-year-old woman is reported to police for having arranged with a traditional FGM/C practitioner to have her 9-year-old daughter undergo FGM/C. The law provides that anyone who seeks to procure FGM/C for a girl under 18 can be sentenced from six months to 3 years in prison. The accused woman has one older daughter who has also been circumcised and three younger children under the age of nine, two of them girls who have not been circumcised. The woman is put on trial and found guilty of conspiring to perform FGM/C, in violation of the criminal law.

Questions for discussion:

1. What sentence should the judge impose?
2. How should the judge seek to promote the "best interests of the child" involved? What about her siblings?
3. Should the sentence be different if the perpetrator were a girl's grandmother or non-custodial uncle?
4. Which role can an organisation advocating for the abandonment of FGM/C play? How can an NGO sensitize judges and prosecutors on the importance of asking these questions?

Activity 5

HOW CAN THE LAW BE USED TO STOP FGM/C? CONSIDERING OTHER LEGAL RESPONSES TO FGM/C

Time: 2 hours

Why do this activity?

Criminal law is not the only legal response to FGM/C.

The Expert Consultation on "Legal Tools to Prevent FGM/C" held in Cairo in June 2003 looked beyond criminal law in developing an effective legal strategy to stop FGM/C. For example, at that meeting, experts agreed that "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." Experts recognized that "The deterrent effect on practitioners of possible civil actions against them involving monetary damages may be significant".
Moreover, in some contexts, the use of non-criminal legal measures to stop FGM/C may be perceived as a less confrontational approach than enforcement of criminal legislation.
This activity is aimed at understanding the various types of legal measures available to help prevent FGM/C and considering how those measures can be used.

Objectives

- To master the types of legal measures available to address FGM/C and consider how they can be used.
- To learn the benefits and drawbacks of each approach
- To lay the groundwork for a legal advocacy strategy as part of an integrated approach to FGM/C prevention

How to do the activity:

Step 1: 45 minutes

Give a quick overview to participants about the legal measures available other than the criminal law. These include:

- **Constitutional measures** may protect women's rights in language that is broad enough to be interpreted to prohibit FGM/C.. In some cases, Constitutions specifically refer to the abandonment of FGM/C.The Constitution of Ethiopia, for example, provides that "Women have the right to protection by the state from harmful customs. Laws, customs and practices that oppress women or cause bodily or mental harm to them are prohibited".

- **Civil remedies for FGM/C** include measures such as civil lawsuit for damages in which girls and women who have undergone FGM/C seek money damages from practitioners or, theoretically, from their parents. Other procedures may be used to obtain protective orders or injunctions, ordering the perpetrators (FGM/C practitioner or parents who want to submit a girl to FGM/C) to refrain from carrying out the procedure. While criminal cases are generally brought by an agent of the state, such as a public prosecutor, civil cases are brought by the individual (or a person authorized by her) who claims to have been wronged. Civil remedies may thus be difficult to obtain in countries with high rates of illiteracy,scarce resources, and under-equipped legal systems.

- **Regulatory measures and ministerial decrees** include regulations and ethical codes passed and implemented by licensing authorities (e.g. ministries of health) regulating the practice of a profession and requiring licensed practitioners to maintain certain standards of competency and fitness. Where medical professionals are ordered not to perform FGM/C, those who do so may be subject to disciplinary proceedings and lose their licenses to work in the medical field..

- **Child protection laws** provide for state intervention in cases of child abuse by a parent or guardian. Unlike criminal laws, child protection laws are concerned less with punishing parents or guardians than with ensuring that a child's interests are being served. These laws may provide mechanisms for removing the child from his or her parent or guardian when the state has reason to believe that abuse has occurred or is likely to occur.

Note to facilitator

Divide participants into four small groups. Distribute a handout with a different Scenario and questions for discussion to each group. Invite the group to discuss the scenario proposed. Using the questions as a guideline, participants will apply the law to the facts of the case before them and discuss the utility of that type of law, as well as its limits.

Small groups

Note, but do not share with participants, that the 4 scenarios distributed refer to the following:

Handout 1/Scenario 1 : Constitutional protection of the rights of women and girls
Handout 2/Scenario 2 : Civil remedies for FGM/C
Handout 3/Scenario 3 : Regulatory measures and ministerial decrees

Handouts

Handout 4/Scenario 4 : Child protection laws

Invite each group to choose a rapporteur to report back to plenary.

Step 2: 1 hour and 15 minutes

Plenary discussion

Invite the rapporteurs to report to plenary, including reading the scenario and questions aloud for the whole group to consider. Guide the discussion so that main points listed below are addressed.

Note to facilitator

Handout 1 / Scenario 1

CONSTITUTIONAL PROTECTION OF THE RIGHTS OF WOMEN AND GIRLS

Questions:
1. Does the Minister's Order violate the Constitution?
2. What can be done to bring the Health Ministers action in conformity with the Constitution?
3. What could be the result of a legal challenge?
4. What if there were no Order, but it was widely known that FGM/C was being practiced in public hospitals. Could the minister be held legally responsible for violating the constitution?

Main points

Points that may come out:

Generally, government officials may not directly contravene the national constitution in their policies and official actions. Policymakers and members of civil society should remain vigilant to attempts of government actors to undercut constitutional protections. Whether or not a judicial remedy is available may depend upon the national legal system. Where a legal challenge is not possible or practical, any advocacy campaign challenging the Ministry's policy should cite the Constitution's clear protection against “practices that oppress women or cause bodily harm”.

Considerations:

In most countries in which FGM/C is practiced, women's equality is enshrined in the national-level **constitution**, a nation's law of highest authority. Constitutions in these countries protect women's rights in language that is broad enough to be interpreted to prohibit FGM/C. Several constitutions, including those of **Ghana**, **Ethiopia** and **Uganda,** specifically condemn traditional customs harmful to women's health. Constitutional measures that uphold the rights of women and girls to be free from FGM/C can shape governmental responses to the practice. The legal effects of constitutional protections vary according to each country's legal system. In some countries, constitutional provisions provide legal remedies for women and girls whose rights have been violated. In addition, in many countries, a judicial body might have the power to strike down laws and policies that are inconsistent with such a protection. Finally, a provision of constitutional status may guide members of the government in their drafting and implementation of law and policy. Whatever the legal significance of a constitutional provision condemning FGM/C, it represents a clear government commitment to stopping the practice and gives weight to a developing movement.

Handout 2 / Scenario 2

CIVIL REMEDIES FOR FGM/C

Questions:

1. Given the legal possibility of stopping FGM/C, what do judges need to know?
What about police?
What about private lawyers?
2. What provisions (safe houses, financial support, protection) are there for the girl who fears her parents?
4. Which are the practical barriers to use civil remedies?
3. Is seeking a judicial order a feasible way to prevent FGM/C in your country?

Note to facilitator

Points that may come out:

Main points

Judges, lawyers and the police need to be aware of the different legal measures available. Targeted information campaigns should be therefore conducted by both, institutions and civil society organisations. If the practice is not perceived by these actors as a human rights violation, they will be less likely to intervene and be helpful to girls fleeing FGM/C. Or, on the other hand, they may privilege only the use of punitive measures, if also available.
Law and enforcement officials and the judiciary also need to be able to refer girls to the means of support while they flee their homes.
Barriers to obtaining civil injunctions include lack of information and economic resources, limited availability of lawyers, and possible mistrust of the judiciary due to extensive delays and other systemic shortfalls.

Considerations:

Legal systems distinguish between civil and criminal actions. **Criminal offences** are often viewed as violations against the community and the state. **Civil law** addresses the wrongs suffered by private individuals and generally covers a greater range of topics than criminal law, including torts, breached contracts, constitutional challenges, and family law adjudications.
In countries with adequate mechanisms for adjudicating civil claims and enforcing judgments, FGM/C can be recognized as an injury that gives rise to **a civil lawsuit for damages** or other remedies. Girls and women who have undergone FGM/C can seek money damages from practitioners or, theoretically, from their parents. Such lawsuits would have a long-term effect of deterring individuals from performing or soliciting FGM/C. Other procedures, such as injunctions or stays, may be available to prevent the procedure from occurring in the first place. While civil legal actions are a potentially effective means of influencing individual behaviour and protecting girls and women from FGM/C, such mechanisms have not consistently been utilized.
There are scattered reports of instances in which civil remedies have been employed to sanction or prevent the practice of FGM/C. In all of these cases, no specific criminal law had been adopted. For example, in Liberia in 1994 a Grebo girl forced to undergo the procedure took legal action against the offending FGM/C practitioner, who was ordered to pay $500 (US$11.75) in compensation for the girl's injuries. Another successful litigation took place in Kenya, prior to the adoption of the Children Act, which specifically outlaws the practice. In 2000, the Iten magistrate, northwest of Nairobi, issued a historic permanent injunction

to prevent a father from coercing his two adolescent daughters into undergoing FGM/C. Using general legal principles, the magistrate ruled that “[FGM/C] is an illegal kind of practice because it is repugnant to morality and justice. The practice also violates human rights as stipulated in our constitution”.

Two major differences between civil and criminal law can influence the decision whether to choose either type of measure, or a combination of both. These differences centre on a) the person who is responsible for initiating the lawsuit and b) the outcome for the perpetrator and the victim.

a. Who may bring claims

While **criminal cases** must, with some exceptions, be carried out by an agent of the state, such as a public prosecutor, civil cases are brought by the individual (or a person authorized by her) who claims to have been wronged. Consequently, in states with criminal laws prohibiting FGM/C, the local prosecutor wields control over whether a law will be enforced in a particular instance. The prosecutor has the discretionary power to decide whether the facts of the case merit prosecution, including whether the violator and the act fall under the definition of the law, and whether enough evidence is available to prove guilt. Therefore, while criminal laws bear the official stamp of state protection and prosecution, their enforcement relies heavily on prosecutors' and judges' discretion in initiating and managing cases.

In **civil actions**, individuals seeking redress for an actual or potential injury lack the status, clout, resources and access to information available to a public prosecutor mounting a criminal case. In addition, most individuals at risk of FGM/C are adolescent girls who may be unable to navigate a complex legal system, gather evidence against their perpetrators, or hire qualified lawyers. As **minors**, they may face intimidation and pressure from family and community members not to bring a case. Moreover, under some legal systems, **minors lack the ability to bring a suit in court**. In such situations, they may be required to authorize an adult to bring a case on their behalf. While some civil systems explicitly allow adult third persons to bring a case on behalf of a child or minor in need of protection, it is questionable whether adolescent girls subject to FGM/C have access to a trusted adult or guardian willing to take up their cause.

In considering which approach is preferable, policymakers should keep in mind that most of the girls and women seeking protection and/or redress may wish or be forced to return to their homes and communities. It is therefore important to consider what approach would best **enable girls and women to obtain relief without antagonizing and alienating family and community members** with whom they reside.

b. Outcome for perpetrator and victim

The type of “punishment” or “remedy” available also merits consideration.

Criminal measures subject violators to punishment, such as imprisonment, or a criminal fine paid to the state. These measures are meant to “penalize” and “punish.”

In contrast, **civil measures** provide for “remedies” - an outcome designed to remedy the wrong inflicted on the individual. Civil remedies include compensation to the victim (e.g. “damages” from the harm, which may include damages for “pain and suffering," physical and mental distress), and protection orders or injunctions ordering the other party to refrain from carrying out or continuing to carry out the alleged wrong. **Civil laws do not carry an imprisonment sentence.**

Given the availability of a legal mechanism to prevent a girl from undergoing FGM/C, advocates and law enforcement officials should seek ways to connect young girls with lawyers and safe houses

Handout 3 / Scenario 3

REGULATORY MEASURES AND MINISTERIAL DECREES

Questions:

1. What should Dr. D do, taking into consideration medical, ethical, legal and human rights aspects of the case?
2. What legal and professional risks can Dr. D potentially face?
3. Are there any steps that Dr. D can take to have the mother less likely to have FGM/C/C performed on her daughter?

Note to facilitator

Points that may come out:

Main points

The most obvious ethical problem is the girl's incapacity to consent to the procedure. In addition, the scenario brings out the ethical questions related to medicalization of FGM/C, which refers to the performance of FGM/C in medical settings in order to minimize the health consequences of the procedure.
The provider must consider whether being a party to a violation of human rights is better than allowing the girl to face a life-threatening procedure by a traditional practitioner.

If a regulation banning the practice has been adopted, Dr. D might face the risk of losing the right to practice the medical profession. Dr. D might also be subject to severe criminal penalties.
Dr. D's best bet approach may be to raise the mother's awareness of why FGM/C is a violation of girls' rights and try to dissuade her from having the procedure done to her daughter. While Dr. D might wish to seek the help of organisations or public institutions working for the abandonment of the practice, it is essential that her patient's confidentiality be respected.

Considerations:

Regulations passed and implemented by licensing authorities regulate the practice of a profession and require the licensed practitioner to maintain certain standards of competency and fitness. While legislation can apply to all potential perpetrators, **professional and regulatory measures only cover registered members of that profession**, such as medical providers or traditional healers.
Medical ethics standards should make it clear that the practice of FGM/C violates professional standards. Medical practitioners who engage in the practice should be subject to disciplinary proceedings and should lose their licenses to work in the medical field. In **Egypt**, a Ministry of Health decree, upheld by the highest administrative court, has declared FGM/C an unlawful practice of medicine, thereby making practitioners susceptible to criminal prosecution. The medical licensing and disciplinary bodies of **Denmark**, **France**, and the **United Kingdom** have declared that physicians who practice FGM/C may lose their licenses to practice medicine.
In 2000, **Ghana** passed the Traditional Medicine Practice Act, which establishes a council empowered to regulate the registration and licensing of traditional healers. Under the Act, the council may revoke, suspend or refuse renewal of a license to practice when the practice constitutes a "risk to public health, safety or is indecent." Though addressing a different harmful practice, the Medical and Dental Council of **Nigeria**, which accredits medical practitioners, announced that any medical practitioner who amputates human hands or legs for non-medical purposes shall lose his or her license.

It should be noted that in most of the contexts in which medical providers are asked to perform FGM/C - generally upon minor girls - basic standards of informed consent can be invoked to prohibit the provider from performing the procedure. **International guidelines on informed consent** have been developed by the International Federation of Obstetricians and Gynecologists (FIGO) and are defined as follows: *"Informed consent is a consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:*
a) the diagnostic assessment;
b) the purpose, method, likely duration and expected benefit of the proposed treatment;
c) alternative modes of treatment, including those less intrusive; and
d) possible pain or discomfort, risks and side-effects of the proposed treatment".

"Although these criteria are clear, to ***implement them may be difficult*** *and time consuming, for example where women have little education, or where very unequal power relationships in a society mitigate against women's self determination. Nevertheless these difficulties do not absolve physicians caring for women from pursuing fulfilment of these criteria for informed consent. Only the woman can decide if the benefits to her of a procedure are worth the risks and discomfort she may undergo. Even if, for example other family members feel they should make the decision, it is the ethical obligation of the physician to ensure her human right of self determination is met by the process of communication that precedes any informed consent….*
The opinion of children or adolescents on a medical intervention should be assessed within the limitations posed by their level of development, age or understanding".

Note to facilitator

Handout 4 / Scenario 4

CHILD PROTECTION LAWS

Questions:

1. Is there a formal structure for such an intervention?
2. If so, what are the powers of the government to intervene?
3. What are the risks of taking this course of action?

Main points

Points that may come out:

In many national contexts, removing a girl from her family - even by an agent of the state - may be perceived as kidnapping. Therefore, it is preferable that child protection laws provide for the availability of shelters and safe houses, where girls can go if they seek to escape the threat of FGM/C.
Where governments do intervene, their actions must be clearly authorized by law, preferably with judicial oversight to ensure transparency and due process. Girls should also be offered psychological support in order to face the conflicting pressures that may be imposed by their families and the intervening governmental authorities.

Considerations:

Most receiving countries, and some African countries, have child-protection laws that could potentially be applied to prevent girls from undergoing FGM/C. A number of countries, such as the **United Kingdom**, have

declared the applicability of child protection laws to FGM/C. State authorities may thus remove a girl from her family if there is reason to believe that she will be subjected to FGM/C. Authorities in the United Kingdom may also prevent a girl from being removed from the country if there is evidence that the girl will likely undergo FGM/C in another country.
Note that because **FGM/C is not an on-going abuse**, child protection measures are best employed as a means of preventing FGM/C, not as a means of safeguarding children once FGM/C has occurred. Whether any such measures would be appropriate in the legal contexts of the African countries in which FGM/C is prevalent should receive special consideration.

Materials

- Handouts for each working group

Handouts

- Handout 1: Scenario 1
- Handout 2: Scenario 2
- Handout 3: Scenario 3
- Handout 4: Scenario 4

Readings

- Laura Katzive/CRR, *"Using the Law to Promote Women's Rights: Considerations in Drafting and Implementing Legislation to Prevent FC/FGM"*, in *STOP FGM. Legal tools to prevent FGM, Proceedings of the Expert Consultation, Cairo 21-23 June 2003*, AIDOS-NPWJ, Rome, 2003

- Legal measures to prevent FGM/C from all over the world are compiled in www.stopfgm.org.

- Anika Rahman and Nahid Toubia, *Female Genital Mutilation. A guide to laws and policies worldwide, CRLP (Centre for Reproductive Law and Policy, now CRR, Centre for Reproductive Rights)*, RAINBO and Zed Books, New York, 2000

• Rebecca J. Cook, Bernard M. Dickens, and Mahmoud F. Fathalla, *Reproductive Health and Human Rights: Integrating medicine, ethics and law*, Oxford, 2003

SCENARIO 1

In country X, which has a constitutional provision identical to Ethiopia's constitutional guarantee of freedom from practices that "oppress women or cause bodily or mental harm to them", a new Minister of public health is appointed. Shortly into his tenure, he announces that in order to reduce the harm caused by FGM/C to the health of women and girls, he is promulgating an Order that allows providers in public hospitals to perform "excision", which he asserts is the least invasive form of FGM/C. According to the Order, excision is to be performed with sterile instruments and with the use of local anaesthesia.

Questions for discussion:

1. Does the Minister's Order violate the Constitution?

2. What can be done to bring the Health Ministers action in conformity with the Constitution?

3. What could be the result of a legal challenge?

4. What if there were no Order, but it was widely known that FGM/C was being practiced in public hospitals. Could the minister be held legally responsible for violating the constitution?

SCENARIO 2

A 13-year-old girl flees her home for fear of being forced to undergo FGM/C. She goes to the police. Her parents do not know where she is. The girl wants a judge to stop her parents from going through with the circumcision. The girl fears that even if an order is issued, she will not be able to return home. She also fears that her parents will disregard the order.

Questions for discussion:

1. Given the legal possibility of stopping FGM/C, what do judges need to know?
What about police?
What about private lawyers?

2. What provisions (safe houses, financial support, protection) are there for the girl who fears her parents?

3. Which are the practical barrier to use civil remedies?

4. Is seeking a judicial order a feasible way to prevent FGM/C in your country?

SCENARIO 3

A mother brings her 9-year-old daughter to Dr. D requesting that she be "circumcised". The mother explains that she wants the procedure done for fear that the daughter will not be eligible for marriage in her community if it is not done. The mother further explains that she wants the procedure to be medically performed because procedures conducted on her older daughters by a traditional birth attendant (TBA) resulted in their severe bleeding and infection of the wounds. The mother says that, unless Dr. D consents to perform the procedure, her mother-in-law will insist on taking the girl to the TBA.

Question for discussion:

1. What should Dr. D do, taking into consideration medical, ethical, legal and human rights aspects of the case?

2. What legal and professional risks can Dr. D potentially face?

3. Are there any steps that Dr. D can take to have the mother less likely to have FGM/C/C performed on her daughter?

Source: Rebecca J. Cook, Bernard M. Dickens, and Mahmoud F. Fathalla, *Reproductive Health and Human Rights: Integrating medicine, ethics and law (*Oxford, 2003), p. 262:

SCENARIO 4

In a country in which FGM/C is legally prohibited, Mrs. Y is opposed to the practice and wishes to see it end. Mrs. Y is deeply disturbed to learn that her sister - at the insistence of her sister's husband - is planning to have her daughter circumcised in the coming week. Mrs. Y pleads with her sister to abandon the idea, but her sister holds firm, saying that her husband cannot be dissuaded. Out of deep concern for her niece, Mrs. Y considers intervening and taking her niece out of her sister's home for a while. She realizes that this is impractical and feels that it would be wrong to interfere in such a way herself. Desperate to keep the FGM/C from taking place, Mrs. Y wonders if there is anyone in government who could help. She does not want to go to the police, for fear of getting her sister in trouble. Still, she wonders if any government official can contact her sister and intervene to prevent the FGM/C from happening.

Questions for discussion:

1. Is there a formal structure for such an intervention?

2. If so, what are the powers of the government to intervene?

3. What are the risks of taking this course of action?

Associazione Italiana Donne per lo Sviluppo (AIDOS)

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.

www.aidos.it

The Center for Reproductive Rights (CRR)

The Center for Reproductive Rights uses the law to advance reproductive freedom as a fundamental right that all governments are legally obligated to protect, respect and fulfil. Founded in 1992 (as the Center for Reproductive Law and Policy), the Center seeks to achieve women's equality in society and ensure that all women have access to appropriate and freely chosen reproductive health services.

www.crr.org