FGM/C

/ A SHORT GUIDE FOR INVOLVED MEDIA /

/ TOWARDS THE ABANDONMENT OF FEMALE GENITAL MUTILATIONS/CUTTING /

AIDOS
ASSOCIAZIONE ITALIANA DONNE PER LO SVILUPPO

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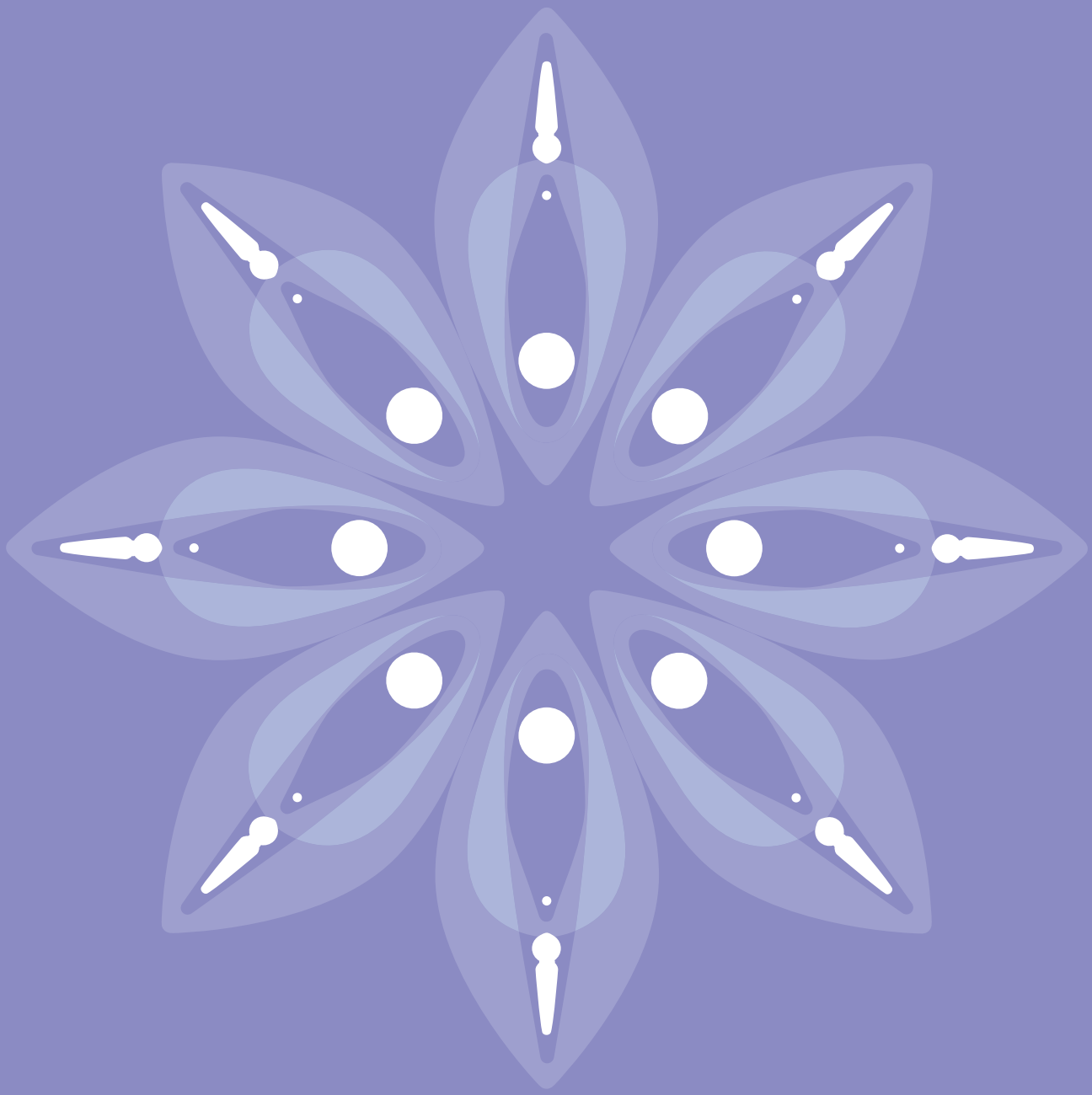

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This guide was designed as part of the project "Abandoning FGM/C on FM", implemented by AIDOS, the Italian association for women in development, with the financial support from UNFPA, the United Nations Population Fund, through the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting.
The project was carried out in collaboration with Audiodoc, an Italian Association of independent authors of audio-documentaries.
After more than thirty years of campaigning to promote the abandonment of this practice, the Demographic and Health Survey (DHS) conducted in many African countries that practice female genital mutilation/cutting (FGM/C) confirms the current progress towards the abandonment of this practice. Nevertheless, each year the number of girls who are subject to cutting still remains too high. FGM/C being a social norm and a cultural convention conforms to the changes related to social evolution for which the media is probably one of the driving forces, especially at a time like ours which is characterised by fast communication, satellite connections, mobile telephony and Internet. Journalists can, therefore, contribute to accelerate the abandonment of the practice process through coverage of ongoing changes on the field, thus encouraging families to adhere to this process, and therefore give their daughters a future that truly respects their human rights.

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/ TOWARDS THE ABANDONMENT OF FEMALE GENITAL MUTILATION / CUTTING /
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Over thirty years of campaigns and initiatives to discourage the practice have resulted in a once taboo topic, such as female genital mutilation/cutting (FGM/C), to now be discussed publicly on radio and TV debates, to be dedicated a series (in Mauritania) and to achieve more than 6 million results on Google and 10,700 videos on YouTube when writing the expression female genital mutilation.
Indeed, as the data from DHS, the Demographic and Health Surveys, confirm, there is almost no one in Africa who hasn't ever heard of FGM/C. If the taboo around the subject is broken, if you talk about it with family and elsewhere, if the decision to submit a young girl to the practice of FGM/C is not automatic but is subject to reflections, then the media must study which aspects of FGM/C are talked about, mainly working on arguments that will possibly guide their choice in favour or against the abandonment of the practice.

The data confirm that in all African countries the abandonment of the practice is ongoing.
And sociology tells us that after reaching a critical mass of people who change their way of acting within a given population, this change in behaviour then rapidly accelerates until reaching almost all the population. The media can play a key role in helping to increase the number of people who abandon the practice in order to reach the critical mass necessary for the process to continue and for it to become irreversible in society.
This guide has been designed as a support to facilitate talks about the practice of FGM/C in its current evolution. It is an invitation to see beyond the stereotyped definitions, which made in fact, hide the progress which is being made towards its abandonment.

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FGM/C

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/ FOREWORD /

Statistics show us an Africa where still too many countries are at the forefront of rankings on poverty, illiteracy, poor health services and humanitarian crises, but another Africa, which rarely makes the front page headlines, is moving forward. This is an Africa that vibrates, that does not want to be cut off from the world and development opportunities, an Africa where the increasing diffusion of mobile telephones and the increasing access to internet are significant indicators (from 4.5 million Internet users in 2000 to 140 million recorded in December 2011).[1] For this Africa which coexists and moves in parallel with the other one, access to information through all kinds of media - from radio, which remains the most widespread means of information, to TV, growing especially in urban areas, to the press, accessible to a limited part of the population, to Internet that attracts more and more young people - is in itself a factor of progress, change and development.

Through the media and the information it conveys, new social models, gender models, and models of relationship between generations, as well as new life and consumption styles are offered, and all this necessarily brings a cultural transformation, sometimes leaving people with the feeling of losing their identity as they gradually lose their traditions.

Sometimes, however, a lot of people really do want to abandon certain traditions, or simply keep the positive aspects. This is the case of female genital mutilation/cutting (FGM/C), a traditional practice widespread in 28 African countries that violates the human rights of girls and women, particularly the right to the integrity of the body, to health, and not to be subjected to violence.

The first African organisation that has openly pronounced the request for the abandonment of the practice was the IAC, the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, in 1984. Since then, the commitment to the abandonment of FGM/C has continued to increase, so much so that the two main UN agencies dealing respectively with population issues (UNFPA) and child protection (Unicef) have made the abandonment of FGM/C one of their priorities.

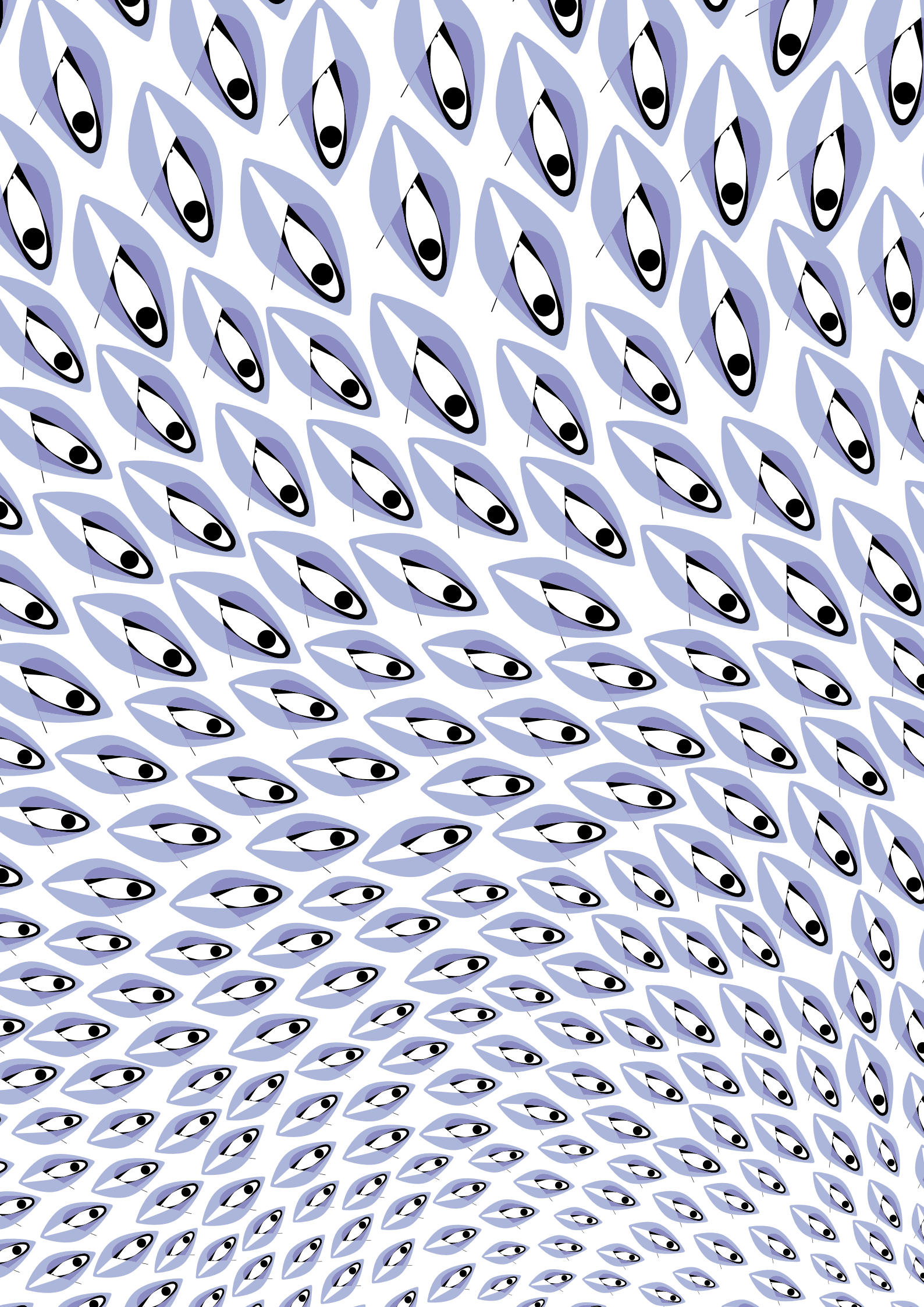
Over thirty years of campaigns and initiatives to discourage the practice have resulted in a topic which was once taboo, like female genital mutilation/cutting (FGM/ C), to now be discussed publicly on radio and TV debates, to be dedicated a series (in Mauritania) and to achieve more than 6 million results on Google and 10,700 videos on YouTube, when you write the expression female genital mutilation.

The data confirm that in all African countries, the abandonment of the practice is ongoing. And sociology tells us that after reaching a critical mass of people who change their way of acting within a given population, this change in behaviour then rapidly accelerates until it reaches almost all the population. The media can play a key role in helping to increase the number of people who abandon the practice in order to reach the critical mass necessary for the process not to be stopped and for it to become irreversible in society.

This guide has been designed as a support to facilitate reports about the practice of FGM/C in its current evolution. It is an invitation to see beyond the stereotyped definitions, which in fact, hide the progress which is being made towards its abandonment. This is an appeal to give a voice to many people who - even in the most rural areas - are en route towards the abandonment of the practice, and if they have not yet chosen to subject their daughters to FGM/C, most probably they are trying to decide whether to do it or not (a dilemma that was not an issue some time ago).

For all these people, the fact of discovering and understanding how other people in the same situation have solved this issue, by deciding to abandon the practice, can be of great help for them to take in turn the same decision. It is the media's role now to give visibility and a voice to the changes that are underway! We hope this guide can help to facilitate this work, which will enable thousands of little girls to go back to a life where FGM/C is just a mere memory of the past.

Daniela Colombo
AIDOS President



1.

/ PROMOTING POSITIVE CHANGES: THE ROLE OF THE MEDIA IN THE ABANDONMENT OF FEMALE GENITAL MUTILATION/CUTTING /

If some prevention programmes of female genital mutilation/cutting (FGM/C) are now giving us some really good results it is also due to the media. Indeed, it is thanks to journalists who realised the importance of this subject and dedicated articles, radio and TV reports on it, that the wider public could be informed on the progress being made and that a wider public was able to think about moving forward in the same direction.

This is the conclusion of a recent study, published in the periodical Insight Innocenti published by the Unicef Research Institute Innocenti, which took into consideration the programmes carried out in five African countries - Senegal, Egypt, Kenya, Ethiopia, and Sudan – which are among the most effective in promoting the abandonment of FGM/C. These programmes are mainly based on the change of perception, understanding and vision of the practice, both individually and in the social context.

These changes were possible because the programmes related to Unicef study took into account **the social structures and relationships that bind people to each other**, even when it comes to making decisions in relation to FGM/C and even when these links are not direct. Programmes have had success because they were able to show that the changes put forward would not only benefit girls who would consequently be spared the knife, but would result in a better well being for all, and also because they were able to value other positive aspects of the culture, focusing on a clear and comprehensive understanding of human rights, not just restricting themselves to the mere criticism of traditional attitudes.

These programmes have widely **used the media**: they have contacted journalists, they have invited them to "come and see" and "relate" with their own means what was happening in the communities concerned by the projects. According to Unicef: "The media as well as traditional forms of communication, such as music, poetry and theatre are powerful tools for social change."

They can transmit a new vision where girls and women can keep their traditional values without being cut. The media are particularly effective when they complement interventions at a local level and the policy measures on a national level and when they not only convey information, but also provide *fora* for discussion and debate, particularly talk shows, documentaries, movies, and educational programmes on the radio and on television."[2]

FGM/C, as well as many other traditions, function as social norms, that is to say norms of behaviour that are not written, but that everyone knows and believes they have to respect - because everyone thinks others within the community have to show respect to them, because each person is convinced that everyone else expects her/him to respect traditions, and because everyone strongly fears that if their daughters do not respect the tradition, they will not be respected in the community and will be marginalised. Discovering that it is possible not to be this way, and **other choices are possible without running risks**, can be decisive to change the fate of girls who would otherwise be doomed to undergo the practice.

The media, by giving visibility to the stories of those - individuals and/or communities - who are working towards putting an end to the practice, allow many people who are uncertain to realise they are not alone; to feel they are part of a new community, the community of families who have chosen to abandon the practice of FGM/C.

Relate **positive stories**, and not just tragic stories such as the death of a little girl as a result of circumcision, also helps to reassure people regarding the possible "social sanctions" linked to the non compliance to traditions. It is as if the protagonists say to those who are listening, "Look, nothing serious happened to me, you too can do it!" And this can lead to other families to take the same path.

Ethiopia gives one very good example, where in the year 2000, the organisation KMG Ethiopia organised the very first public wedding for a couple where the bride was not excised. The event was held in front of 2000 guests, among them, 317 uncut young girls who accompanied the bride. As reported by Insight Innocenti "During the ceremony, the bride and bridesmaids held signs with written: "I will not be circumcised. Do like me!" The groom had his own message: "I am happy to be marrying an uncircumcised woman". Officials addressed themselves to the crowd to support the newlyweds. The event was widely covered by international, national and local press and news from the couple was sent to neighbouring districts and across the region."[3] After 4 years, thanks to the visibility that the media continually gives to these public weddings, KMG Ethiopia has managed to replace the annual celebration ceremony of newly excised girls with the "intact body" party - a radical change in social norms

(we do not cut anymore) - while maintaining and enhancing traditional celebrations.

The media coverage of the events that **involve institutional personalities**, ministers and parliamentarians is also very important. If newspapers publish the news of a commitment to a FGM/C prevention policy, associations fighting for this goal will always be able to refer to an article/radio/TV program when they want to hold institutional personalities accountable for promises made.

On the same principle - **visibility/responsibility** - are based on "public declarations of abandonment of FGM/C and early marriage" that are the basis of the program implemented by Tostan.[4] Around 6,000 villages in Senegal have publicly adopted a declaration like this, some after a project implemented by Tostan, others simply by adhering to the initiative by signing the public statement, after seeing on TV or hearing on the radio what was happening in the villages concerned by Tostan work.

As it has, of course, been repeatedly stated by its founder, Molly Melching, it is not said that all families abandon the practice, though it is a first step, and you can always remind the person or family who continues the practice about their responsibilities, especially if the commitment was made public. If this commitment is moreover broadcast on TV, on the radio and the newspapers, it becomes all the more formal and binding.

In order to enable the media to really support campaigns for the abandonment of FGM/C which are promoted by civil society associations, governments and international organizations, they must take into account changes that have occurred from when - in the late seventies - the first campaigns to promote the abandonment of the practice were launched.

Indeed, after more than thirty years of campaigning, there is hardly no one in Africa who has never heard of FGM/C, as confirmed by DHS, the Demographic and Health Surveys data. If the taboo around the subject is broken, if we talk about it in our family and elsewhere, if the decision to submit a young girl to the practice is not automatic, but it is subject to reflections, then it is necessary that the media studies aspects of FGM/C, which today are the subject of these reflections, **working mainly on the arguments that determine the choice in favour of or against the abandonment of the practice.**

One of these arguments is the need to "**respect traditions**" by continuing the practice because it was passed on by ancestors. "It has always been done this way" some point out, and this represents a certain guarantee as well as a warning, it is as if the life of a person could not be protected by the spirits of the ancestors if traditions were abandoned. By talking about FGM/C, the media could develop the idea that traditions are constantly changing, that they adapt to the spirit of times, like every aspect of culture, and so they might as well support the idea of abandoning FGM/C now that the negative effects on the girls and women's lives are known.

However, due to the respect of traditions, there is a problem related to the **impression of the loss of cultural identity**, which is mainly due to the speed with which globalization has modified the lifestyles of people, whereas before the changes were made much more slowly. Abandoning FGM/C is often perceived as a step towards an umpsteen expropriation of African culture by Western lifestyles. But through the media we can promote **other traditions**, to ensure they are not lost, promoting their rediscovery, to enable people to abandon FGM/C without having the feeling of "betraying" their own culture.

The aim of this guide is **to give more visibility and a voice to those who are directly concerned by the decision to circumcise or not to circumcise**; it is an alternative to having "experts" talking about it like in newspapers, as it is usually the case. Indeed, it is the people who face these issues, especially those who have abandoned the practice, who can better than any expert, relate "how they did it" thus becoming models to imitate.

2.
/ FGM/C - WHAT IS IT? /

Female genital mutilation/cutting (FGM/ C) is a traditional practice in many African ethnic groups. A generally accepted and adopted definition in statistical Demographic and Health Surveys (DHS), is as follows:

Female genital mutilation/cutting refers to the partial or total removal of the external genitalia or other injuries to female genitals for cultural or other non-therapeutic reasons. The practice is generally regarded as harmful because it is potentially very dangerous to the health and well-being of girls and women who are subjected to it.

FGM/C is spread in 28 countries of the African continent, but it is also practiced in other countries such as Oman, Yemen, among the Kurds in Iraq and Iran and in Indonesia. Although it is difficult to trace the origins of this practice we know it is very old, and it is very likely that it was already present in Ancient Egypt and was probably successively passed on to the territories of the Roman Empire. Indeed, the word infibulation which is used to define the form of FGM/C potentially the most dangerous to health, derived from the Latin *fibula*, which was a kind of safety pin that was fixed on the genitals of slaves to control their sexuality.

In general girls are subjected to this practice during childhood and before puberty, with significant differences according to the ethnic group. For example among the Masai of Kenya and Tanzania, girls undergo the practice just before the wedding which is usually arranged between families at the age of 15, while among some ethnic groups in Ethiopia and the Eritrea it is the new born baby girls who are subjected to it. However, there is a widespread decline in the age at which girls are subjected to the practice, especially in countries which have adopted laws prohibiting FGM/C. In this case the excision is, in general, more limited and less mutilating since the body is at the beginning of its development, but once they become adults, the women have almost no recollection of the event, they do not believe to have suffered, and they tend to think that the practice is not such a harmful tradition, as the expression "female genital mutilation" seems to indicate.

In all African countries where the practice is widespread, campaigns to promote the abandonment of the practice have been carried out for at least three decades. These campaigns have certainly contributed to the documented changes in DHS statistical surveys, namely:

• **decrease in the number of girls subjected to the practice**, to the extent that for example in Kenya, according to the 2008/09 DHS, the percentage of women between 45 and 49 years who were subjected to the practice is 48.8%, and the number drops to 14.6% among girls between 15 to 19 years;

• **decrease in the more bloody kinds of mutilation and an increase of less severe ablations**: Some Somali women recount that the suture of the infibulation needed "7/8 stitches" but today it only needs "3/4 stitches";

• **decrease in the number of women and men who declare they want to submit their daughters to the practice.**

These campaigns have also contributed to put the practice in a framework that promotes human rights and gender equality by fostering institutional commitment and by increasing the number of basic organisations, networks, associations, religious leaders, intellectuals, artists and individuals engaged in promoting the abandonment of FGM/C.

At the same time, **the phenomenon reached new visibility in western countries**, in part due to the stabilization of migration flows from countries where FGM/C is traditionally carried out. This brought, on one hand, an increase in national and/or local initiatives in different countries of the European Union, the United States and Canada in order to create pathways towards the abandonment of the practice by offering support services for women who have been subjected to it, to contrast the phenomenon through penal laws, and on the other hand reach a real commitment from organizations of the African diaspora.

BOX 1.
THE NEW CLASSIFICATION OF THE WHO

Female genital mutilation is classified into four categories:

Clitoridectomy: partial or total removal of the clitoris (small sensitive and erectile part of the feminine genitals) and, rarely, just the prepuce (folds of skin surrounding the clitoris).

Excision: partial or total removal of the clitoris and the *labia minora* (the inner folds of mucous membrane of the vulva), with or without excision of the *labia majora* (the outer folds of skin).

Infibulation: narrowing of the vaginal orifice through the creation of a covering seal obtained by cutting and repositioning the *labia minora*, and sometimes also the *labia majora*, with or without removal of the clitoris.

Other: all other harmful procedures to the feminine genitals for non medical purposes, for instance pricking, piercing, incising, scraping and cauterizing of the genital area.

Source: OMS, Aide mémoire n. 241, http://www.who.int/mediacentre/factsheets/fs241/fr/index.html

/ 2.1. CHOOSING THE CORRECT TERM /

"**Female genital mutilation**" is a fairly recent definition which has gradually been imposing itself since the late seventies when the practice began to be known in the West. This definition includes all forms of the practice, known as clitoridectomy, excision, and infibulation, as classified by the World Health Organisation (WHO).

The use of these terms, however, is not shared by the majority of African people who practice some sort of FGM/C. For example, in most countries in West Africa the term "**excision**" refers to all kinds of FGM/C, including one that foresees the healing of the *labia minora* that was cut and given no real suture, leading to a kind of infibulation for which some have used the term "sealing".

The term "**female circumcision**" is also very widespread, and compares the practice of FGM/C with male circumcision. This comparison, however, only conceals the basic differences between the two practices since in the case of male circumcision only the foreskin is removed, whereas in the case of female circumcision, a female organ (the clitoris) is cut, which results in the deterioration of its functions. As pointed out in a recent Digest[5] from the Unicef Research Centre Innocenti: "The word **mutilation** not only establishes a clear linguistic distinction from male circumcision, but moreover, because of its strongly negative connotation, it underlines the gravity of the act."

In 1990, the term was adopted at the third conference of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC), the first network of African organisations, created in 1984, with the explicit objective of eliminating female genital mutilation/cutting.

In 1991, the WHO recommended the adoption of this terminology which has since been widely used by the United Nations in documents and by the international and scientific community in general. The word "mutilation" **reinforces the idea that the practice is a violation of girls' and women's human rights**, thus strengthening the national and international commitment to its elimination. However, in the communities, the term can be problematic as it gives a negative connotation to this custom which is by no means shared by those who perpetuate it, who on the contrary perceive it as a necessary and beneficial tradition for women as it helps to curb their sexual impulses that they would otherwise be victims of, which is detrimental to a woman's dignity, and in the case of adultery, to her marriage.

Local languages generally refer to the practice with less categorical words such as "excision"; it is understandable that parents do not appreciate the suggestion that they are "mutilating" their daughter. This is why **the expressions used in local African languages have references to other concepts**, such as purity/purification (in the religious sense), cleanliness (in the sense of hygiene), cutting/the act of cutting, the sewing /reduction.

In the late nineties the expression "**female genital cutting**" (FGC) then started to spread. It refers only to the act of cutting. It has no value judgement and respects local/traditional cultures for which this custom is an intrinsic element. By the same reasoning, the term "Female genital changes" was adopted by anthropologists such as the Italian Michela Fusaschi.

The WHO, the World Health Organisation, finally, as well as some French organisations, starting with the GAMS (Groupement des femmes pour l'abolition des mutilations sexuelles) which is a women's group for the abolition of female genital mutilation, the very first organisation in the world whose objective was the abandonment of FGM/C, created in France in 1982, uses the term "female sexual mutilation". This expression is preferred because it highlights the fact that the practice results in a negative change of women's natural sexuality. This definition suggests that it is more a mutilation of women's sexuality rather than an anatomical mutilation.

In order to convey the meaning of the term "mutilation" at the political level and at the same time, with the intention of recognising the importance of not using a term that expresses a judgement towards communities who practice it, UNFPA, Unicef, and other UN agencies, along with a growing number of non-governmental organisations, have chosen as a possible mediation between two legitimate requirements, the term "**female genital mutilation/cutting**" (FGM/C). An expression which should be used from now on.

BOX 2.
FGM/C: SOME TERMS USED IN LOCAL LANGUAGES AND THEIR MEANING

COUNTRY	WORD	LANGUAGE	MEANING
Burkina Faso	**Bangu**	*Bissa*	The word means respect which is what women are given thanks to the practice
	Marwala	*More*	The word literally means pigeon, a bird which brings luck in Burkina Faso
Egypt	**Thara**	*Arabic*	The word derives from the word tahar, which means to wash, to cleanse
	Khitan	*Arabic*	Circumcision, it is used for both FGM/C and male circumcision
	Khifad	*Arabic*	The word derives from the Arabic word khafad, which means to reduce, to diminish (it is rarely used in everyday language)
Ethiopia	**Megrez**	*Amharic*	Circumcision/Cutting
	Absum	*Harrari*	Ritual where a name is given
Eritrea	**Mekhnishab**	*Tigregna*	Circumcision/Cutting
Gambia	**Niaka**	*Mandinka*	Word which literally means to cut/ "pull out weeds"
	Kuyango	*Mandinka*	Word which means "the affair" but it is also the word used to designate the initiates' shelter
	Musolula Karoola	*Mandinka*	Word which means "Women's part" / "what regards women"
Guinea- Bissau	**Fanadu di Mindjer**	*Kriol*	Female circumcision
	Fanadu di Omi	*Kriol*	Male circumcision
Kenya	**Kutairi**	*Swahili*	Circumcision, word used for both FGM/C and for male circumcision
	Kutairi was ichana	*Swahili*	Female circumcision
Mali	**Bolokoli**	*Bambara*	Word which literally means to "wash ones hands". It is not clear whether the term is used in the sense that FGM/C involves purification or if it refers to the fact that the Practitioner washes her/his hands after the intervention
	Negekorosigui	*Bambara*	Word which literally means to "sit on a knife" and is not used in everyday language

COUNTRY	WORD	LANGUAGE	MEANING
Sierra Leone	**Sunna**	*Soussou*	Tradition/religious obligation for Muslims
	Bondo	*Temenee*	Integral part of an initiation rite of passage into adulthood for non-Muslims
	Bondo / Sonde	*Mandingo*	Integral part of an initiation rite of passage into adulthood for non-Muslims
	Bondo	*Limba*	Integral part of an initiation rite of passage into adulthood for non-Muslims
Somalia	**Gudniin**	*Somali*	Circumcision, word used for both FGM/C and for male circumcision
	Halalays	*Somali*	It derived from the Arabic word halal, that is to say "what is allowed /permitted". It is a term which implies purity. The word is employed by the Northern Somali and the Arabic Somalis
	Qodiin	*Somali*	To stitch/To tighten / To sew. The word refers to infibulations
Sudan (North)	**Khifad**	*Arabic*	The word derives from the Arabic word khafad, which means to reduce, to diminish. This term is rarely used in everyday language
	Tahoor	*Arabic*	The word derives from the word tahar, which means to wash, to purify

Source: Forward UK/AIDOS

3.
/ FGM/C - WHY /

According to surveys from the DHS, Demographic and Health Surveys, "respect of traditions" is among the most frequent arguments put forward regarding the persistence of FGM/C. Indeed, female genital mutilation/cutting is universally designated as "traditional practice". The central notion is that of **tradition**.

Traditions are intrinsically part of the culture, as is nowadays the production of media. This is why FGM/C are often labelled as "cultural practice." Referring to FGM/C as a "cultural practice" can help contribute to change from the instant when we recognize that they are part of a cultural fabric that is in constant evolution, which is variable and impregnated by the sociability of both men and women, with their biological differences and their gender, which are open to change primed by contacts with other people and other contexts, which in turn have different "cultures" that are in constant evolution.

Traditions, and their consideration, are historical, hereditary and behavioural legacies of the past that give the individual a sense of belonging to their native context and social community. In most African countries the legacy covers also a character of sacredness. Traditions however necessarily evolve and changes observed in the growing number of studies on FGM/C, are the proof of it. Indeed, these studies show that:

- **Health workers** often replace traditional practitioners;
- **Collective ceremonies** are replaced by individual procedures performed by family members;
- The **age** at which girls undergo the practice is going down;
- FGM/Cs are **less severe**, especially in the case of infibulation;
- The health worker practicing FGM/C can be a man and not only a woman, which has been noticed in Egypt.

Today FGM/Cs are no longer practiced in the same way as they were 30 or 40 years ago, because all the surrounding context has changed and is constantly changing. This is why it is very important to always question yourself regarding the attitude to adopt towards the traditions of the people targeted by the media, especially in relation to women who are the main actors in the pursuit of the practice because they perpetuate it on the girls to whom they are mothers, grandmothers or aunts. Some of them, especially in rural contexts, remain attached to the customs and values of their cultural context despite the change brought by modernity and globalization that often make them feel distressed and strange about. For them, FGM/C is an obligatory step in a women's life that is accepted as a "natural" fact.

But for others, things are different. For example, for girls and women who have a better academic training and work which guarantees them an income regardless of the husband. They are more independent, more pushed by self-determination, and thus more conducive to break the cultural fabric, and challenge FGM/C which they perceive as a handicap, as well as all other traditional or custom values that a regarded as a limitation to their development.

Recognize, by writing/speaking of FGM/C, that traditions evolve, and that "dropping something" (... FGM/C) does not mean betraying your own culture, or losing your identity or waiving your values, but rather it means that you respect them differently, by recognizing the full subjectivity of women, their ability to make decisions, their universal human rights, it can really help support and accelerate the ongoing process towards the abandonment of FGM/C.

/ 3.1 FGM/C AND MARRIAGE /

As written by the anthropologists Veronique Petit and Severine Carillon in a research[6] report carried out in Djibouti: "FGM/C is a social norm that is based on informal and implicit agreements validated by authority due to the seniority of traditions, whose legitimacy is in the ancestral memory. What gives authority to this norm is, in fact, its repetition. It is neither prescribed by god or a written law. Its respect is provided by the beliefs that surround it ; the young non-"circumcised" girl will not become a real woman, she will always be a victim of her sexual impulses such as it is the case for animals, nobody will want to marry her ... ".

In some contexts, therefore, FGM/C is a rite of passage, that regulates the lives of girls and marks their **transition to adulthood**: their acceptance and respect within the community depends on it, especially from other women. Without this act, which is meant to help discipline the body's instinctive drives which are considered otherwise uncontrollable like the sexual instinct of animals, a girl not only does not become a woman, but moreover she does not become a person, that is to say she does not accede to the social role

assigned to her as a female, and that materializes itself in the role of wife and mother regarded as the foundation of feminine identity by traditional society.

At present, Africa lives between tradition and modernity. The tradition reassures people, but it is often questioned by modern life, especially in urban settings where populations are more and more concentrated while countryside is gradually abandoned. Modernity is often experienced as a frustrated aspiration because of poverty. For many women and families, the respect for traditions remains an inevitable choice in order to assure a social status that marriage keeps on giving.

The studies that have led to a better understanding of the underlying of socio-cultural dynamics of FGM/C, as well as campaigns and many projects that promote the abandonment of FGM/C and which have broken the taboos concerning them, are the elements that have contributed to the rethinking of traditions.

/ 3.2 FGM/C AND CONTROL OF FEMALE SEXUALITY /

If you ask: "Why do you carry out excisions?" often we get allusive responses such as "To keep women quiet," or "So that women can control themselves", or "So that girls don't run after men." The allusion here is to sexuality, it implies that, without modification of their genitals, women would not be able to control their sexual desire.

FGM/C is therefore **a complex and painful way to limit the female sexual desire**, and consequently ensure the virginity of the girl until marriage and, or rather especially, her faithfulness as a wife. Once deprived of the organ most explicitly linked to pleasure and therefore, for this, the female sexual desire, women leave the initiative of sexual intercourse to the husband, but often they will be subjected to it, supported by the desire to become mothers as it is expected from a married woman. As sexual intercourse happens only at the initiative of the husband, he will be sure of being the father of the children conceived,
to whom he will pass on the family property.

This dynamic is even more visible in the communities where marriage is linked to **the payment of a "bride's price"** by the family of the husband. As the anthropologist, Carla Pasquinelli, underlines it, marriage in Africa "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 the amount of the bride's wealth that the groom must pay to the bride's family. By bride's wealth we mean all the goods that the groom's family hands over to the bride's family on the occasion of the marriage... It is the groom who pays the family of the bride a compensation for the loss of a woman and her services." ..."The bride's price 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 a woman that is given but only the right over her (for her work, sexuality, and fertility), and over her children. Since the bride's wealth is the compensation paid in exchange for woman's fertility, 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 beliefs, is clear."[7]

/ 3.3. POWER DYNAMICS: MALE/FEMALE, PARENTS / CHILDREN, INDIVIDUAL/ COMMUNITY /

FGM/C can be, for many African women, the price to pay in exchange for a marriage "as it should be," which is able to ensure maternity, a roof, revenue, freedom of movement and social recognition. That is why, according to the Sudanese doctor Nahid Toubia: "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 options for choices in livelihood, the room for negotiating a limited amount of power is extremely small. Circumcising your daughter and complying with certain social norms, particularly around sexuality and its link to the economics of reproduction, is an essential requirement to these silent power negotiations. Women instinctively know this. We may scare them with all the possible risks of FGM/C to health. We may bring religious leaders to persuade them that the practice is not a requirement. We can try to bring the wrath of law to bear upon them. But in the 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."[8] An advantage with regards to the status of women as a whole and therefore which can only be the resultant of **an overall change in society**, where the same rights are guaranteed to men and women in terms of access to education, work, income, and in terms of recognition and social participation.

In general, when it comes to deciding to submit a daughter to FGM/C it is because of pressure from the family's elders: mothers in law, grandmothers and aunts are very influential. The respect of "parents and seniors," which materializes itself through the accession to their decisions even when they are not completely shared, is an integral part of African education and relations between parents and children, even after reaching adulthood. In this sense, the elders always keep a kind of "power" over the youth. And it is this power dynamic that grand mothers rely on when asking their grand daughters to be subjected to FGM/C. For women and families to oppose to such a request becomes a lack of respect to seniors.
Last of all, there is **the role of the community**. As Jerry Mackie and John Le Jeune explained: "What a family decides to do depends on what other families in the community decide to do. No family has any reason to change: If they did, their daughter would be destined not to marry or get an uninteresting marriage"[9].

Traditionally, the community exercises a tight control over women's sexuality through the practice of female genital mutilation/cutting and marriage. An "appropriate" woman does not show her desire and leaves the initiative of sexual intercourse to the man. The community perceives a non excised woman to be unable to manage her sexual urges and this way of thinking is also internalized by women. Women adultery **aggrieves the honour** of the man and his family: female genital mutilation/cutting is performed in order to preserve his honour in a preventive way.

/ 3.4 RELIGIONS AND FEMALE GENITAL MUTILATION/CUTTING /

Although FGM/C is prevalent among various religiously orientated populations, we tend to associate it with Islam. "In most Muslim societies of the world, female circumcision is not practiced: in fact, in 80% of the Muslim world, this practice is unknown," notes anthropologist Sara Johnsdotter, who did her research with Somali women refugees in Sweden.[10] "It (excision) was strongly anchored in some parts of Arabia and Africa thousands of years before these areas were Christianised and Islamised. After the arrival of Christianity or Islam, these customs were integrated into the systems of religious beliefs."

FGM/C is a tradition that Islam, when it expanded to Africa, did not contradict, but instead ended up accepting or, in some cases, promoting by assimilating it to male circumcision, and thus being shown as a religious obligation. This is a very important issue because a lot of religious Islamic people believe that FGM/C is an Islamic practice, especially in countries where the word "Sunnah" - custom, tradition that comprises the acts and words of the prophet Mohammad and other people's acts and words, that he accepts and is an example to follow for every Muslim - is used to name the least severe form of FGM/C.

The various Islamic schools have adopted different positions based on the Koran and on some hadiths, that is to say the words of the prophet Muhammad and by extension all the words, deeds or even situations that took place before his eyes and that he tacitly approved yielded by his companions. In some cases, these schools consider the practice as being incoherent with the principles of religion and therefore encourage abandoning it, in other cases; they condemn simply the most severe forms of FGM/C such as infibulation and not the "lighter" forms such as clitoridectomy or excision.

However, often the mullah in the village support the practice, which brings a lot of people to believe that it is an obligation prescribed by Islam. "The most quoted hadith," says Mr. Johnsdotter," is the one where the prophet Muhammad addresses a woman who is going to perform the practice: according to one of the many English translations, the Prophet says to her: "do not cut excessively (don't exaggerate) because (the clitoris) is a blessing for a husband and a delight for her." But the chain of narration of this hadith is weak which means that some scholars argue that there is no Sunnah to follow in matters of excision.

Mr.Johnsdetter adds: "Another hadith, among the few who talk about excision, offers these instructions." If the two circumcised parts enter in contact with each other, a purification ritual is required (ghusl) "The purification ritual of the whole body, ghusl, should be made when a man and a woman have sex. Must we therefore interpret these words as the prophet supporting circumcision? This statement can be read as a comment linked to the fact that there were excised women in the area where the prophet Muhammad lived during this specific historical period, and should not be construed as an agreement with the practice".[11]

This hadith, however, seems to reinforce the idea that the **practice existed before the birth and spread of Islam**, as confirmed by the discovery of the ancient mummies of Egypt who were excised.

Religious leaders, usually silent about the taboos concerning the sexuality of women, have started to engage openly against the practice, especially in Egypt, because many Egyptians believe it is a religious Muslim and Christian duty. Following the death of Shaker, a girl who died because of the practice in 2008, the Chief Mufti Ali Gomaa stated that Islam forbids female circumcision. Mohammed Sayyed Tantawi, the sheikh of Al-Azhar university, the highest Sunni Muslim authority, and Coptic Patriarch Shenouda III, have also stated that FGM/C "have no basis" in Christian and Islamic religious texts.[12]

If the **Coptic church** has begun to officially distance itself from female genital mutilation/cutting it is also thanks to the commitment of the Egyptian organisation Coptic Evangelical Organisation for Social Services (CEOSS), which, in the early nineties implemented a project focused on women's empowerment and the involvement of communities including religious Copte leaders. UNICEF recalls: "In 1991 the city of Deir al Barsha (in the government of Minya in Upper Egypt) publicly condemned FGM/C, with the help of CEOSS"[13]. This is a change that over the last 15 years has steadily consolidated itself thereby helping to strengthen the idea that this is not a practice prescribed by the Coptic religion.

The Catholic Church, however, is not so keen. Indeed, as noted the researcher Natacha Henry: "In his Apostolic Exhortation, published as a result of the Synod of the African Bishops, Pope John Paul II simply declared:" The Church deplores and condemns, as they persist in various African societies, all customs and practices which deprive women of their rights and the respect they are entitled to"[14] and this is despite the fact that many people, not just women and their organisations, have stood up over time within the Catholic Church to request a formal condemnation of the practice.

4.

/ FULLY EXPLOIT THE DATA AVAILABLE TO TALK ABOUT FGM/C TODAY /

In 2008 with the publication of the essay **Numbers of women circumcised in Africa: the production of a total number**[15], statisticians from Macro International have calculated the number of women who are likely to have been subjected to the practice in Africa, that is to say the prevalence rates. According to these calculations:

• The number of women over 15 years who underwent some form of FGM/C in Africa is 79,195,692, that is to say about **80 million**;

• The number of girls between 10 and 14 years who have suffered from some form of FGM/C in Africa is approximately **12.4 million**.

• All girls and women over 10 years who have suffered from some form of FGM/C in Africa is calculated around **91.5 million**.

These data do not include non-African countries - such as Yemen, Oman and the Indonesia - where the practice of FGM/C is prevalent. The same applies to Western countries where African immigrants reside. It is estimated for example that in the European Union there are around 500,000 women who underwent some form of FGM/C.

More widely, Macro International believes that the number of women in the world who have suffered from some form of FGM/C amounts to **130 million**.

The DHS surveys, carried out in many African countries since the nineties, are carried out on average every five years which enables to measure changes over time. These surveys are conducted by ICF Macro International, a statistics company based in Maryland (United States of America) and are mainly financed by the U.S. Agency for International Development (USAID), and more recently also by international organisations such as UNFPA and Unicef. Investigations are repeatedly performed in collaboration with governments and the national statistical centres of the countries concerned. Their main quality is the selection of samples of surveys that are taken from national censuses, and thus reflect the composition of the population by:

- sex (men and women);
- age (between 15 and 49 years, divided per ages of 5 years);
- residence: urban / rural;
- territorial distribution;
- level of education;
- income (divided by quintile, that is to say every five income brackets).

In some cases, a breakdown by major religions (Islam and Christian religions) is also planned. In addition, in the questionnaire on female genital mutilation/cutting, several questions help to have an "image" of the trend heading toward the abandonment of the practice.

These issues are very useful in order to relate, thanks to the strength of the data, the changes that the practice is undergoing beyond just the simple rate of prevalence.

/ TABLE 1. PREVALENCE BY AGE /

Country	Data source	Date of survey	Prevalence (% of women who were subjected to FGM/C by age)		
			Total sample 15 - 49 years old	Younger age bracket 15 - 19 years old	Older age bracket 35 - 39 years old
Benin	EDS	2006	12.9	7.9	16.3
Burkina Faso	EDS	2003	76.6	65.0	81.6
Cameroun	DHS	2004	1.4	0.4	1.2
Chad	EDS	2004	44.9	43.4	46.2
Ivory Coast	MICS	2006	36.4	28.0	43.8
Egypt	DHS	2008	91,1	80,4	96.4
Eritrea	DHS	2002	88.7	78.3	92.6
Ethiopia	DHS	2005	74.3	62.1	81.2
Gambia	MICS	2005/06	78.3	79.9	79.5
Ghana	MICS	2006	3.8	1.4	5.7
Djibouti	MICS	2006	93.1	—	—
Guinea	EDS	2005	95.6	89.3	98.6
Guinea-Bissau	MICS	2006	44.5	43.5	48.6
Kenya	DHS	2008-09	27,1	14,6	35,1
Mali	EDS	2006	85.2	84.7	84.9
Liberia	DHS	2008	91,3	75,5	96,4
Mauritania	EDS	2000/01	71.3	65.9	71.7
Niger	EDS	2006	2.2	1.9	2.9
Nigeria	DHS	2003	19.0	12.9	22.2
Central African Republic	MICS	2000	35.9	27.2	43.3
Senegal	EDS	2010-11	25,7	24	29
Sierra Leone	MICS	2006	94.0	81.1	97.5
Somalia	MICS	2006	97.9	96.7	98.9
Sudan (North)	MICS	2000	90.0	85.5	91.5
Tanzania	DHS	2010	14.6	7,1	21,6
Togo	MICS	2006	5.8	1.3	9.4
Uganda	DHS	2006	0.6	0.5	0.8
Yémen	PAPFAM	2003	38.2	-	-

Legend: DHS - Demographic Health Surveys; EDS - Enquetes Démographiques et de Santé (Macro International); MICS - Multiple indicator cluster surveys /, PAPFAM Pan-Arab project for family health /

Source: Population Reference Bureau (PRB), Female genital mutilation/cutting: data and trends, PRB, 2008. Re-elaboration by AIDOS.

/ 4.1 MAJOR DIFFERENCES IN THE DISTRIBUTION OF THE PRACTICE WITHIN EACH COUNTRY /

The national prevalence rate "masks" the big differences there may be inside of each country. FGM/C is indeed a widespread practice that is distributed differently across ethnic groups. In turn, the various ethnic groups tend to focus on different geographical areas inside of each country. When we speak of facts that refer to a specific area of a country, it is important to include and quote the specific data of prevalence of the relevant area and not the national average. This can be clearly seen in the synthetic table below which has been prepared by PRB Population Reference Bureau, in 2008, and taking Senegal as an example (2010 data).

/ TABLE 2. PERCENTAGE OF WOMEN WHO HAVE SUFFERED SOME FORM OF FGM/C BY REGION /

Country	Prevalence in urban areas	Prevalence in rural areas	Prevalence in the region with the lowest rate	Prevalence in the region with the highest rate
Benin	9.3	15.4	0.1	58.8
Burkina Faso	75.1	77.0	44.4	58.8
Cameroun	0.9	2.1	0.0	5.4
Chad	47.0	44.4	3.5	92.2
Ivory Coast	33.9	38.9	12.6	88.0
Egypt	92.2	98.3	71.5	98.0
Eritrea	86.4	90.5	81.5	97.7
Ethiopia	68.5	75.5	27.1	97.3
Gambia	68.5	82.8	44.8	99.0
Ghana	1.7	5.7	0.5	56.1
Djibouti	93.1	95.5	—	—
Guinea	93.9	96.4	86.4	99.8
Guinea-Bissau	39.0	48.2	28.7	92.7
Kenya	21.3	35.8	4.1	98.8
Mali	80.9	87.4	0.9	98.3
Mauritania	64.8	76.8	53.6	97.2
Niger	2.1	2.3	0.1	12.0
Nigeria	28.3	14.0	0.4	56.9
Central African Republic	29.2	40.9	—	—
Senegal	21.7	34.4	1.8	93.8
Sierra Leone	86.4	97.0	80.8	97
Somalia	97.1	98.4	94.4	99.2
Sudan (North)	91.7	88.3	—	—
Tanzania	7.2	17.6	0.8	57.6
Togo	4.1	7.3	1.0	22.7
Uganda	0.2	0.7	0.1	2.4
Yémen	33.1	40.7	—	—

Source : Population Reference Bureau (PRB), Female genital mutilation/cutting: data and trends, PRB, 2008 on data from DHS, the Demographic Health Surveys (IFC Macro International) and MICS –Multiple indicator cluster surveys (Unicef).

/ TABLE 3. PREVALENCE OF FGM/C BY AREA OF RESIDENCE IN SENEGAL 2010 /

Regions	Numbers of women who have been subjected to some forms of FGM/C	Numbers of women who have participated in the Survey
Dakar	20,1	4.078
Ziguinchor	55,5	581
Diourbel	0,5	1.851
Saint-Louis	39,5	1.034
Tambacounda	85,3	725
Kaolack	5,6	1.172
Thiès	3,5	2.030
Louga	3,8	1.130
Fatick	7,3	1.130
Kolda	84,8	640
Matam	87,2	595
Kaffrine	10,3	572
Kédougou	92	115
Sédhiou	86,3	448
Total national	**25,7**	**15.668**

Source : National Agency for Statistics and Demography (NASD), Senegal, ICF International, Demographic and Health Surveys with Multiple indicators in Senegal (DHS-MICS) 2010-2011, NASD and ICF International, Calverton, Maryland, USA, 2012

/ 4.2. ENHANCE THE TREND IN FAVOUR OF THE ABANDONMENT OF FGM/C RECORDED BY DHS DATA /

In order to talk about the abandonment of female genital mutilation/cutting in different countries several data can be useful, especially when comparing the DHS results conducted every 5 or 10 years, we need to take into consideration that:

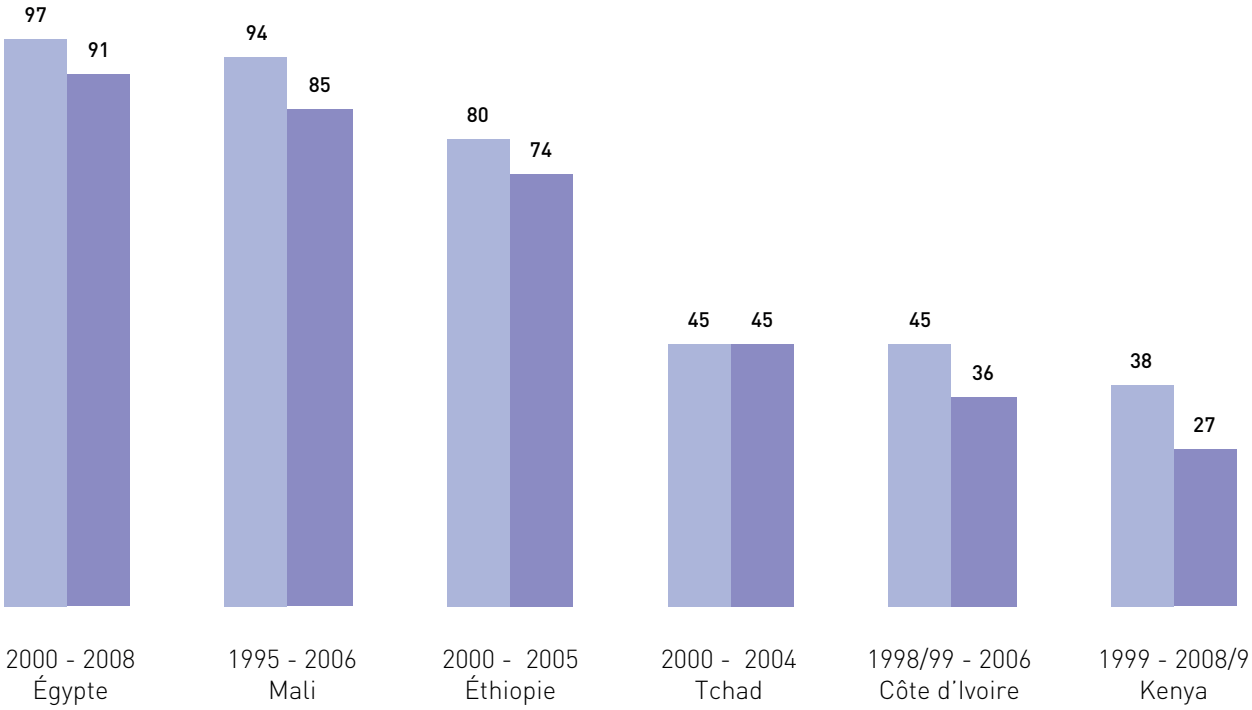
a. The percentage of women who have undergone FGM/C over time
It is possible to calculate it by comparing the data of various DHS or MICS surveys (Unicef's Multiple Indicator which in many countries includes the same DHS indicators) conducted in each country.

It should be noted that the changes that these data records refer to facts that occurred in the past, that is to say at the age where FGM/C is generally practiced in the country concerned. In Kenya for example, where the majority of women are subjected to the practice between 5 and 15 years, the prevalence rate among women between 45 and 49 years, in 2008, refers to an event that occurred 30 to 40 years before, that is to say during the period which generally goes from 1962 to 1978 when they were between 5 and 15 years. Whereas for girls between 15 and 19 years old, in 2008, it refers to an event that would have taken place the year before (or during the ongoing year), or to 10 years before.
In Senegal however, where the practice is generally carried out before the age of 5, girls who in 2010, at the time of the DHS, were aged between 15 and 19 years old are likely to have been subjected - or not subjected to the cut 10 to 15 years before (that is to say between 1995 and 2000). The statistics show a trend that started 10-15 years ago already, and that is likely to continue, leading us to believe that the prevalence should be even lower for girls less than 15 years of age, for which, however, to this date there is no collection of data of this kind.

b. The number of people who have heard of the practice
The data show an increase of knowledge regarding the practice and reflect the level of penetration of information and awareness raising campaigns over time.

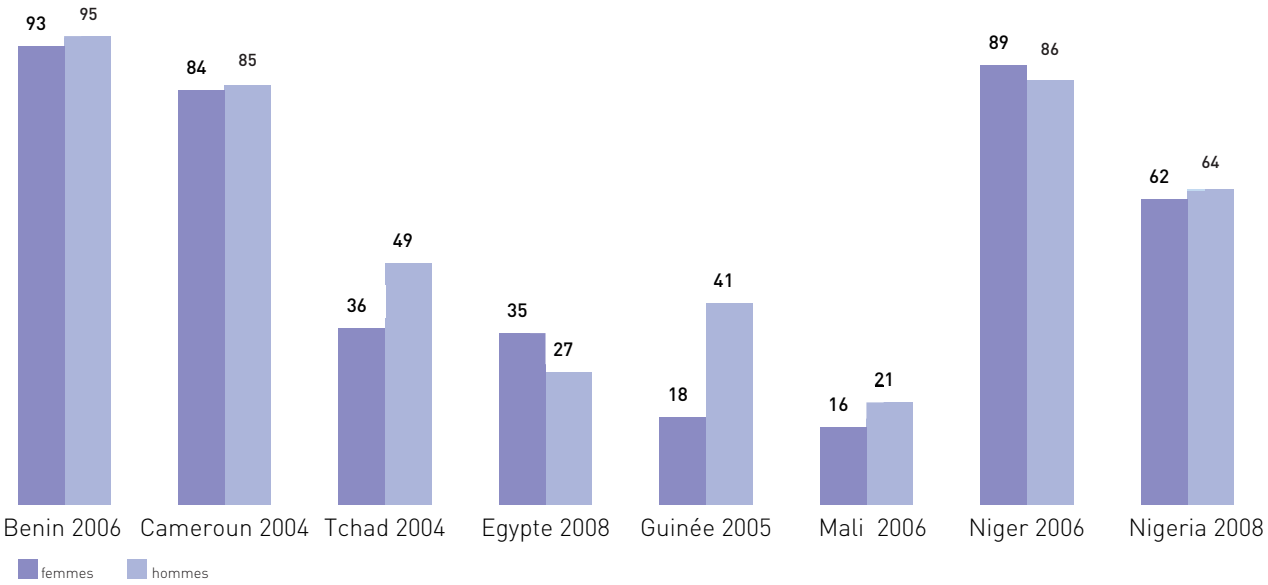
c. The percentage of women and men favourable or contrary to the abandonment of FGM/C
The data shows the transformation of public opinion regarding the perpetuation of the practice. Indeed, often they confirms an increase in the number of people contrary to the practice, although they are not really able to oppose to it, it is a data growing among youth.

/ GRAPH 1. PERCENTAGE OF WOMEN BETWEEN 15 AND 49 YEARS WHO HAVE BEEN SUBJECTED TO SOME FORM OF FGM/C AS TIME GOES BY /



Source: PRB, Population Reference Bureau, Female genital mutilation and cutting: Telling a story with trends, Power point, PRB, 2011

/ GRAPH 2. PERCENTAGE OF WOMEN AND MEN FAVOURABLE TO THE ABANDONMENT OF THE PRACTICE IN DIFFERENT COUNTRIES /



Source: PRB, Population Reference Bureau, Female genital mutilation/cutting: Telling a story with trends, Power point, PRB, 2011

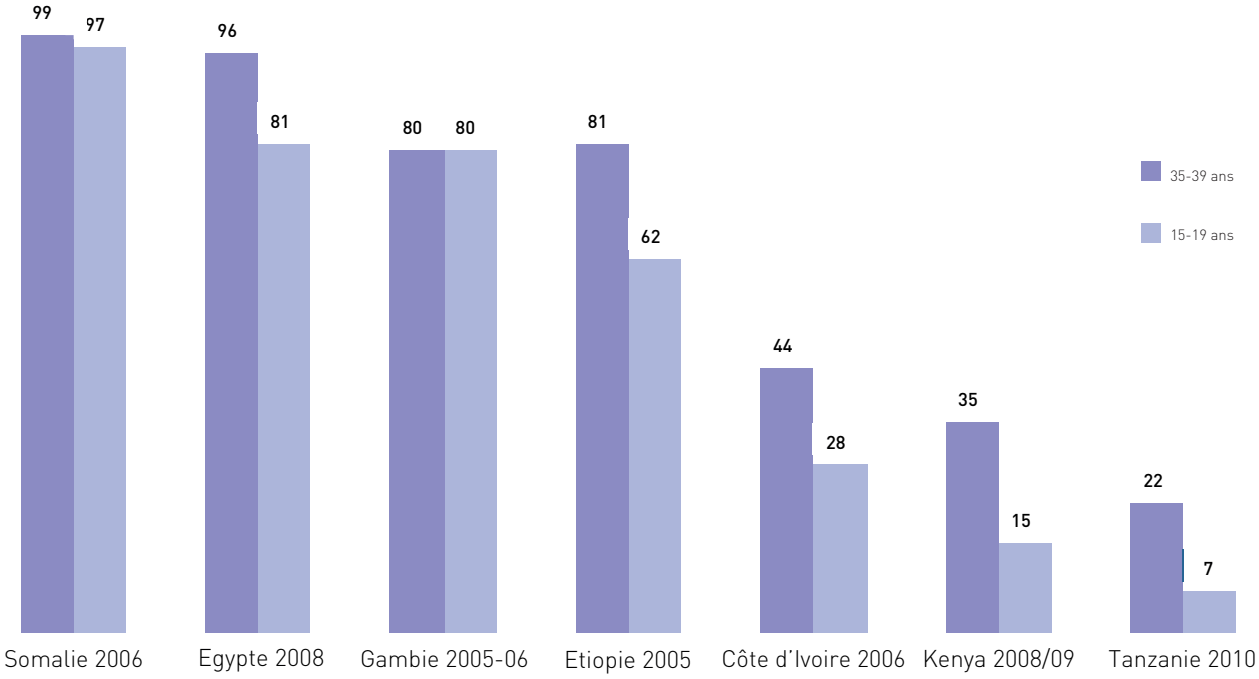
d. The differences between generations
These differences concern both percentages of women who have undergone the practice, which are all at the lowest level in the age group between 15-49 years, a sign that even mothers who have undergone the practice often do not subject their daughters to it , and the percentage of individuals whose opinion with regard to the abandonment or the continuation of the practice, within the younger age segments of the population (the parents of tomorrow), are generally rather widely favourable to its abandonment.

e. The change in the type of FGM/C
The questionnaires commonly used in DHS do not make a distinction between FGM/C Type I and II, according to the WHO classification of 2007, but only if a girl or woman has been cut, if some tissue has been removed, and if the tissues have been knit. Changes in the type of FGM/C incurred suggest a trend towards less severe forms of the practice, thanks also to information and awareness campaigns that over time have highlighted the negative health consequences of the different types of FGM/C. These changes are reflected in qualitative studies where, for instance, women interviewed relate how the hole left by infibulation no longer has to be as small as it used to in the past, when we they were told that it had to be "as large as a grain of millet. "

f. The decline in the age at which FGM/C is carried out
The age at which FGM/C is practiced can vary considerably depending on the ethnic group one belongs to and the country. However, the gradual decline in age is a change that can be seen in many countries, and could also be influenced by the adoption of laws that prohibit the practice, and therefore the requirement to make its execution less "visible", where it is considered a crime.

g. The "medicalisation" of the practice
Gradually changes have occurred in this area too, where FGM/C has been carried out for an increasing number of girls not by a traditional practitioner, but by health workers. This change can be made in relation to different elements: the growth of urban populations, which is "more distant" from the traditional rural context, the effect of health information campaigns, which have increased awareness regarding the immediate risks related to the intervention and that people are trying to avoid by using health workers, and the gradual loss of the collective rituals that used to accompany the practice.

/ GRAPH 3. PERCENTAGE OF WOMEN WHO HAVE SUFFERED SOME FORM OF FGM/C BY AGE AND COUNTRY /



Source: PRB Elaboration – Population Reference Bureau on Demographic and Health Surveys by ICF Macro International ;, Multiple Indicator Cluster Surveys, Unicef, PRB, 2012

5.

/ THE ROLE OF THE LAW IN THE PREVENTION OF FGM/C /

The legislation banning FGM/C is one of the topics to which the media devote the most of their attention. While almost in all African countries and for decades now, female genital mutilation/cutting has been subjected to government interventions and information/awareness raising campaigns, as promoted by civil society and by agencies of the United Nations, it is only in the nineties that governments started using legislative tools to stop the practice. This approach, with some variations, essentially gives rise to the adoption of criminal sanctions against those who perform, promote or encourage FGM/C.

It is time to assess how these measures can integrate more detailed strategies to abandon the practice, analyse legislative approaches which have already been implemented in order to identify ways to optimise existing laws, while promoting and protecting the rights of girls and women. Of the 28 African countries where FGM/C is practiced, 21 have at least one law or a specific norm which refers to the practice. In most cases, they are criminal laws, three of these countries have constitutional provisions and two have laws that protect childhood by prohibiting the practice.

/ TABLE 4. COUNTRIES THAT HAVE ADOPTED NATIONAL LAWS ON FGM/C /

Country	Source of data	% of FGM/C carried out by traditional practitioners	% of FGM/C carried out by health workers	National law
Benin	EDS 2006	99.0	0.6	●
Burkina Faso	MICS 2006	-	-	●
Cameroun	EDS 2004	89.0	4.0	◐
Central African Rep	MICS 2004	-	-	●
Chad	EDS 2004	94.2	2.7	◐
Ivory Coast	MICS 2006	95.2	0.5	●
Djibouti	MICS 2006	-	-	●
Egypt	EDS 2008	66.3	31.9	●
Eritrea	EDS 2002	94.5	0.6	●
Ethiopia	EDS 2005	-	-	●
Gambia	MICS 2005/06	-	-	○

Country	Source of data	% of FGM/C carried out by traditional practitioners	% of FGM/C carried out by health workers	National law
Ghana	MICS 2006	-	-	○
Guinea	EDS 2005	88.7	10.0	●
Guinea-Bissau	MICS 2006	-	-	●
Kenya	EDS 2008/09 [c]	-	-	◐
Mali	EDS 2007	-	-	●
Mauritania	DHS 2006	91.7	2.5	○
Niger	MICS 2007	-	-	◐
Nigeria	EDS 2006	97.0	0.5	●
Nigeria	EDS 2008	73.6	8.9	●
Senegal	EDS 2005	92.5	0.6	○
Sierra Leone	MICS 2006	-	-	●
Somalia	MICS 2006	-	-	○
Tanzania	EDS 2004/05	89.1	2.0	○
Togo	MICS 2006	-	-	●
Uganda	EDS 2006	-	-	●
Yémen	PAPFAM 2003	-	-	●

Caption:

- ● Specific penal laws on FGM/C;
- ◐ General Provisions which can be used to criminalise FGM/C ;
- ○ No law

Source: Population Reference Bureau (PRB),
Female Genital Mutilation/Cutting: Data and Trends. Update 2010, Population Reference Bureau (PRB), 2010.

Some of these measures existed before 1994, the year of the **International Conference on Population and Development held in Cairo**. At this conference, FGM/C aroused keen interest and governments agreed to strengthen, and in some cases adopt, measures to stop the practice. The adoption of the Protocol to the African Charter on Human and Peoples' Rights, on the Rights of Women, in 2003, better known as "**the Maputo Protocol**", has also contributed to the introduction of ad hoc laws, as in Article 5 .

BOX 3.
HUMAN RIGHTS AND FGM/C:
THE MAPUTO PROTOCOL

The Protocol to the African Charter on Human and Peoples' Rights, on the Rights of Women, adopted on the 11th July 2003, during the Second Summit of the African Union in Maputo, Mozambique, introduced ad hoc measures in matters of female discrimination. It comes in addition to the African Charter on Human and Peoples' Rights to promote women's human rights in Africa and ensure the protection of these rights in particular in relation to art. 2 of the Charter which supports a principle of equality without distinction of

any kind in particular regarding race, ethnicity, colour, sex, language, religion, political opinion or any other kind of opinion, of national or social origin, property, birth or any other situation, including marital status; and in relation to art.18 which requires that all State Parties eliminate all forms of discrimination against women and insure the protection of women's rights, such as it is stipulated in international declarations and conventions. This provision is repeated and elaborated more fully in art. 2 of the Protocol. In addition, the Protocol integrates in art. 5 a specific provision for the elimination of harmful practices. Indeed, this article obliges State parties to adopt specific measures to promote the abandonment of FGM/C, including promoting awareness among all sectors of society, its prohibition through legislative measures, provision of support to the victims of MGF/C and protection to girls and women who run the risk of being subjected to the practice.

BOX 4.
HUMAN RIGHTS AND FGM/C: CEDAW

Art.5 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) requires State parties to "take all appropriate measures to modify men and women's socio-cultural behaviour patterns and models in order to eliminate prejudices and customary practices, or any other type, which are based on the idea that one or the other sex is inferior or superior or based on stereotyped roles of men and women."

This article lays the legal foundations to promote the abandonment of FGM/C as it refers explicitly to the duty of all State Parties to eliminate these standards and practices that contribute directly or indirectly to gender inequality and the maintenance of FGM/C. Among others: Low consideration of girls in the family hierarchy, arranged marriages and dowry for the bride, polygamy and acceptance of male extramarital affairs and demanded fidelity of women, and furthermore the gender disparity in all aspects of family and social life often determine whether women/mothers can abandon FGM/C or not.

/ 5.1 PENAL LAW AND FGM/C[16] /

Among the supporters of the laws against FGM/C, few claim that they are sufficient to change individual behaviours. **The effectiveness of such laws depends on several factors**, including the effectiveness of enforcement mechanisms and true political will of the State concerned to stop the practice through the implementation of various support measures.

The penal laws can encourage the abandonment of the practice thanks to the threat of sanctions (imprisonment, fines). In addition, they can act as educational tools, promoting information about the risks associated with the practice of FGM/C. The adoption of a law criminalising FGM/C creates an opportunity for media coverage on the subject and leads people to reflect on the dangers of FGM/C. In the same way, an official condemnation of the practice may bring some people to seek more information.

However, **the penal laws on FGM/C remain difficult to put into practice**, especially in social contexts where there is a widespread support of the practice. This is why their effectiveness is directly proportional to the socio-cultural changes that affect people's perception regarding the role of the practice, the position of women in society, women's rights, and freedom of choice.

Anti-FGM/C laws will probably only have small effects in a legal context where women's rights are not recognised or are downright hindered. By reforming the laws at the national level it is essential that governments change laws that discriminate against women. Constitutions should be expressed unambiguously regarding the guarantee of equality between men and women, and the protection of the rights of minors, women and girls against these harmful practices. Governments should not only eliminate formal discriminations in their constitutions and other national laws, but more widely, they should take measures to promote women's rights. Women will not be able to abandon the practice of FGM/C if they don't have information, concrete advantages and capacities to enable them to do so.

Since African **customary law** often defines issues such as marriage and inheritance, the refusal of a government to enforce the equality of women to customary law, can contribute to relegate them to a subordinate position.[17] In turn, the condition of women's inferiority increases their inability to oppose to the practice of FGM/C. In relation to the aspects that influence individual rights, national constitutions should assert their supremacy on customary and religious law. To date several explicit statements in favour of the supremacy of the Constitution on the customary and religious law and the guarantee of individual rights are included in various constitutions, including that of Ethiopia, Eritrea, Gambia , Ghana, Niger, Nigeria and Uganda.

In countries where FGM/C is an eligibility criterion to marriage, and where marriages are arranged by families when the girls are very young, for girls and women whose financial security depends on marriage, it is more difficult to escape from the practice. Governments should **adopt measures that allow women to improve their social**, economical and political status, including measures about equal opportunities regarding access to education,

employment, public services and enable them to participate actively in social life.

A law against FGM/C can prove to be effective only if the harmful effects of the practice are recognised as such by the community. In communities based on family ties, it is difficult to change individual behaviours without changing the community beforehand. In such a context, using the law to contrast the demands of parents or community members, **could give rise to social and economic implications** which would be more serious for the person who opposes the practice than for the one who tries to impose it.

In some countries **the mechanisms to implement the law are weak** and have inadequate resources. In places where FGM/C is widespread and supported by the majority of the population, cases brought to justice are rare. It is those who are responsible for law enforcement who must investigate and verify the execution of the practice, but the logistical difficulties that relate to this kind of investigation, especially in rural areas, are obvious. The introduction of penal sanctions which are not being applied, may lead to contempt of the law itself and more widely to all applicable laws. And after a criminalisation of FGM/C, the practice tends to "disappear" underground.

It is therefore essential to promote a broader government strategy that involves information and awareness raising programs in relation to individual behaviour and social standards to accompany criminal measures and make sure they really act as tools of prevention of the practice.

BOX 5.
PROHIBITION OF FEMALE GENITAL MUTILATION IN AFRICA: A TEST BENCH FOR THE AFRICAN REGIONAL SYSTEM FOR THE PROTECTION OF HUMAN RIGHTS

In 2008, the World Health Organisation and other United Nations Organisations issued an Inter-institutional Statement that detailed the necessary efforts in order to reduce - and in the long term eliminate - the practice of FGM in the world. Although progress has been made since these same partners highlighted the prevalence of FGM in 1997, the practice is still incredibly widespread, especially in Africa. According to an estimate of the Same statement, in the continent more than 91 million women and girls over 9 years have undergone FGM often causing severe psychological and health consequences. Each year, always on the African level, 3 million girls are likely to suffer the same fate.

Opposition to FGM/C in Africa can be read in the legal instruments of the founding regional system for the protection of human rights. Both **the African Charter on Human and Peoples' Rights (Banjul Charter) and its Protocol on Women's Rights (Maputo Protocol)** highlighted the promotion and protection of women's rights. The African Charter on the Rights and Welfare of the Child (ACRWC) can also be helpful to the opponents of FGM/C since the practice is essentially performed on minors. However, the most explicit and precise language on this subject is in the art 5. of the Maputo Protocol, which requires that 28 state parties to the Protocol to prohibit "all forms of FGM" thanks to legislative measures with sanctions.

Although the word "sanction", whether criminal or not, is subject to interpretation, art. 5 is quite clear about the measures that State Parties must adopt. Art. 5 puts in the forefront both the capacity of State Parties to adopt and implement legislative measures consistent with regional objectives in matters of human rights that could go against rooted customary practices, and the actual capacity of African institutions for the protection of human rights to control and punish states violating their international obligations.

Of the 28 State Parties to the Maputo Protocol, twelve have criminalised FGM either before or after its ratification. However, in many of these countries, the legal prohibition has had little or no effect on the continuation of the practice. For example, Burkina Faso, Djibouti and Mauritania all adopt legislative measures prohibiting FGM, yet the UN Inter-institutional Stetement of 2008 indicates that in each of these countries, at least 70 percent of girls and women aged 15 to 49 years have undergone FGM. This figure rises to 93 percent in Djibouti, which however criminalised the practice well before the adoption of the Protocol that is to say in 1994. Among the African countries analysed, the average percentage is 54 percent. While in countries where FGM/C has been criminalised, supporters of the ban of the practice apparently win over the political opposition, these legislative measures have not really been applied in the communities where FGM/C is still part of tradition, of community identity and femininity.

In fact, the States adopts legislative measures primarily to satisfy the international community and to comply with international instruments of human rights, but they do not have a real desire to implement these provisions. The success seems to depend not only on the ability of State Parties to enact laws, but also on their ability - and political will - to implement and thus prevail over the intransigent communities. For these states FGM/c becomes a kind of a test bench on concrete measures to be adopted to accelerate the achievement of these regional objectives in matters of human rights, which seriously threaten the well-rooted social conventions in local communities.

For other State Parties to the Protocol, there is not enough political will among governments to pass legislative measures. In Gambia, for example, where the rate of FGM among women aged 15-49 amounts to 73.3 percent - the government seems annoyed by, or even intolerant of the campaigns for the abandonment

of FGM. In places where State Parties do not make any efforts to meet their commitments in matters of human rights, such as those prescribed by Art. 5, it is the African institutions for the protection of human rights which necessarily are invested and which must find the means to enforce these obligations.

In 1999, the African Commission on Human and Peoples Rights appointed the first Special Rapporteur on the Rights of Women in Africa in charge of, among other things, to monitor the efforts made by State Parties in the implementation of the Banjul Charter and the Maputo Protocol. As part of its management mechanism and the scope of its mandate, the Special Rapporteur's office can perform both promotional projects and field visits to collect and report information on the situation of women's rights in the countries concerned and make recommendations to the Commission. Nevertheless, although the office remains the main mechanism at the disposal of the Commission to control the efforts of States in matters of integration of international obligations in domestic law, it has no real tool to sanction countries that do not meet their commitments. Worse, the recommendations that the Commission adopts following a complaint by individuals or NGOs are generally not regarded as legally coercive.

On the other hand, according to article.27 of the Maputo Protocol, the new African Court of Human and Peoples' Rights is "competent to hear disputes related to the interpretation (of the Protocol), arising from its application or its implementation ". However, although a complaint about a presumed violation of Art .5 can theoretically be submitted to the Court, it should not be based on a violation regarding a case of FGM in a given country, but rather the inability of the state's government to adopt legislative measures prohibiting the practice. The text is, however, not clear as to who can sue, that is to say which entity is able to demonstrate that it was aggrieved by the inability of the state to legislate on the subject. In the same way, there is no clarity as to what measures should be taken to implement the decisions of the Court even if they are legally coercive.

As it is the case with other pressing human rights issues in Africa, efforts to reduce and eliminate the term FGM should focus on two fronts. First, the states that meet their commitments should convey the regional standards in matters of human rights in communities that have deep opposite beliefs. Art.5, in this sense, requires states to implement campaigns and programs of information and awareness addressed to all sectors of society together with legislative measures that ban the practice. The inter-institutional declaration of 2008 suggests that the practice falls particularly in States that do not only focus on punishment but also on prevention. This dual approach has already borne fruit in the State Parties such as Senegal, where efforts to inform practitioners about the adverse consequences of FGM have led more than 4,200 communities to abandon the practice by 2010.

Secondly, at the regional level, African institutions for the protection of human rights must continue their work, despite their limitations, to ensure that the State parties gradually move towards compliance with the commitments they have voluntarily undertaken by ratifying legal regional instruments. Until these institutions find a more effective way of making sure that the States respect their international commitments, it is unlikely that norms forbidding harmful traditional practices such as FGM will reach the affected communities.

By Christopher Tansey
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6.

/ FGM/C AND SEXUAL AND REPRODUCTIVE HEALTH /

Informing about the consequences that FGM/C can have on health has been a key strategy of the first campaigns to promote the abandonment of the practice. Often, in fact, **women do not relate a health issue which manifests itself in adulthood with an event that caused a change to the body in childhood.** Female genital mutilation/cutting can indeed lead to serious health consequences, immediate as well as long term. These consequences depend on the extent and type of intervention carried out, the skill of the practitioner, the hygienic conditions under which the act is carried out and the healthiness of the girl at the time of intervention.

It is important to note that **these consequences may never occur in many women who have been subjected to the least severe form of FGM/C**, that is to say clitoridectomy, while there is no doubt they will manifest in women who were subjected to the most severe form of FGM/C, that is to say infibulation. Female genital mutilation/cutting may promote sexual infections, especially in cases where the vaginal opening has been reduced by suturing the *labia majora* and *minora*. In addition, the reduction of the vaginal opening and the presence of scars in the suture can prevent a satisfactory gynecological examination without prior incision. It can prevent, for example, the introduction of the speculum in order to do a pap smear for cervical cancer screening of the cervix, or the insertion of an intrauterine device. This is another reason to promote the abandonment of the practice.

/ 6.1 PREGNANCY AND BIRTH /

Having suffered from female genital mutilation/cutting does not lead to any particular consequences on pregnancy but it does on giving birth. Indeed, labour in **childbirth** can be excessively long, and can cause severe lesions in the vulva or downright an obstetric fistula, that is to say a hole between the vagina and the bladder or between the vagina and the rectum. Giving birth to a child when the vulva has been modified through an intervention that caused very rigid scar tissues, and in the case of infibulation, also very extended, involves more risk for the mother and the unborn child because at the time of delivery, the opening of the vulva does not expand as it should to let the baby out.

Deinfibulation, that is to say the procedure to re-open the orifice after it has been stitched or narrowed, allows natural childbirth that African women generally prefer. The intervention must be done a few months before delivery to allow proper healing of the reconstructed vaginal opening. **Deinfibulation implies, in any case, a change in the shape of the external genitalia**, a part with a non-natural shape, since there are not the typical curves and folds like in an intact female sex. But above all a shape that does not coincide with the one - modified in childhood - that women are accustomed to see and that they consider aesthetically more attractive. They will have to get used to this new shape, a process which could also influence the sexual relationship with the husband, who has known and loved his wife's body as it was, that is to say modified. "Is he going to like me like this?" This is the question asked by women with a certain anxiety. A dilemma with which they should not be left alone.

In the case where a deinfibulation is not possible and there are childbirth complications in the delivery of the child, that is to say when the dilatation is insufficient to enable the baby to come out, there are two main solutions for people who practice birth: an episiotomy, that is to say to cut the perineum from the vulvar ring to facilitate the release, or perform a **caesarean section**.

In countries where infibulation is widespread it often happens that after giving birth where the tears occurred or when they have had an episiotomy, women often require to "be closed up", this intervention is called the reinfibulation procedure. To restore the external appearance of the genital as it was after infibulation, for fear of not being sexually attractive to their husbands anymore, who in polygamous countries could therefore seek other wives. In countries where FGM/C is defended by the law, infibulation too is not authorised.

BOX 6.
THE CONSEQUENCES OF FGM/C FOR THE HEALTH OF WOMEN AND GIRLS

Immediate consequences

- **Haemorrhage** which may cause long term anaemia if it is not dealt with immediately. The extent of bleeding and infection can cause death by bleeding, for example if the artery in the groin is cut.
- **Shock** which may be due to blood loss or extreme pain.

- **Infections**, due to the lack of instruments sterilisation, poor hygiene conditions in the environment where the intervention is carried out, a possible urination and/or defecation on the wound, especially when the legs are immobilised in particular after infibulations, or due to the application of certain traditional ointments on wounds.

- **Urine retention**, common especially when the skin is sewn above the urethra. Additionally, urination can be painful because of the inflammation of the wound. This complication can lead to an infection of the urinary tract.

- **Injury to adjacent tissues** such as the urethra, the vagina, the rectum and the perineum.

- **Tetanus**, due to the use of non-sterilised instruments. In addition, FGM/C can contribute to the spread of HIV when one blade is used on several girls, of whom one is HIV positive.

Long-term consequences

- **Urine retention** which in the long term, can lead to incontinence and infections in the urinary tract.

- **Chronic pelvic infections**, which are common in women who have been infibulated since the partial closure of the vagina and urethra increases the likelihood of infection.

- **Infertility**, due to pelvic infection.

- **Keloids**, which are painful cysts and thick scars that can reduce the vaginal opening.

- **Dermoid cysts** which can give rise to tumours.

- **Clitoral neuroma** can appear when the clitoral nerve is trapped in a suture or a scar, causing hypersensitivity and dyspareunia of the genital area.

- **Stones** which may form as a result of menstrual debris accumulation and urinary deposits in the vagina or in the area near the scar tissue resulting from infibulation.

- **Fistulas** which are holes that form between the vagina and the bladder or rectum, and lead to chronic incontinence. Urinary or fecal incontinence can last a lifetime and can have serious social consequences such as remoteness.

- **Dyspareunia** (painful intercourse) is a consequence of many forms of excision due to scarring or narrowing of the vaginal opening and complications such as infections. Vaginal penetration can be difficult or impossible, and re-incision may be necessary. The lesions of the vulva area and repeated vigorous sex can cause vaginismus, which leads to sexual dysfunction for both partners.

- **Complications during pregnancy and childbirth** because of hardened scar tissue that causes partial or total occlusion of the vaginal opening. These complications can cause tearing of the perineum, haemorrhage, the formation of a rectovesical and/or vagina fistula, and uterine rupture. Genital prolapse of the uterus may occur subsequently. These complications can lead to neonatal problems (including stillbirth) and maternal death.

Sexual and psychological problems

- **Sexual problems:** frigidity, no orgasms due to the removal of the clitoris; difficulties during penetration due to the occlusion of the vaginal opening;

- **Psychological problems:** stress behaviour disorders, psychosomatic illnesses, anxiety, depression, nightmares, psychosis.

/ 6.2 SEXUALITY AND FGM/C /

The first periods are a mystery for the majority of girls because they are usually kept in the dark about how the female body works. The periods mark the beginning of fertility and the "risk of pregnancy" in case of sexual intercourse. It is a risk that has traditionally believed to be controlled thanks to the practice of FGM/C, since the **cutting of the clitoris at a young age should prevent any sexual genital experience of the girl**, including masturbation, and therefore any knowledge of sexual pleasure.

All this happens when the body of the girl has a hormonal upheaval that will transform the girl into a woman. It is as if in the body of the girl there were two opposing forces facing each other, at the level of the senses and at the level of the soul: on the one hand an explosion of senses and the emergence of attraction for the opposite sex; on the other hand the cutting of the clitoris, the experience of pain, and the teaching of "modesty" which brings the girl to not show her sexual desire or any kind of pleasure experienced in order to be "proper". Virginity until marriage and fidelity during marriage are conditions that contribute significantly to ensuring a future to women: it is not just about becoming a mother, but also about providing financial support and an essential social status to survive and to have a minimum of autonomy within the family and community dynamics.

But the traditional educational model generally ensures that regarding their sexuality, young girls learn to **perceive their role as being passively subject** to the male desire, subordinate to his decisions. So much so that girls often accept or undergo sex without really having chosen to. This educational model opposes itself to the evolution of customs that

is underway thanks to the **promotion of the equality between men and women** and to different behavioural models that the media conveys. These are models that give a picture of girls and women who are able to make decisions, who behave as equals when facing their partners and are therefore able to choose in complete awareness when it comes to their sexuality.

Moreover, today, **sexual pleasure is recognised as a natural experience linked to both the physical and mental wellness of the individual, whether man or woman**. The experience of sexual pleasure is therefore an integral part of how sexual and reproductive health is regarded, according to the Programme of Action of the International Conference on Population and Development (Cairo, 1994), as "a state of general well being, both physical and mental "and not just as an absence of disease or infirmity."

An increasing number of **men recognise that sharing sexual pleasure with their partner is an essential element of the well being of the couple**. They are therefore on the side of those who want to end the practice, and recognise that limiting the experience of sexual pleasure in women is not necessarily a "pledge of loyalty" as one used to say.

/ 6.3 RECLAIMING THE ABILITY TO FEEL PLEASURE: DEINFIBULATION AND RECONSTRUCTION OF THE CLITORIS /

Deinfibulation and the **reconstruction of the clitoris**, which started in France with Dr. Pierre Foldes and also practiced in some African countries, for instance in Burkina Faso, are interventions which are chosen by women, generally, to improve their sexuality. In the first case, it is to facilitate the penetration of the penis into the vagina by limiting the pain that involves penetration when the vaginal opening has been particularly reduced by infibulation and the scarred tissues have become very rigid, taking care to rebuild the outer part of the genitals so as to avoid a genital prolapse. This intervention is essential at the time of delivery to facilitate the **passage** of the child without causing wounds that can cause severe haemorrhage and/or obstetric fistulas. In the second case, it is a procedure that involves the recovery of the "body of the clitoris," which continues to develop under the skin despite the fact that the upper part was cut during childhood, and which can be freed and moved forward to recreate the tip of the clitoris. This intervention can enhance the sensitivity which is needed for a more fulfilling sex life.

/ 6.4 FGM/C VERSUS VAGINAL SURGERY /

It is possible to hear people defending the practice of FGM/C based on the fact that it is a form of **vaginal plastic surgery**. It would therefore be an intervention that would **no more no less be comparable to cosmetic surgery** and respond to a desire to improve one part of the body such as the face or breasts, following the fashion of interventions which are more and more widespread in the West. However, these vaginal surgery interventions, when they are done for aesthetic reasons, cannot be assimilated to FGM/C as they are acts chosen by adults, generally people who are knowledgeable about the possible consequences of the intervention, they are people acting in full consciousness, though certainly influenced by prevailing models of beauty that make "youth" and seduction elements to preserve at all costs.

In the case of FGM/C, it is a practice where the girl has virtually no possibility of opposing herself to it: generally she does not know exactly what is done, she has no idea of the pain she will experience if the intervention is practiced without anaesthesia (which is often the case), and she also lacks information on the possible effects of the practice over time, both in terms of sexuality as in terms of health. It is for this reason that FGM/C is internationally regarded as a violation of the rights of girls and women and as a form of gender violence.

However, the clitoral reconstruction technique, developed in France by Dr. Pierre Foldes, where deinfibulation and reconstruction of the vagina of women who have undergone infibulation to facilitate intercourse, to reduce pains associated with scarring and facilitate deliveries, can be assimilated with restorative surgery and non-aestetic vaginal surgery.

7.

/ FGM/C: CHANGING SOCIAL NORM STANDARDS /

In 2003, in an essay written for the Afro-Arab Expert consultation on Legal Tools for the prevention of female genital mutilation, organised by AIDOS and NPWJ in Cairo, 21-23 June 2003[18], Nahid Toubia asks the question "Why is FGM/C such a strongly upheld 'traditional practice' and is it in fact 'harmful' or useful to women?"

And she answered by making the following Hypothesis:

1. Women use FGM/C as a power gaining. 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.

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

3. shifting women's power base will be ineffective (and may be detrimental) unless community support and consensus is built around them.

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.)

This goes in the same direction as, for example, the approach adopted by the NGO Tostan because it involves entire villages in literacy classes and citizenship law which are targeted for the adoption of a public declaration for the abandonment of Female genital mutilation and early marriages. The first public statement concerned a single village, Malicounda Bambara, in 1995. But the local Imam noticed that in the process of abandoning the practice, if you do not involve the villages where girls were expected to marry, then they might remain unmarried, or be anyway subjected to FGM/C under the pressure of step-mothers.

It has been well recognized that FGM/C worked like a social convention [19], which continued to be perpetrated because, in a context where the majority of girls are subjected to the practice and where women believe that men will not want to marry uncircumcised women and where men are convinced that an uncircumcised woman will never be a faithful wife, the practice is an essential requirement of eligibility for marriage.

But there is more than that behind the perpetuation of FGM/C. According to a study conducted over three years in three different areas astride between Senegal and Gambia (similar in terms of ethnic composition, language and cultural practices), supported, among others by the UNDP / UNFPA / WHO /World Bank Special Program of Research, Development and Training in Human Reproduction [20], only 34 percent of women interviewed were in agreement with the statement that "an uncircumcised girl has more chances to find a good husband," and only 28 percent were in agreement with the statement that "a girl who is not circumcised will have difficulty in finding a husband," while 51 percent agree with the statement that " female circumcision helps girls to stay virgins until marriage. "

What emerges from this study, and which brings us back to the statement of the Sudanese Nahid Toubia is **the role played by FGM/C to ensure women's access to social capital**, as Bettina Shell-Duncan, Coordinator of the study, explains: "the concept of social capital refers to resources anchored in a person's social network that he may have access to by adhering to this network or thanks to specific relations." And she adds: "In the socio economic conditions of Senegambia, where poverty is widespread, with frequent crises, and limited opportunities, adults rely heavily on social networks to access resources and opportunities in several areas [...] If everyone being circumcised means increasing the probability that two individuals form a social connection (the currency of social capital), then circumcision becomes a viable strategy to access capital. These 'ready-made' connections can be particularly useful for young women, who, after their wedding, have to face the prospect of their original social relations coming second and have to rebuild their social capital within their new marital home."

Mothers know it thanks to their own experience as young wives. They know the mechanism of derision and stigma which is associated with non excised girls and which makes their lives hell, especially in the context of polygamous marriages where other wives are circumcised. This is why they continue to subject their daughters to FGM/C. "Focusing on what circumcised women have in common and what uncircumcised women are lacking, can facilitate the formation of social relations between circumcised women, allowing them to maximize the value of their circumcised status." Relationships among women are an essential element of female social capital. And they are not exempt from internal power dynamics, or rather intergenerational ones, especially in social contexts which are highly ranked according to age, that is to say in many African contexts, not only in Western Africa, as highlighted by the study and the report

on the project implemented in the south of Senegal by an organization, who with reason, is called the Grandmother project[21]. It is through the involvement of grandmothers, intergenerational forums involving all kinds of social actors, the rediscovery and promotion of positive traditions such as stories, dances, poems, and songs that the Grandmother project is going to contribute to the abandonment of FGM/C in rural communities of Kandia (Senegal).

FGM/C, perpetrated between women, especially older women on younger women, thus also serves **to consolidate the power of older women over younger women, and thus keeps the social structure of gender distribution.** On this subject, Shell-Duncan explains: "... in order to access the women's network, young women offer their obedience and deference to older women of the network, thereby increasing the power and status of the elders [...]. Female circumcision is, in this sense, a sign that the girls were raised in the art of submission to their husband, brothers of the husband, but more importantly, to their future mothers in law. "

In a society which has undergone significant changes due to modernization and globalization, the collective ceremony but also the learning period of feminine subordination has been lost. In the past, the ceremony was carried out in "the forest", that is to say in a remote area, where for several weeks or even months, while the wound healed, older women taught the younger women how they should behave within a couple and as a family. Today, **all that remains is the cutting**, that is to say the symbol, which is most often carried out individually and the age in which it is carried out is getting lower and lower, both to reduce the traumatic experience of suffering, and to potentially escape from legal sanctions.

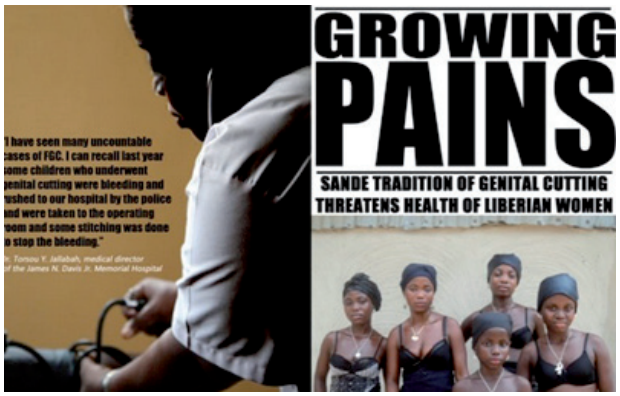
FGM/C is therefore perpetuated in an "intergenerational peer convention" whose mechanism is perpetuated from generation to generation and as long as small girls become young girls, women, mothers, older women, and grandmothers. "To access a social network of peer women, girls and young women show their subordination to older women in the community. This allows young women to extend their capital and in turn benefit from the deference and obedience of younger women, allowing them to gain power within the community. In order to access a network, young women use circumcision and thus show their willingness to participate in the hierarchy of power."

These power dynamics and feminine solidarity have already been highlighted by another researcher, Fuambai Ahmadu from Sierra Leone[22], in Sierra Leone, where FGM/C is carried out in secret societies - the Bundu, a secret society of Kono women, which Ahmadu decided to join as an adult, despite having been raised and educated in the United States. They are societies with a strong cultural connotation which keep a significant link with the traditional spiritual heritage, and in particular, that play an important role in a social context where gender roles are well defined both for men and for women. But even in Sierra Leone things are changing. And the media, as is related by the journalist Mae Azango's experience in Liberia, another country where FGM/C is practiced in women's secret societies, can play a leading role.

BOX 7.
IN LIBERIA THE REPORTER MAE AZANGO MOVES A NATION

By Peter Nkanga / CPJ Africa Program

The story of the courageous Liberian journalist Mae Azango, which feeds an international polemic and is subject to threats, has eventually forced the government to take a public stand on the dangerous ritual. For the first time, Liberian authorities have declared that they want to do away with female genital mutilation, a traditional practice perpetrated for generations. The ritual, which involves the partial or total cutting of the clitoris, is carried out by the secret society of Sande women. According to recent estimates, at least two out of three Liberian girls in 10 of 16 tribes present in Liberia are subjected to the practice.



The story that triggered the polemic forced the government to take a stand.

Last week during an interview with "The World" on Public Radio International, the Minister of Gender and Development, Julia Duncan Cassell announced "The Government said." This must stop." The Minister was responding to the controversy sparked by an article written by Mrs. Azango, published on March 8 by the largest independent newspaper in Liberia FrontPage Africa. The story, entitled "Growing Pains: the Sande tradition of genital cutting is threatening the health of Liberian women.", described the practices of the Sande secret society.

But the tenacity of Mrs. Azango came at a price: the affiliates of the Sande secret society violently threatened the journalist. Mrs. Azango and her 9 year old girl have been forced into hiding.

In a pretty interesting way, the Liberian government had discreetly taken position against female genital mutilation a few months ago. In a letter dated December 9, 2011, the Delegate Minister in charge of Culture at the Home Office, Joseph Junger, demanded that the activities of the Sande society cease before the end of the year after. The decision apparently goes back to a ceremony which took place in November 2011 where the land of the Sande society used for ritual had been transfered to the leaders of the Poro secret society of men. President Ellen Johnson Sirleaf and many other powerful spiritual leaders attended the ceremony.

Nevertheless, the government's position is neither coercive nor permanent. According to a declaration by Mr. Junger, in an interview with FrontPage Africa "There is no fixed due date" as regards to the demand of the cessation of the activities of the Sande society, "It could take three years, four years or even 10 years."

And of course the Liberians were not informed as to the government's position. That is to say before Mrs. Azango's story started to feed the polemic both on a national and international level and pushed the government to pronounce itself openly. "We were not aware. No journalist was." Mrs. Azango declared today to CPJ. Even President Sirleaf's spokesman Jerelinmik Piah, said he was not aware of the existence of the measures taken to stop the activities of the Sande society.

Mrs. Azango was slightly skeptic about the government's public stance. She announced today to CPJ that: "The application (of these actions) is a problem. It is still being practiced as we speak." She said the government must prove that its announcement is not just a public relations exercise. And she adds, "They have done this just to respond to the pressure put on them, the polemic was huge, they had to say something."

CPJ has contributed to the internationalization of this local case and rallied the people who ask that Liberian authorities protect Mrs. Azango through a news alert, an advocacy in international institutions such as the United Nations Mission in Liberia, as well as a social media campaign with the hashtag #MaeAzango. CPJ continues in this direction with a letter addressed to President Sirleaf - the first African woman at the head of a state, who won a Nobel Prize for her work regarding women's rights - urging her to use her moral authority and political leadership to ensure the safety of Mrs. Azango. Amnesty International has also launched an international call to the Liberian government to act. The Company of Professional Journalists through the Columbia University Graduate School of Journalism responded with a letter addressed to Mrs.Sirleaf declaring "we do not turn a blind eye on members of families threatened to death" referring to Mrs. Azango who writes for NEW Narratives, a journalism project implemented by former students of the school. The pressure on the Liberian authorities has risen thanks to the response to the event by international press and the attention given to it by social media generated by the columnist Nicholas Kristof from the New York Times.

Initially, according to local journalists, Liberian authorities appeared dismissive regarding the threats Mrs. Azango received, with the spokesman of Mr. Piah's government who accused international groups of trying to "dictate" the actions to be taken by governement. Under pressure, the Liberian Information Minister finally published a public statement to the press declaring "the Government of Liberia's is paying serious attention to the death threats addressed to a Liberian journalist." Signed by the Press Secretary, Isaac Jackson, the statement added "all necessary precautions measures have been implemented to ensure that all those associated with the report are in security."

Today, Mrs. Azango told CPJ that she was able to move around more freely but she was still in the process of assessing the situation because her security is still not assured. The journalist, who in November won a grant from the Pulitzer Center based in the U.S. in order to make reports on topics related to health and reproductive rights, remains unwavering. Keeping a low profile, she continues to work on FGM/C.

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Source: http://cpj.org/blog/2012/04/in-liberia-journalist-mae-azango-moves-a-nation.php

8.

/ RELATE THE CHANGE /

Quotes and **interviews**, that is to say quoted words reported by the journalist in articles or stories, are central to the work of the media. The journalist tells the facts. The words of those who lived, or the opinions of those affected by these facts are essential to build the narrative.

This also applies for female genital mutilation/cutting. If we look at the press review available on the www.stopfgmc.org portal, we discover that a lot of articles talk about public figures - political representatives, activists, experts - who support the abandonment of the practice. These are items that show the extent of the changes that are underway, especially on the political level, seeing as they show the commitment of institutions and civil society which are prepared to promote the abandonment of the practice.

Some of these articles **give voice to people who have undergone some form of FGM/C**: it is often the most effective testimony, although they provide a picture of women as victims, while everyday life is made of all kinds of women, women who do not remember the practice because they experienced it when they were newborn, women who have not undergone the practice but who go through similar problems of women who have suffered from it. Their voices are rarely heard.

Very few articles **give voice to those who have abandoned the practice**, who talk about the steps they had to go through to make that choice, what motivated them, and how they responded to possible objections. When they tell their story, they often prefer to talk about a dramatic event which influenced their choice: the death of a young girl, a sister's suffering.

A very beautiful story along those lines is the film Moolaadé by the famous Senegalese film director Ousmane Sembène, a fictional story based on actual or possible facts, which tells the story of a community's process of abandoning the practice and how their decision was influenced by a dramatic fact. In this fiction Mr. Sembène highlights the role of the media, especially the one of the radio. The film is effective not only for the information it provides on FGM/C (for instance that the practice is not prescribed by the Koran), but also because it gives an overview of awareness in relation to women's rights, the opportunities and the changes taking place and the role of the media, especially the role of the radio. In addition, it broadens the mind and creates new affiliations (and not only among women). Whoever has attended public screenings of Moolaadé talks about the discussions it generates, active public participation, identification with the characters, the issues it raises and the courage it gives to those who still hesitate regarding the abandonment of the practice.

Giving voice to agents of change, that is to say to mothers, fathers, grandmothers, aunts, and families who are about to abandon the practice, is a winning strategy to build a "critical mass" which - according to social sciences enables a social norm to change.

/ 8.1 WHOM TO INTERVIEW?[23] /

The interview can be done with an ordinary person, a particular witness or an expert on the issue. There are many ways to prepare an interview, and each author or reporter has her/his own way and her/his own style. Here are some suggestions to enhance the role of the media in promoting the abandonment of FGM/C.

a. The voices "from the streets"

The voice on the streets is widely used in journalism. We can thus collect impressions and opinions expressed by people meeting in the street for a general vision of "what people think" of the practice. The usefulness of this kind of interview varies according to the type of report one will do (for TV, radio, press, etc...).

Generally the people you meet on the street have other things to do and are thinking about their personal problems. They find themselves facing a microphone which is often quite large and intimidating. The first thing that comes to mind is that their response will be heard - and seen in the case of television - by several people, and this impression can condition their response. In this case, the sample recorded may not be helpful to understand "what people think". However, these interviews can prove to be valuable if one interviewee provides a clear and simple reflection or shows inconsistency or a contradiction regarding the state of affairs. This voice could be the start of a new research path.

b. The "key informers"

Interviews with key informers are very important. The informer is a person who was, at some point in his life, directly affected by the subject that interests us, whose direct experience is the most important element, with all the emotions that may follow. It could be a woman who has suffered some form of FGM/C, but also a father who rescued his daughter from the practice, a health care professional who did not manage to save

a woman or a baby whose birth was difficult because of infibulation, a judge who decided the fate of a woman who carried out excisions on women and who was respected in her community, a young man who had to abandon the girl he dreamed of marrying as his family opposed to the marriage because of different traditions ...

To work in the best conditions, we must **gain the confidence of the informer**. If, for example, we have the opportunity to interview a person who carries out excisions in a village, it is preferable to present the interview as a "report on the practice", avoiding the use of words such as "mutilation" and replacing them with "female circumcision" or "excision" or any other term used to describe the practice in this specific cultural context. There are several techniques to prepare an interview. A basic rule is **to study the problem well before, without however programming the whole content of the interview**. Thus, we can start the conversation without prejudices and without taking a personal position.

When you interview a key informer, for example a woman who has lost her daughter because of the practice, we often find ourselves facing sharp pain. We must make sure we treat the pain of this person with **extreme delicacy**, **attention** and **meticulousness**, such a surgeon with the open wound of a patient.

Each author is in everyday life, an individual with a personal history, opinions and points of view. When carrying out an interview with a key informant, we have **to forget all our personal considerations**. Our goal is to describe the reality from the perspective of the interviewee: if we add our thoughts to those of the person interviewed, we cannot achieve this goal. We must accept the fact that **everything a key informant tells us and shares with us is true and as legitimate** as any other testimony, even if we do not share his opinion. When reality is described, there is no hierarchy: no right or wrong, no one has more the right to speak than another. If we want to collect a testimony that is free of external influences, we must never forget this principle.

An interview should be prepared step by step. It may also be useful to involve a friend of the key informant to make her/him feel more comfortable.

If we have studied the problem, our questions will be more spontaneous and can result from a answer from the interviewee. This will give more confidence to the person who will feel heard and useful, s/he will therefore feel like an integral part of the project rather than just like the person interviewed. We must therefore be prepared for surprises, and able to change the course of the interview without notice. We must not be frightened if the interview drifts to something we had not planned: we are here to serve history and documents and not vice versa.

c. Interview with experts
Interviews with experts are a fundamental part of the journalist's work because they have a double value. **The experts are, on the one hand, key informers** because they have dedicated their lives to a problem (regardless of whether they have been personally touched by the practice), and on the other hand, we assume that they possess knowledge that relates to the "scientific" aspect of the problem that is different from ours or those of other interviewees. **They may also complete information** by providing explanations and examples to elucidate obscure points or clear up any doubts or controversies. It might be useful to carry out these interviews after the other ones, when most of the interviews on which we will base our articles and our report have already been done. Thus, we can present the expert with concrete examples, anecdotes and testimonies gathered during previous interviews and invite her/him to comment on a specific example.

/ 8.2 ASKING THE RIGHT QUESTION /

When it comes to FGM/C the journalist should avoid superimposing her/his own point of view to that of the interviewees. But, given that this is an extremely delicate subject, against which individuals may experience different feelings, and especially that closely affects an aspect of their life and their body of which it is not always easy to talk about 'in public', it becomes essential to pay particularly attention to the way in which questions are asked.

We propose here a brief passage of an interview[24] with Zara, a 29 year old woman from a Somali community, living in Nairobi. In this phase, **the interviewer tries to ask open questions that should enable a person to respond in a free way**, so that the public can enter Zara's private life all the while assimilating the heart of the problem through the description of her private life.

Interviewer: *Do you want to talk about your relationship with young men?*

Zara: *Ok.. I was dating a guy for 6 years, but he does not come from the same community as me. When I spoke with my mother, the first time, I had the courage to say "Oh I'm going out with a guy who comes from Western Kenya." She answered, "Are you crazy?" I do not want to hear about it ", so I had to talk to him and say," My mother said this and that "... So I think our relationship ... I loved him ... But it took me much ... Even today I think I should have something with this guy, but because of the interference of my mother, I said, "Okay, I have to stop this. But today I am still in contact with him, we talk on the phone, we go to have a coffee and things like that. Yeah...*

The question of the interviewer generates an answer. There is no subliminal indication in the way in which it is placed. We simply request Zara to describe the relationship she has with young men. In fact Zara does not begin her reply with 'an opinion'. She immediately

starts to provide descriptive evidence about her relationship with a guy who does not belong to the Muslim Somali community in Kenya.

In her reply, we can identify a major problem associated with this relationship: the announcement to the family. If infibulation is practiced to allow a girl to marry within the community, what could happen in the case of a relationship with a foreign person, who may not understand these cultural values? Indeed, the mother answers: "I do not want to hear about it." No other possibility is considered or envisaged.

This exchange provides an overview of FGM/C that can inspire an intervention which promotes change in social norms: we can put family members in a condition where they would consider the possibility that their daughters go to work or study and meet and get involved with people who do not have the cultural skills to "understand" FGM/C. As a journalist we can also highlight positive examples of families who were in the same situation and have finally opted to abandon FGM/C in order to allow a daughter to marry in a different context where the practice is frowned upon.

Interviewer: *Is circumcision a problem when you go out with a guy?*

Zara*: Oh yes, it is! In fact, a man ... when you are circumcised ... In fact, when I went out with this guy, you know, we knew each other for a long time. We talked and he asked me: "So are you circumcised?" and we were very free together, we had faith until today. But I told him: "Yes but why you asking me this question?" You know, his friends told him that a circumcised woman can not satisfy a man. But he said: "These are the comments of my friends, not mine."*

But ultimately it gives you the impression that he thought a lot about it. I said, "Okay, you told me this and that but, you know, your friends have a great influence on your life, like when they tell you:" You're going out with this girl? Did you know that Somali women are circumcised "[...] and I said," Yes, I am. Because it is not my fault, I was only 9 or 10 or 12 years old. I do not remember the age, but I'm sure it's more or less that, in general it is around that age. So when I said "yes" and he said "ok", I asked him: "Why are you asking me this question?" "Because my friend told me you would make me convert to Islam and that I will have to allow my daughter to be circumcised." It was hard for him, but he's a good guy, he understands me, he is not quarrelsome, you know.

The issue involved an implicit conditioning for Zara. Even if the answer was long, the risk was to close the doors to the narrative. The conditioning is evident in the choice of the word "problem" as the interviewer put a label on what should have been left to the response of the interviewee. It is very important to avoid, whenever possible, questions that could generate the responses that begin with a "yes" or "no." In this case, it was a "yes." Zara then continued to explain the reasons of her "yes". It happened because Zara and the interviewer saw this as a "problem".

The interviewer could ask the same question to the father, a man who decided to perpetrate the practice, and the answer probably would have been "no" and nothing else. The fact of not agreeing with his point of view could make the interviewee distrustful of the interviewer. In this case, the question could be: In what way does the fact that you are circumcised affects your emotional connections?" In that way, Zara could not hide behind a" yes "or" a no ", but would have been "obliged" to give a narrative type of answer.

Interviewer: *Do you believe that your circumcision affects your sexual relations?*

Zara*: Well, I think it really does affect it.*

Zara's previous answer which was already detailed prevented the interviewer to see that he was conditioning his interviewee. The risk which appeared in the previous question materializes itself in this answer, where it is as if Zara was responding "Yes, it's like this (it is exactly as you say)." Questions of this kind bring nothing to the purposes of the reporting that we must do.

The aim of our work is **to discover narrative elements on which we can intervene to generate change**. With this last question, not only was Zara not put in a position to provide narrative elements, but she proved to be a witness with completely no influence. The people we interview are not simple subjects that could legitimize our theory on the reality that we are exploring, but rather they must be considered as sources of narrative and of elements that will be used to support our work. In this case, the interviewer would ask the question differently: "In what way does the fact that you are circumcised affect your relations from a sexual point of view?" The answer would have been more structured and narrative, Zara would have told how her condition as a victim of FGM/C affects her when she has sexual intercourse.

/ 8.3 USE OF IMAGES /

Showing the genitals of a girl or woman who was subjected to a some form of FGM/C can have **an educational value**, and it is certainly important for those who make medical studies and must therefore know the anatomy on which they will eventually carry out the practice. However, experience shows that **these images have no deterrent value** in relation to the continuation of the practice, because they cause embarrassment and suffering to those who have been subjected to it, or disgust to those who are not concerned by this tradition, but without actually helping to better understand the issues related to FGM/C and therefore not contributing to its abandonment.

The authors of videos, both documentary and drama, who are faced with the choice of images to show, **need to seek a balance** between the material facts, including the suffering of girls subjected to the practice, and the ability of viewers and spectators to manage the emotions that these images and sounds can create. Of course, filming or photographing a ceremony of FGM/C means that nothing was done to spare the fate of the little girl being filmed or photographed. Justifying it by saying it is for the "good cause" and by thinking that these images will serve to discourage the people who will see them, doesn't really make sense because those who subject their daughters to FGM/C know very well the suffering that they generate. It is precisely because they know it, that they are trying to appease it with medications or by contacting health workers (the "medicalization" of the practice is a quite common phenomenon and repeatedly condemned by the WHO, World health Organization).

Drawings, comic books and animations are sometimes an alternative to photographs and videos. They help to show what is difficult to watch, leaving the artistic trait to mediate between the often too crude realities.

These decisions, however, are in the hands of each author who, in addition to her/his own sensitivity, will have to take into account different criteria such as: the editorial line of the newspaper, the target audience, the quality of images available, the cultural context of the countries, and the diffusion of his product. Today, the web is an incredible source of pictures and videos that address FGM/C, whether they are documentaries, films, docu-fictions, extracts of TV programs and series. What actually matters is the stories they tell. And the stories that best can inspire change are those where women and men find their way to the abandonment of the practice, as did the great master of the African cinema Ousmane Sembène in his Moolade, which earned him an award at the Cannes Film Festival 2004.

/ 8.4 SOURCES /

The documentation that exists today on female genital mutilation/cutting is really impressive, though it is all mostly in English. Thoroughly searching for information before writing or making a audio or video report is the first basic rule of journalism. Henceforth the Internet is the first source we refer to: There are huge archives where you can find everything although sometimes the research can be long and complicated.

To facilitate the research work in this section, we will mention just a few websites that are points of departures for further research. These websites are accessible to everyone, they do not require registrations or passwords. Note, however, that many studies, among the most interesting and serious, conducted as part of university projects and published on academic and scientific journals of medicine, anthropology, sociology, law and others are generally available through specific portraits, but for which a registration procedure is required.

We will not insert the list of many sites of non-governmental organizations dealing with female genital mutilation/cutting as they are easily accessible through search engines.

UNFPA-Unicef Joint Program on FGM/C
This is the site that presents the UNFPA-Unicef Joint Program on female genital mutilation/cutting, the Reports on the results achieved since 2008 (in English and French), and 'stories from the field that can be a good base for articles and reports.
www.unfpa.org/gender/practices3.htmll

Demographic and Health Surveys (DHS)
The DHS programme collects, analyzes and disseminates reliable and representative data on population, health, HIV and nutrition collected through more than 300 surveys in over 90 countries. In twenty African countries DHS also includes a questionnaire on FGM/C. Surveyss are carried out approximately every five years. You can download the full annual country reports, or use the tool "Statcompiler" to elaborate tailored statistic tables.
www.measuredhs.com

The female Genital Mutilation / Cutting (FGM/C) News Blog
This blog publishes all the news about female genital mutilation/cutting. It selects only content where FGM/C is the main subject. The page is designed as a resource for researchers and for those who want to be updated on this subject.
fgcdailynews.blogspot.it

INTACT
The network INTACT (International Network to Analyze, Communicate and Transform the Campaign against Female Genital Mutilation or FGM) is an international group of researchers, intellectuals and activists dedicated to present scientific evidence for campaigns to promote the abandonment of FGM/C.
www.intact-network.net/intact/index.php

STREAM - Sharing technologies and resources for engaged and active media
A portal run by AIDOS that collects different types of documents: magazines and press releases, information on various laws in force in different countries, researches with brief summaries, and international organization documents. The website is coordinated by AIDOS, the Italian association for women in development.
www.stopfgmc.org

FGM/C facts according to the WHO
Recent fact sheet (February 2012) on FGM/C from the World Health Organization.
www.who.int/mediacentre/factsheets/fs241/fr/index.html

Views on excision
Female genital mutilation from different viewpoints: historical, sociological and literary. This insight was written in the year 2000 by the senegalese Pierette Herzberger Fofana, a doctor at the University of Erlangen-Numberg, in Germany.
aflit.arts.uwa.edu.au/MGF1.html

Population Council
Since the year 1990, the Population Council research center dedicated much attention to FGM/C with a rich literature on the evaluation of the impact of initiatives promoting the abandonment of the practice in many African countries.
www.popcouncil.org / topics / fgmc.asp# / Resources

Population Reference Bureau (PRB)
Center for research, information and advocacy that aims to support the media with data, statistics, studies and an in-depth study for better media coverage on issues concerning population issues, including reproductive health and FGM/C. PRB is the author of 'Female genital mutilation/cutting: data and trends', which provides a picture of the evolution of the practice in the world from an analysis of the statistical data available.
www.prb.org/

Centre for Reproductive Rights
This research and advocacy center concentrates especially on Sesual and Reproductive Health and Rights with a gender approach, through a critical analysis of existing laws and proposals of innovative and effective measures. It has produced several documents related specifically to the legislative framework of FGM/C and its application.
www.reproductiverights.org

Equality Now
Equality Now deals with FGM/C as part of its activity to "put an end to violence and discrimination against women and girls in the world". On its web-site one can find updated information on the adoption of laws prohibiting the practice.
www.equalitynow.org

9.

/ FOOTNOTES /

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3. Idem

4. Tostan is a non-governmental organization in Senegal, created in 1991.

5. UnicefInnocenti Research Centre, Insight Innocenti (Digest), "The dynamics of social change towards the abandonment of female genital mutilation in five African countries", Unicef Innocenti Research Centre, Florence 2010

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15. In DHS Working Papers, n.39, USAID, USA, 2008

16. Text adapted from: Katzive Laura, "Using Legislation to Promote Women's Rights: Considerations in Drafting and Implementing Legislation to Prevent FGM" in Afro-Arab Expert Consultation on Legal Tools for the Prevention of Female Genital Mutilation, Proceedings of the Cairo Expert consultation 21-23 June 2003 AIDOS-NPWJ Rome, 2003

17. The term "customary law" used in this text refers to the legal systems applicable to specific communities. The term refers, among other things, to a practice that may be deemed culturally mandatory, but not from a legal point of view.

18. Nahid Toubia, "Legislation as a tool for behavioral and social change", in the Proceedings of the Afro-Arab Expert Consultation on Legal Tools for the Prevention of Female Genital Mutilation, Cairo 21-23 June 2003, AIDOS-NPWJ, Rome 2003

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23. Text adapted from: Abandoning FGM/C on FM! Innovative media tools to foster the abandonment of female genital mutilation/cutting - AIDOS, Rome, 2012

24. By Beatrice Rappo and Jonathan Zenti/Audiodoc. Text adapted from: Abandoning FGM/C on FM! Innovative media tools to foster the abandonment of female genital mutilation/cutting - AIDOS, Rome, 2012