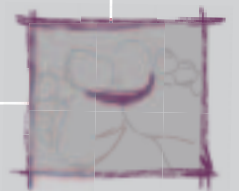


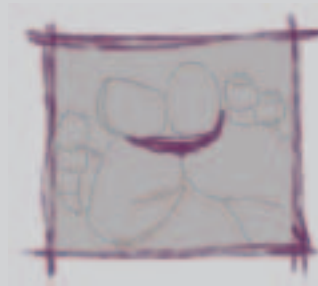
Norwegian Church Aid



Female Genital Mutilation

UNDERSTANDING THE ISSUES





Acknowledgements

This paper is a tribute to all women – and the increasing number of men – who have taken up the struggle to end the practice of Female Genital Mutilation (FGM). It is written with the young girls and women in mind, who stand at risk of undergoing FGM today. The content is based on experiences, comments and reflections by individuals and partner organizations in Eastern and Western Africa with whom Norwegian Church Aid stand in a fruitful working relationship. Without their contributions, this paper would not have been possible, nor made much sense. Thanks also go to Thora Holter, Kari Øyen, Isaiah Kipyegon Toroitich, Fatuma Abdi Mohammed, Hali Farah Hassan, Riborg Knudsen, Gwyneth Berge for important inputs, comments and support.

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Foreword

by Secretary General Atle Sommerfeldt



Atle Sommerfeldt

To safeguard the rights and dignity of the poor, vulnerable, and marginalized is a key goal for Norwegian Church Aid (NCA). Any form of violence is an obstacle to the attainment of this goal. Each day more than five thousand girls and women undergo female genital mutilation (FGM). The procedure poses a threat to security and health, it trespasses the sanctity of a person's bodily integrity, and it adds pain to the lives of girls and women who already carry the brunt of suffering and discrimination. FGM is widespread in eight of the African countries where NCA's partners administer projects. As a humanitarian organization we cannot close our eyes to the fact that girls face violations of elementary rights within their own home. Many of them will face complications to last them a lifetime.

Bringing an end to FGM and other harmful traditional practices is one step towards the fulfillment of the Millennium Development Goals. FGM relates to the first five goals concerning equal rights to education, women's empowerment, and reduction of infant and maternal mortality rates.¹ Preventing FGM needs to be an integrated component in governments' health and education programs.

FGM is interwoven with culture and putting an end to the practice is a demanding task. Neither condemnation, commandeering nor prohibition can stop this age-old practice. True change can only come from within as people acquire knowledge, begin to reflect critically and change their behavior. It is crucial to involve not only girls and women, but also boys, fathers, husbands, brothers, and local leaders. Building the capacity of local organisations should be a main strategy.

Neither Christianity nor Islam prescribes such a practice. Even so, people believe that God or Allah instructed them to "modify" His creation. Religious leaders should speak out in unison against FGM. NCA cooperates with faith-based partner organizations in countries where FGM is widespread. Herein lies a potential for ecumenical and inter-religious action waiting to be explored.

This paper is a contribution to understanding the practice of female genital mutilation. It also suggests ways to hold all duty bearers responsible for protecting the rights of girls and women. There is need for action at all levels – from house visits and school campaigns to presidential decrees and international declarations.

The challenge may seem overwhelming. Yet there is reason to be optimistic as an increasing number of African girls say no, young men announce that they will marry uncircumcised girls, villages denounce the practice, and voices join to declare zero tolerance against FGM. Our European history of violence in Africa gives us no reason to boast. Rather it urges us to support African's movement to end violence against women and children. African women have taken the lead. Thanks to their commitment, I rest assured that one day female genital mutilation will be history.



Introduction

The challenge

“The girl is made to sit on a low stool. Her legs are drawn apart and each leg held by two strong women relatives or friends. Two other women hold the girl’s arms and shoulders to prevent her from struggling. The clitoris, labia minora and parts of labia majora are removed. Later, sewing is done using acacia thorns. A small hole is left for urine and menstrual flow to pass. The area is covered with herbs and egg yolk to control bleeding. Afterwards, the girls’ legs are tied together from waist to toes for several days...”²

Habiba Isaack Barrow from Mandera in Kenya describes how the procedure of female genital mutilation (FGM) takes place in her Somali community. Imagine you were a six-year-old girl. Women you trust the most – your mother, grandmother, aunt – have just given their consent for you to undergo such treachery and may even take part in the ritual. When you call out for your father, he is not around. For the rest of your life you are likely to vividly recall the pain, shock and feeling of betrayal that overwhelmed you that terrifying moment.

How is it that such a practice continues in 2003? Female genital mutilation (FGM) is not a “curiosity item” anthropologists discovered among ‘remote tribes’, but a practice which takes place on a large scale today. Infants, small girls, teenagers and women – thousands – are subjected to this ritual each year. According to the World Health Organization’s estimates, *100 to 130 million girls and women in today’s world have undergone female genital mutilation. Another 5000 girls per day or two million girls per year are at risk.*³ Health complications, shock, and intolerable pain accompany these figures. To people practicing it, FGM nevertheless carries a symbolic meaning and is associated with pride, affirmation, and respectability.

People in the West regard the custom as a remnant from a barbaric past with no room in a time when globally ratified human rights were to safeguard body and soul. However, there are parallels in the Western societies. A few decades ago clitoridectomy was carried out to cure “psychological derangements” in Europe and the US. In our times teenage girls and grown women have silicone implanted to enlarge their breasts. Adolescents grapple with eating disorders stemming from a thwarted perception of their own body and self. TV programs follow women who undergo plastic surgery on the face, breasts, and stomach. A surgeon who was featured in one of Norway’s leading newspapers makes a living out of operating on women to enlarge, reduce or adjust their vaginal lips⁴. The effort to become sexually more attractive and have ideal looks knows no limits. Yet Westerners describe “the others” as bound by harmful customs. Anders Holth Johansen rightfully points out that “... it is not difficult to agree that FGM is a brutal custom. To cut off the flesh of small female children is both unnatural, harmful, unethical and illegal ... Still, the custom cannot be regarded as an isolated problem. FGM must be regarded as perhaps the worst symptom of society’s and culture’s pressure on women’s bodies and sexuality.”⁵ Globally women struggle to reach ideals that breach with the way they were created. They undergo costly or risky procedures to gain acceptance and respect.

This paper is a contribution to understanding Female Genital Mutilation. It will highlight aspects of *culture* and *gender* as a backdrop for understanding the practice. Moreover, it will address FGM from a human rights and development perspective. It seeks to point out critical factors, opportunities and challenges and suggests an agenda for continued efforts.

Unless otherwise stated, information and reflections in this paper are based on the experience of NCA and partners. Some of the partner organizations have obtained substantial expertise in the field of FGM prevention. Nevertheless, the time NCA has administered a regional program on FGM spans less than four years. The experience gained is limited or waits to be documented. Therefore, the discourse on challenges and vulnerabilities will reflect this limitation. When evaluations of the first program phase (2001-2004) have been completed, both the failures and successes will come out more precisely. As far as the term ‘we’ is used, it refers to *NCA and its implementing partner organizations*. References are given in those cases where facts and views are taken from external sources, unless they are considered generally known.

Why Norwegian Church Aid (NCA) got involved

- Local women and partners challenged NCA to address FGM.
- FGM is a violation of basic human rights. In many countries neither family nor society provides protection from it. It is detrimental to development because of its effect on education, health and household economies.
- The foundation for involvement lies in NCA’s mission to promote the rights and uplift the dignity of suffering, poor and oppressed men and women.
- The high prevalence rates, ranging from 38 to 98% in the countries where NCA and its partners work, constitute a call for action.
- FGM is one form of gender-based discrimination found in Eastern and Western Africa. While women play a key role in sustaining the family and society at large, they lack freedom to make decisions about their own bodies and lives. Through its efforts to end FGM, NCA believes that women’s dignity, self-esteem, and power will be enhanced and that men will gain from it as well.



What is Female Genital Mutilation?

»»»

- Faith-based organisations (FBOs) – NCA’s key partners – represent a unique potential in the elimination of FGM due to their broad grassroots base and the influential positions of their leaders. Dissociating FGM from religion can be a turning point for those who believe that their faith demands the practice. Dialogues on FGM also provide opportunities for increased inter-religious dialogue and action.
- Preventing FGM is in line with the objectives of the United Nations Millennium Goals, the “International Decade for a Culture of Peace and Non-Violence for the Children of the World” 2001 - 2010, and the “Decade to Overcome Violence: Churches seeking reconciliation and Peace” 2001 - 2010.

Origins

Little or no evidence exists to document when or how the practice began. Some say it originated in southern Egypt or northern Sudan 2000 years ago. Others suggest that it started in several places simultaneously along the middle belt of Africa. What is clear is that it was practiced from early times in many African communities and evolved before the rise of Christianity and Islam. Some areas of West Africa established the practice as late as the 19th or 20th century and there are even a few communities who are instituting it today⁶.

Other historical examples of communities’ attempts to curb female sexuality include the early Roman technique of slipping rings through the labia majora of female slaves to prevent pregnancy, or the chastity belt introduced in Europe in the 12th century. FGM is the most severe form since it involves ‘physiological change’⁷.

The procedure

Female Genital Mutilation (FGM) is a collective name for practices that *involve the cutting or partial / total removal of female genitalia*. The World Health Organization categorizes the procedure into four types.⁸

Type I (‘clitoridectomy’)

Removal of the prepuce (hood or foreskin protecting the clitoris) with or without removal of part or all of the clitoris.

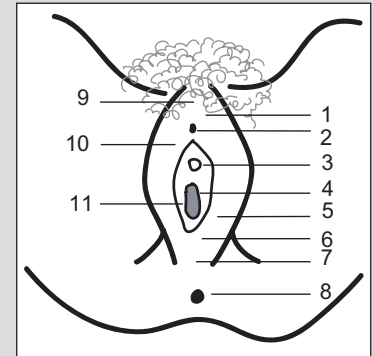
Type II (‘excision’):

Removal of the clitoris along with the prepuce and part or all of all of the labia minora (small vaginal lips).

Type III (‘infibulation’):

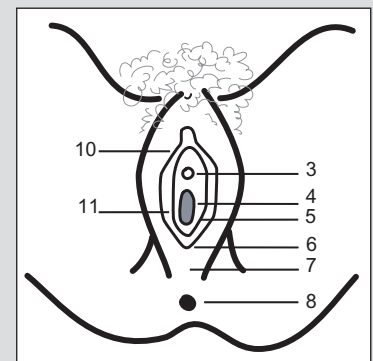
Removal of part or all of the external genitalia (clitoris, labia minora, and labia majora/ large vaginal lips) followed by stitching (suturing) or narrowing the two sides of the vulva with thorns, thread, or things that will facilitate the fusing together of the

The female genitalia

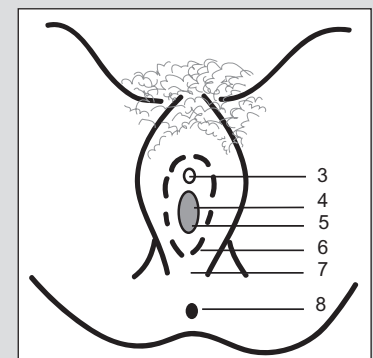


1 Clitoral hood, 2 Clitoris, 3 Urethra, 4 Vaginal opening, 5 Hymen, 6 Bartholin's glands, 7 Perineum, 8 Anus, 9 Mens veneris, 10 Labia majora, 11 Labia minora

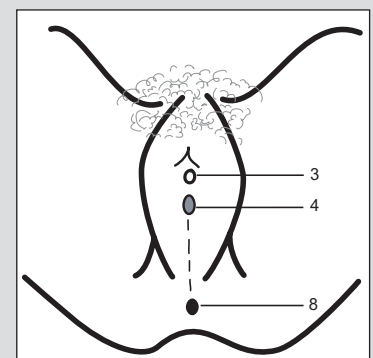
Type I (‘clitoridectomy’)



Type II (‘excision’)



Type III (‘infibulation’)



Based on illustrations from www.fgm.network.org



sides or the vaginal opening, leaving only a small hole for urine and menstrual flow. This is sometimes called the 'Pharaonic' or 'Sudanese' type. It is the most extreme form since it involves sewing after cutting.

Type IV (unclassified):

All other procedures involving the female genitalia: pricking, piercing, stretching, cauterization (burning) of the clitoris, scraping or incisions in the vaginal wall, or introduction of corrosive substances into the vagina.

Types I and II are most widely practiced, estimated to comprise 80% of the cases worldwide. Only 5% of all cases involve the clitoris only. Approximately 15% of all FGM-cases involve infibulation (Type III)⁹. The 'operation' may be repeated if 'experts' or those who requested it are not satisfied with the first attempt.

Defibulation: 'Opening' is performed on a bride-to-be to allow intercourse or on a delivering mother to enlarge the passage

scarred from infibulation. Re-infibulation: A procedure of 're-stitching' or 'closure' of women who were 'opened' during delivery or on wives during long absences by their husbands. Many women are re-infibulated after each childbirth, despite the risk of complications.

The *instruments* used are special knives, razor blades, scissors or sharp pieces of glass. In order for bleeding to stop and the wound to heal faster, mixtures of egg yolk, ashes, soil, herbs, etc., are applied.

A wide spectrum of *terms* exist to determine which procedure of FGM should be employed. Most communities have expressions which refer to the 'operation' itself such as 'cutting', 'stitching' or 'narrowing' or they may allude to the symbolic meaning, such as 'circumcision', 'cleansing', 'ceremony', 'purification for prayer', 'initiation', 'passage into adulthood', etc.¹⁰ In Western Africa, the term 'excision' is used as a collective name for all types, while in Eastern Africa,

the term specifically refers to Type II. When Muslim communities use the term 'Sunna' or 'Tahara Sunna' in connection with FGM, they usually refer to types I and /or II. 'Sunna' means 'tradition' or 'the way of the Prophet' and 'Tahara' means 'to purify'. 'Sunna' is especially taken to mean a small incision in the clitoris to produce a few drops of blood. In Somalia, Sunna is used as a collective term for all operations that do not involve stitching¹¹.

Prevalence and geographical spread

FGM is practiced extensively in more than 29 countries in Sub-Saharan and north-eastern Africa. (It is *not* practiced in southern Africa, and not in the Arabic-speaking nations of North Africa – with the exception of Egypt.) FGM is also found in parts of Asia and the Pacific, some countries in the Middle East and among immigrant communities in North and Latin America and Europe¹². >>>

Photo: Bente Bjerkke



"Among those who practice Type III in Eritra, if the labia fail to stick together, the operation is repeated after the wound heals."

(From Worku Zerai's Eritrea-study for NCA/NORAD)

Equipment used by circumcisers in Kenya.

What is Female Genital Mutilation?

There are *great variations* in the practice. Differences run along geographical and ethnic distinctions, and the meaning attached may vary widely. Economic class, urban or rural living, exposure to other cultures, level of education are influencing factors. Differences are seen in the following ways:

– **which parts of the genitalia are removed** (see variations in types I-IV p. 6). This will also depend on the eyesight and skill of the person performing the operation and on the struggling of the child. The effects on health vary, too. Generally, type III is the cause of the most serious health complications.

– **the girl's age**: There is a general tendency to subject girls to FGM at a younger age than before. In Eritrea 44% of the girls were circumcised before reaching the age of one year¹³. Among the Dogon communities in Mali and many others (such as the Pokot and Masai in Kenya), the procedure is performed on girls about to enter puberty¹⁴. Among the Mossi in Burkina Faso, the woman

is circumcised while she is pregnant or about to deliver.¹⁵

– **who carries out the operation**: This may range from 'specialized' circumcisers, mothers or neighbors, to Traditional Birth Attendants, to local health officers, hospital surgeons and others. In Mali, the cut was traditionally done by members of the local blacksmith family.¹⁶ Among the Bilen in Eritrea, 47% of the women were circumcised by their mothers or grandmothers¹⁷.

– **whether it is a public or private ceremony** and whether it is done on individual girls or whole groups: Among many people groups in Kenya, the procedure is a communal ritual conducted on girls as a rite of passage. It may include gifts, food and festivities and the community celebrates that a new group of girls has become women. In other countries it is a domestic affair involving little or no festivity.

– **the reasons given for practicing FGM**: Perceptions about FGM and why it should continue are many and different, although underlying values and attitudes are similar.

Reasons for female genital mutilation

The most common arguments for sustaining the practice are:

- FGM is a tradition which the community inherited from their ancestors.
- FGM preserves virginity and prevents promiscuity: It helps control a woman's sexual urge, making her less likely to seek extra-marital adventures¹⁸. Infibulation is also seen as a means of preventing rape and unwanted pregnancy, as reflected in an Eritran saying: "An un-infibulated vulva is like a box without a locker (i.e. 'easily accessible')".¹⁹
- FGM is seen as a physical sign of marriageability and parents expect a higher bride price for their daughter.
- FGM will *increase fertility* or make delivery easier.²⁰
- FGM *maintains 'cleanliness' or 'purity' ('Tahor', in Arabic)*: The clitoris is considered 'unclean' and a source of illness and 'poison'. Secretions produced by the female organs are believed to be foul-smelling or unhygienic²¹. Some communities think the clitoris and surrounding area is a breeding ground for bacteria and infections. If the head of the baby touches the clitoris at birth, it may die, and it may be dangerous for a man's penis to be in contact with the clitoris. FGM is believed to help avoid illness and problems during sexual intercourse.
- FGM is prescribed by *religion*.
- *Aesthetic reasons*: Many ethnic groups consider the natural female genitalia ugly to look at. Some believe the clitoris may grow very large if it is not cut.
- FGM is a *token of sexual identity*: The clitoris is seen as a 'male' part in the female body, just like the foreskin of the penis is considered a 'female' part in the male body. FGM is thus believed to preserve femininity.²²
- Infibulation (type III) is believed to give more *sexual pleasure* for men due to the narrow opening to the vagina.

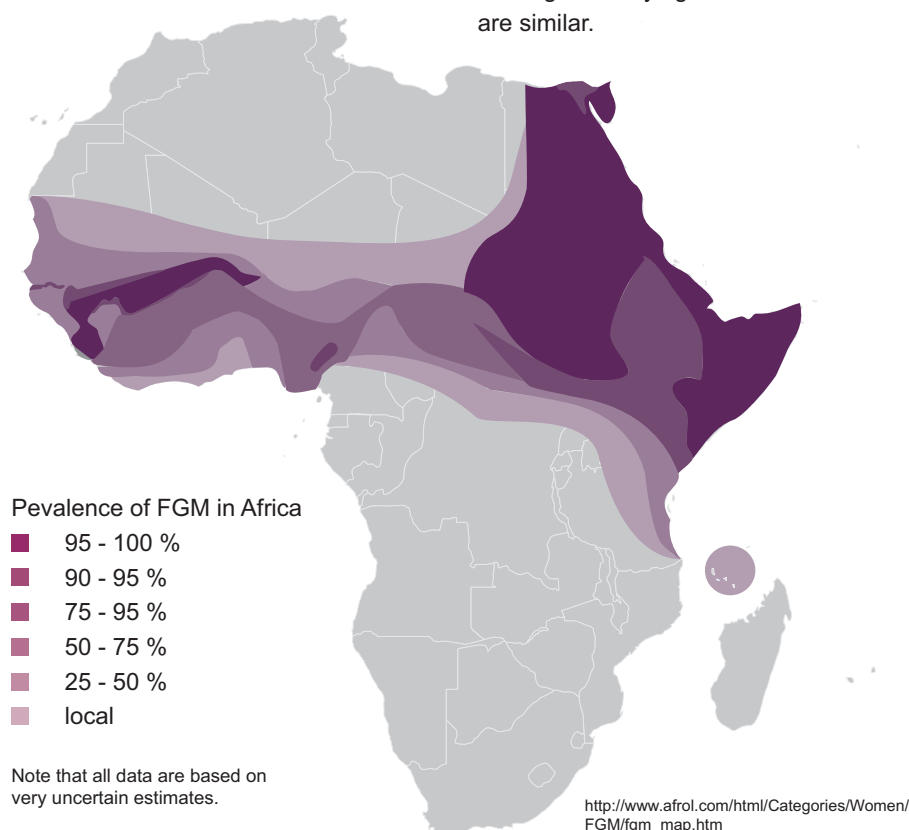




Photo: Bente Bjercke



Adult woman demonstrating how a girls' legs are tied for days and weeks after FGM.

- FGM is a rite of *passage*, marking the transition from girlhood to womanhood by getting rid of the 'unclean' body part which signifies immaturity²³. Among the Kunama in Eritrea, an un-circumcised girl is buried alongside children, since she is considered immature.²⁴ FGM tests whether a girl is strong and able to endure pain and thus be of use to society (bear children and work hard). Among the Kikuyus in Kenya a girl must "know the pain of the knife" to become an adult²⁵.
- FGM may also serve as a symbol of cultural identity, an "ethnic marker" or a sign of political resistance.

Effects on health²⁶

Beyond the extreme pain during the procedure, **immediate health complications** include severe bleeding, blood poisoning, shock, urinary retention, incontinence, infections, tetanus and fatalities due to these. Amputation of the clitoris involves cutting across the clitoral artery, and cutting of the labia further damages arteries and veins. Severe

bleeding may lead to long-term anemia and even sudden death. Infection is a very likely outcome and may spread to internal organs. Binding the girl's legs for days after the mutilation prevents drainage of the wound. When carried out on groups of girls, the circumciser may use the same non-sterile cutting instrument on all, thus increasing the risk of HIV-transmission.

Beyond the immediate effects, FGM has **long-term physiological and sexual effects**, such as slow flow of urine and menstrual fluid, genital malformation, pain and bleeding during intercourse, recurrent urinary infections, development of cysts and keloids (severe scars), as well as pelvic and urinary tract infection. Sexual dysfunction in both partners may come from painful intercourse and reduced sexual sensitivity following FGM. Type II and especially Type III may cause a range of complications **during delivery** including tearing of tissue, excessive bleeding, prolonged and obstructed labor. Fistulae (ruptures between the vagina and urinary tract or between the vagina and intestine) may form as the result of an injury during FGM or due to defibulation/re-infibulation, intercourse or obstructed labor. Complications during delivery may also expose the baby to infections and sometimes cause brain damage due to a narrow opening and prolonged labor. In the worst cases it can cause stillbirth.

For women with FGM, the risk of HIV transmission may increase due to damaged genital tissue. Scar tissue is less flexible and may tear during intercourse. In addition, the small vaginal opening is prone to laceration during intercourse²⁷.

The psychological effects

are less well-documented and less understood. "For the majority of girls and women, the psychological effects are likely to be subtle and buried beneath layers of denial, mixed with resignation and acceptance of social norms."²⁸

"My daughter was circumcised at the age of seven by one of my friends while I was away. She nearly bled to death and was rushed to hospital. My girl is still traumatized by the experience."

Habiba Issack leader of Habiba International, local NGO, Kenya

A 1991 survey of 1200 women in Kenya indicated that

48.5% experienced hemorrhage, 23.9% infection, and 19.4% urine retention at the time of the FGM operation.

PATH (Program for Appropriate Technology in Health)

A recent study in Eritrea revealed that

48% of women claim they had problems during sexual intercourse and delivery due to circumcision. 65% of the women in the study confirmed that they are required to be re-sutured after delivery.

Worku Zerai, p. 24

"The pain of circumcision is like a heavy burden I always carry with me. It is like darkness in my life, in my chest. You can never forget it."

Halima, woman in her late 30s; OK-project, Norway

What is Female Genital Mutilation?

Among the Kunama in Eritrea, the ritual is expensive. The family slaughters a cow or a goat and invites the whole village to attend the ceremony. Food is provided for all. The girl also receives a cow or goat as a gift, plus new clothes and money. The circumciser receives 6 kilo of sorghum, incense, butter, honey and traditional eyeliner.

Worku Zerai, p.29

“In Tigrinya no word exists for mutilation – we use ‘circumcision’. But we feel the term is ‘too harmless’. We need to find a stronger word for a harsh practice.”

– NCA/Eritrea staff at regional consultation, 2002.

It is well known, however, that FGM may leave a lasting mark on the girl or woman. Numerous personal testimonies recount the feelings of anxiety, humiliation and betrayal, incompleteness, lack of sexual enjoyment, marital conflicts and depression. One serious effect is the possible loss of trust and confidence in caregivers²⁹. Many women/girls also grieve due to the loss of a body part and feel angry with the parents or relatives who made it happen. Experts suggest that the shock and trauma of the operation may contribute to behavior described as “calm” or “docile”, considered positive for women in societies that practice FGM.³⁰

Economic implications

In some communities the ‘service’ is paid for in kind or cash and may be the main source of income for the practitioner. Elsewhere the cut is carried out for free or as a ‘favor’ by a relative or elder and rewarded with respect and status in the community. While being a source of income for the circumciser (and thus a motive for continuing the practice), FGM may be a costly ‘operation’ for a poor family. In places where it is

a collective ritual, families are obliged to arrange community feasts with food and gifts. Among the Kunama and Nara peoples in Eritrea, feasts that last from three days to one month are thrown to celebrate circumcision of girls³¹. Other ethnic groups spend sums of money that are very scarce except for payment to the circumciser in cash or kind, and perhaps by inviting a few women for porridge and coffee. For most people the practice thus has direct financial bearings. What is more, the medical expenses due to complications that can arise may also tap a family’s financial reserves. An Ethiopian middle-class woman shared with the author how her infibulation brought not only severe pain and health problems, but also a heavy strain on their economy. For each of her three children, she had to travel to the capital to arrange for attendance of a specialist during delivery. Her family spent a significant amount on travel, hospital fees and treatment.

Complications for men

Men may also experience complications during intercourse if their partner has undergone FGM, especially in the case of infibulation. A study in Sudan revealed that two out of three young men admitted difficulties in penetration, wounds and infections of the penis as well as psychological problems³². Marital conflicts may arise from a relationship that is sexually dysfunctional or where one partner’s pleasure is attained at the cost of the other. Sexual pleasure may be reduced on the part of the woman due to FGM (although not always) and husbands are troubled because their wives suffer during intercourse.

‘Circumcision’, ‘Cutting’, ‘Mutilation’: Do the terms matter?

Female Circumcision (FC)

For many years Female Circumcision was the most common term for describing the practice. Some are still using it, while most experts have abandoned the term since it bears clear analogies to male circumci-

Female Genital Cutting – FGC

The term was debated in the 1994 UN summit on population issues as well as in other forums. Muslim leaders have been proponents of the term and individuals and agencies are using it, on the grounds that it is a more neutral term. Opponents maintain that ‘cutting’ is not fully descriptive, since there are procedures which involve the female genitals (pulling, pricking or burning), but no cutting.

Female Genital Mutilation – FGM

Health advocates, women activists and international bodies have come to treat the practice as a case of violence against women. Male circumcision involves cutting the foreskin without harming the male organ, while FGM can be a far more damaging and invasive procedure, hence the term ‘mutilation’ is used.

FGM, FGC, and FC are all debatable terms. The practice is seen variously as a cultural practice, a criminal act, violence against women and a human rights violation. ‘Circumcision’ is a less charged word - but may downplay the serious nature of the ‘operation’. On the other hand, ‘mutilation’ has judgmental and emotional connotations, and may be felt as stigmatizing by those affected.

Norwegian Church Aid proposes a *contextual strategy*: Terms should be selected on the basis of target group and communication needs. NCA prefers the term Female Genital Mutilation for advocacy purposes, and this term will be used in this paper. There are contexts and situations, however, where less charged terms like ‘circumcision’ or ‘cutting’ may be appropriate. Aud Talle, a Norwegian anthropologist well acquainted with FGM, reminds us that communities practice it as “circumcision”, not as “mutilation”³³. Any intervention should include analysis of local names for the custom and care must be taken to avoid offense or stigmatization.

FGM in a changing world



As the custom of FGM spread, its meaning was shaped by surrounding social realities³⁴. Our time is no exception, and trends both in attitude and practice are presented in the following. Some changes reflect the custom's innate capacity to survive, while others are encouraging as they indicate that FGM is on the retreat.

With increased awareness of the adverse effects of FGM on health, many countries saw a medicalization of the practice: Medical personnel carry out the procedure in a hospital or in their homes, with a scalpel and under anesthetization. In Kisii and other areas of Kenya, parents take their children to the hospital to be circumcised, although the Ministry of Health has banned health personnel from involvement in FGM³⁵. Rather than imposing a strict ban, some countries like Egypt, Djibouti and Sudan tried to encourage less radical forms of FGM and that they be carried out by medical personnel³⁶. Such initiatives were condemned by the World Health Organization, as medicalization only serves to legitimize it. The fact that the 'operation' takes place under cleaner conditions does not guarantee fewer complications later. Also, lack of resistance from a girl under sedation may lead to deeper cuts and the removal of more tissue.³⁷

In Muslim communities there is a tendency to choose less severe forms, that is, to move from infibulation to 'Sunna' (Types I or II). Reports from NCA's project areas in Somalia and Ethiopia confirm this tendency. An increasing number of parents choose not to have the girl 'stitched' after the cut. A study by the Sudan National Committee on Traditional Practices (SNCTP) and Save the Children Sweden found that among women in Sudan born after 1980, 57% had undergone infibulation, while nearly 43% were subjected to so-called "milder" forms. The figures for their mothers were 85% and 15%. The same study showed a statistical relationship between the level of education and type practiced: Among illiterates, the ratio

was 90 % infibulation and 10 % 'Sunna'; while among university graduates, the ratio was 50 % infibulation and 50% 'Sunna'.³⁸

The move from infibulation to 'Sunna' is positive in the sense that it diminishes the harm inflicted upon the girl. 'Sunna', however, is not harmless in itself. And the message remains unchanged: A girl must undergo an operation to become acceptable.

While some communities are abandoning the practice, others are taking it up. A recent study carried out by Ahfad University in Sudan revealed that among internally displaced Southerners in Khartoum state, at least 6.8% of the girls had undergone FGM. The peoples of the Southern Sudan do not traditionally practice FGM. The tendency was explained as an attempt to adapt to Northern culture or to be accepted among the Muslims and to increase marriageability.³⁹ In Southern Ethiopia, church staff report how Guji people have their daughters circumcised as they move from rural areas to the town of Hagera Maryam. Gujis do not practice FGM traditionally, but have taken up the custom possibly to assimilate to urban life⁴⁰.

FGM may serve as 'stabilizing factors' in times of war and chaos. Traditions become symbols of stability and people return to what is known in an attempt to create a sense of normalcy. In such times, the number of girls undergoing FGM may rise. Upon returning home, girls who served as women soldiers in the civil war in Sierra Leone were put through FGM as a mass "cleansing" ritual, so that they could fulfill their role as girls and women in times of peace and according to tradition⁴¹.

During the first half of the 20th century missionaries and representatives of the colonial power in Kenya tried to stop the practice by banning it. It was a time when anything traditional was discouraged, thus FGM became a symbol of resistance and

Said Salaheldin Al-Said, a medical student in Norway and an anti-FGM activist is concentrating on men with origin in countries where the custom continues. He found that men under 35 tend to oppose the practice. One of his target groups are men who recently arrived in Norway. According to Said, these men are more open to and aware of the need for change. Those who have been in the country for a longer period of time are more difficult to work with, as they became deadlocked when the topic emerged in the media. His general impression is that most younger men prefer an uncircumcised woman for marriage.

NCA Magazine, Special issue on FGM, Jan. 2004.

defense of traditional values. This idea saw a renaissance with the recent advent of fundamentalist sects such as the Mungiki movement. They demand FGM as a symbolic act of adherence to traditional values.⁴² The group has been reported to capture women and perform forced FGM. Women adherents submit themselves to the 'operation', and force their daughters to undergo it, too.⁴³

On a general note it seems that the prevalence of FGM is lower among educated women in countries where it is practiced. The level of education is also decisive. Those who have primary/no education are more likely to have undergone FGM than those who attended the secondary level⁴⁴. Worku Zerai's study in Eritrea suggests the same tendency: While 73% of the illiterate women supported the continuation of the practice, the percentage was 24 % among women who had 8 to 12 years of education⁴⁵. Dr. Olayinka Koso-Thomas explains: "... with the improvement in women's education in Africa and ... migration from rural areas into the cities, African women have been exposed to ... new thinking of female



sex roles, fulfillment, independence and security... Educated women fail to see the rationale of the practice.”⁴⁶ It is important, however, to note that this does not apply universally. Other studies showed that FGM prevalence remained near the same level among illiterate and educated women. Modernization and education are in themselves not enough to break a tradition like FGM.

In times of globalization and migration, people as well as information move between continents. The custom of FGM followed immigrants from Africa and other countries to Europe, Australia, Canada and the USA. FGM is banned by law in most of these countries, but is nonetheless assumed to take place. Some families send their girls back to the country of origin to have the operation done. Others choose to abandon the practice. Moving from one context to another provides exposure to other life choices and a process of new self-reflection and change in attitudes may start. As the information reaches the countries of origin, it may influence people's choices about their daughters. When Haali Farah Hassan came to Norway, she gained new insight and became convinced that FGM is unnecessary and harmful and began to inform fellow Somali women about the effects of FGM. With the support of NCA, she visited her home area in Ethiopia to convince local people to end the practice.⁴⁷

Another encouraging fact is that FGM and other harmful practices have gained increasing global attention. The international human rights community has paid more attention to issues of violence against women, hereunder FGM. But above all, increased attention is attributable to the formation of numerous women's and gender-focused organizations. In fact, African women have been fighting this practice for twenty years! Thanks to their persistence and courage, eliminating FGM now ranks higher on national and international development agendas.

Efforts to put an end to FGM started long before modern times. In Kenya and Sudan missionaries and representatives of the colonial powers tried to put an end to the practice as early as the 1910s and -20s, but with little success.⁴⁸ In the 60s and 70s women activists campaigned to create awareness about FGM. Doctors in Sudan, Nigeria and Somalia documented their observations in medical journals. Health experts helped break the silence by bringing out the facts and lobbyists began to make use of international legal instruments to obtain consensus against FGM.

The Inter Africa Committee against Harmful Traditional Practices Affecting the Health of Women and Children – the **IAC** – was formed in 1984. It became the umbrella organization for national committees on FGM and other harmful traditional practices (HTPs). IAC's primary goal is to do advocacy work and provide training, information and support to its branch members. The IAC coordinated important international conferences on HTPs for youth, religious leaders, lawyers, etc. The work of IAC has grown. To date, there are national committees in 29 African countries. Norwegian Church Aid is cooperating with several of the branch committees. February 6th was instituted as the **International Day of Zero Tolerance against FGM/HTPs** at an international conference hosted by the IAC in Addis Abeba in 2003.⁴⁹

Organizations like RAINBO (Research Action Information Network for Bodily Integrity of Women), PATH (Program for Appropriate Technology in Health), Equality Now, Forward International, Save the Children Alliance members, Commission pour l'Abolition des Mutilations Sexuelles (CAMS), The Population Council, The International Planned Parenthood Federation, The Center for Reproductive Law and Policy, The Centre for Development and Population Activities, Amnesty International, The Population Reference Bureau, and many others contributed

significantly through research, support to local agencies, awareness creation, materials production, and in mobilizing international concern.

At the inter-governmental level FGM began to draw attention in the late 70s and especially in the 80s and 90s due to the sustained efforts of activists and NGOs. In 1979 the WHO sponsored the first special meeting on FGM and other harmful practices. Reproductive health and maternal and infant mortality emerged as major challenges in international development debates. FGM and other harmful traditional practices appeared in important UN conferences, e.g. The Vienna Human Rights Convention in 1993, The Cairo Conference on Population and Development in 1994 and the Beijing Conference on Women in 1995. The Vienna declaration expanded the human rights agenda to encompass gender-based violence, including FGM.

From the late 80s the WHO and other UN agencies shifted their position on FGM to include more of the **human rights** dimension.⁵⁰ African governments, women's organizations and professional organizations recognized the practice as **both** a health and a human rights issue⁵¹. Moreover, FGM came to be treated as a form of **gender-based violence**. The application of instruments of human rights law helped establish that FGM involves violations of basic rights of girls and women. Although originating from a Western philosophical tradition, human rights have become the globally approved platform for judging human behavior.

During the UN international summit on Children in 2002, one important step was taken as UN member countries set themselves the ambitious goal of ending FGM by year 2010.

International treaties have been supplemented by regional treaties, such as the African Charter on Human and People's



Rights – ratified by nearly all the African countries that practice FGM. In the 2nd ordinary summit of the African Union in Maputo in July 2003, the heads of state made an addendum to the African Charter: **The Protocol On The Rights Of Women in Africa**, which was a highly significant move in the right direction. This protocol consists of 32 articles, of which articles 5, 6, 14 and 20 deal with FGM and other HTPs. It is a tool which is sharper and more relevant to the African context than many of the international instruments. The decision came after years of effort by women organizations, particularly the IAC.⁵²

Another key regional event is the Cairo meeting in July 2003: During a high-profile Afro-Arab consultation, 28

countries signed a declaration stating that “...**All states must commit themselves to adapt legislation prohibiting FGM and promoting the human rights of women.**”

It also urges civil society organizations to work together to change attitudes. The Declaration was approved by Egypt’s two most senior Muslim and Christian religious leaders, who confirmed that FGM has no root in religion.⁵³

Instruments of international law have been significant in the formation of **national** constitutions and laws. National level laws and policies, penal codes and domestic laws are essential tools in interpreting international law and human rights standards. The contribution of **women’s lawyers associations** on legal aspects of FGM has been significant in

international and national/local debates. By 2003, twelve African countries had enacted laws criminalizing FGM⁵⁴. Seven developed countries that receive immigrants from FGM-practicing countries have passed laws which ban the practice. Enforcement of these laws is extremely uneven, both in Africa and the Western hemisphere.⁵⁵ And banning FGM cannot eradicate it alone. At times the international debate on FGM was heated and biased. Women from the West were accused of ethnocentrism, while their African colleagues considered the problem to be African and therefore best handled by themselves.⁵⁶ Today the climate is characterized by greater understanding and cross-cultural cooperation.

Major human rights violated by FGM¹:

- The right to the highest standards of physical and mental health, including reproductive health
- The right to be free from gender discrimination
- The rights to life and physical integrity, including freedom from violence
- The right to be free from sexual violence
- The right to dignity and to not be subjected to torture or other cruel, inhuman or degrading treatment
- The rights of the child to healthy development, to special protections and to have his/her best interest as the primary consideration
- The right to modify traditions/customs that violate women’s rights

Relevant international tools on human rights²:

- The UN Declaration of Human Rights (1948)
- The Convention on the Economic, Social, and Cultural Rights (CESCR)(1976)
- The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)(1979)
- The Civil and Political Rights Covenant (1976)
- The Convention on the Rights of the Child (1989)
- The Vienna Human Rights Convention (1993)
- The Beijing Platform for Action (1995)
- The African Charter on Human and People’s Human Rights (1997)
- The Addis Abeba, the Banjul and the Ouagadougou Declarations
- The Protocol to the African Charter’ on Human and Peoples’ Rights on the Rights of Women in Africa (2003)

¹ Center for Reproductive Law and Policy:

Female Genital Mutilation: A Matter of Human Rights. An Advocate’s Guide to Action. pp.12-20.

² Anika Rahman & Nahid Toubia, *Female Genital Mutilation:*

A Guide to Laws and Policies Worldwide (Zed Books, 2000). Chapter 2.

Article 5 of the protocol on the Rights of Women in Africa (shortened version) in the African Charter:

Elimination of Harmful Practices:

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

- creation of public awareness
- prohibition, through legislative measures
- provision of necessary support to victims of harmful practices through
- protection of women who are at risk of being subjected to harmful practices or all other forms of violence, abuse and intolerance.”

Adopted in July 2003 by the AU

http://www.achpr.org/Protocol_Women-_Maputo_final03.doc 1

Understanding FGM

“The culture of silence surrounding FGM in Mali has been a great obstacle for its elimination and a hindrance for reflection and analysis. This ‘silence’ is taken to be expressions of discretion, honorability and stoicism. So women suffer in silence on behalf of such ‘values’.”

Mali representative at Regional Consultation on FGM, Nairobi, 2002.

In the Kita region in Mali, members of the blacksmith family traditionally performed the procedure. It took place as a collective ritual on teenage girls. First in the row of girls to be circumcised was the daughter of the blacksmith, second, the girl from the family of the chief. Close ties were established between the two families and these ties were revitalized by the FGM ritual. Now the operation is done on much smaller girls. However, such ties still exist between families of influential positions in the community and form powerful coalitions, providing services to each other.

Oral accounts from the NCA/Mali program.

Judging the practice – not the people

The past three decades brought much information about FGM to daylight. The way it was presented, especially in the West, however, did not always reflect a will to understand the cultures of which the practice is a part. Debates were often characterized by gross generalizations or patronizing. Immigrant women and men in the UK, Norway and elsewhere felt stigmatized by the media’s coverage and by comments from health personnel⁵⁷. **Judging the practice but not the people is a challenge in any context where FGM or other harmful practices are raised.** While FGM is a negative practice in the light of human rights, there is a range of practices in the very same societies which are **beneficial** and worthwhile keeping, such as breast-feeding, visiting the ill, communal mourning, sharing of food, etc. Such customs are at a loss vis-à-vis urbanization and Western individualism and materialism.

For people who do not practice female genital mutilation, it is difficult to perceive how such a practice can continue in the 21st century. Even those who defend FGM admit that it is painful and involves use of force. Many mothers and fathers choose to be absent at the operation because they cannot bear the sight and sound of their child suffering⁵⁸. Elsewhere, however, the mother is present and helps hold the girl or even performs the ‘surgery’ herself. Worku Zerai’s recent study in Eritrea for NCA found that 24% of the ‘operations’ were conducted by the mother, grandmother or mother-in-law.⁵⁹ How can a mother, who experienced FGM on her own body, let her girl child go through the same ordeal? It must be because she sees no alternative if the girl is to be accepted into society and become an ‘decent woman’.⁶⁰

The complex nature of FGM

To understand FGM, one must look at variations in type, consequences, and cultural, religious, and social meanings. FGM is also surrounded by taboos, myths and silence, making public debate and research difficult.

There are great contextual differences and girls’ and women’s personal experiences vary as well. Aud Talle rightfully maintains that a credible portrayal of FGM should consider **both cultural meaning (the collective experience) and individual experience (which may contradict the collective)**⁶¹. Also, youth’s views may differ from those of elders, women’s views from those of men. During a debate in a consultative workshop facilitated by NCA in Somalia, the two gender groups accused each other of sustaining the practice: The women said that FGM existed for men’s sexual pleasure and that they wanted to repress women’s sexuality. The men responded that women were the main proponents of its continuation. As men they would rather see an end to the practice, because it made sex less enjoyable since their wives were passive or even suffered during intercourse.⁶²

FGM as an expression of norms

Norms constitute basic rules and standards for interaction between community members. Adherence to norms helps create a sense of identity, normalcy and belonging to a fellowship of “same-doers”. Norms reward compliant behavior with honor and punishes deviant behavior with social exclusion⁶³. FGM sets the standard for ‘normal’ and ‘good’, ‘clean’ (a woman whose genitals have been cut) and ‘unclean’ (a girl whose genitals are uncut) and ‘mature’ vs. ‘immature’.

When Haali Farah Hassan came from Somalia to Norway, she worked as a care assistant at a nursing home. She



discovered with shock that none of the Norwegian women were circumcised. “Suddenly it dawned on me that the things we do back home are not common in the rest of the world,” says Haali.⁶⁴ She faced a complete counterpoint to what she had always perceived as the normal.

FGM serves to define who is a normal and ‘true woman’ and as such it is ‘necessary’ in order to be accepted⁶⁵. The inner meaning or usefulness of a practice may not necessarily be clear to those who practice it. But who wants to be considered ‘abnormal’ or ‘unclean’? “A convention may not necessarily be useful, but people hold on to it for the very reason that no one breaks it,” says Aud Talle⁶⁶.

Tradition and community above individual

Traditions carry more weight than the interests of the individual, since they are manifestations of a community’s collective heritage.

While **practicing** traditions is a collective responsibility, the **tradition bearers** are the guardians of cultural and religious heritage. They have the authority to interpret how heritage applies to present life. Community elders, religious leaders, traditional healers and circumcisers are all such bearers of tradition. They influence opinions about ‘good’ and ‘bad’ and ‘moral’ and ‘immoral’. While most people sustain culture by living it, the opinion leaders define its meaning. Simon Rye compares culture to a spider web, where opinion leaders are the ones who spin: “Who spins the web of significance? The majority are simply caught ...”⁶⁷ In the effort to put an end to FGM, it is crucial to consult and convince tradition bearers and opinion leaders.

Circumcisers (‘excisers’) play a key role as reinforcers of tradition. When the circumciser also has the function of

traditional healer or traditional birth attendant, their position can be even more influential, as they render a wider range of services. In societies where FGM is a rite of passage, such women introduce the girls to age-old secrets and teach the ‘candidates’ what it means to be a woman.

Some communities pay the circumcisers in cash or kind for her ‘service’ – hence there is an **economic motive** for sustaining the practice. For the circumciser it may be the main source of income or a welcome extra source of income. Unless she is convinced that FGM is an unethical practice, she is likely to continue her work. In other communities where FGM is practiced, the cut is done as a ‘favor’ by a relative or neighbor, rewarded with respect and authority but little or no payment.

Family above girl

Just as tradition is positioned above the individual, **family** stands above the **child**. Dr. Olayinka Koso-Thomas emphasizes how the belief in the unity of the extended family dominates African thinking. Children – girls and boys alike – are to act in the interest of their family.⁶⁸ A girl’s behavior is understood to reflect whether she comes from ‘a good family’ or not. Hence, FGM becomes an issue of family shame or honor. An uncircumcised girl is not only considered ‘abnormal’, or ‘unclean’, but her chances of getting married are diminished. Her parents will gain a smaller bride price, she will carry less status and through her deviant behavior bring shame upon her family. Among the Somalis “...the family honor depends on making the opening (during infibulation) as small as possible, because the smaller the artificial passage, the greater the value of the girl and the greater the bride price.”⁶⁹ Through FGM a girl’s capacity to endure pain and hardship is put to test. If she can cope with the pain, she is considered strong, able to bear many

children, and work hard – hence an asset to the family and to her future husband and children.⁷⁰

Why gender matters

In many communities girls’ and women’s primary role in life is to be married and have children. And in societies where a woman gets her support for life from her husband, marriageability becomes extremely important.⁷¹ FGM is thus linked with socio-economic interests and the idea that marriage provides economic and social security. **At the heart of all reasons given for FGM lies rendering a woman marriageable.**

Drawing the distinction between the terms sex and gender may be useful here. **Sex** refers to the **biological** characteristics, i.e. the male vs. female organs and their functions: Women bear children, men impregnate. These characteristics remain unchanged. **Gender** on the other hand, changes in time and place. Gender is **learned** through socialization and identifies ideas and expectations about men and women in a society. How should women think, act and feel? And how should men? Sex is manifested in male or female reproductive organs whereas **gender** is expressed through roles and responsibilities ascribed to males and females by the community. Our **gender identity** is shaped by what we learn at home, in school, from peers, etc.

Removing or cutting the clitoris or surrounding area has a symbolic value in shaping the child into ‘a real female’ and ‘preparing’ her for sexual reproduction⁷². The clitoris is perceived as a ‘male’ element, just like the foreskin of the penis is considered ‘female’. It is necessary to rid the female body of vestiges of maleness to overcome sexual ambiguity⁷³. FGM is thought to help ‘define’ a girl’s sex. At the same time, it is an instrument for socializing the girl into prescribed gender roles: FGM reasserts women’s relegation to the

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“...Awrala’s mother is preparing Awrala for female genital mutilation...This might be one of the reasons why her father hated having a baby girl. Girls were born to suffer and nobody wants their children to suffer.”

Fatuma Abdi Mohammed, Kenyan consultant and anti-FGM activist.

domestic sphere.

In societies where FGM takes place, gender roles are quite clear-cut. Patriarchal family structure and the idea of male supremacy reinforce gender imbalances in power, rights and duties. Male stands above female, adult above child, mother above daughter, boy above girl. A ‘no’ to FGM may be perceived as a revolt against existing roles and relations, a devaluation of community heritage and a threat to those who hold power within family and community. In Longinotto’s recent film about FGM in Kenya this hierarchical thinking comes out clearly in a statement by a father whose girl refuses to undergo FGM: “**My daughter should obey her mother [i.e. undergo FGM] the same way her mother obeys me.**”⁷⁴

Dr. Nahid Toubia, a renowned women’s rights advocate and specialist on FGM, describes FGM as a case of **negotiated power space**. Excluded from most positions of power in the community, women still make decisions in some arenas, e.g. the domestic sphere. FGM exemplifies a ‘comfort zone’, in which women have power and control. To obtain this ‘power space’, women give up a body part. In return they gain social and economical security and the right to marry. To many women it comes as news that they do not have to give up a part of themselves to be empowered⁷⁵.

Men play key roles in sustaining the practice of FGM. Fathers may give their

consent or actively demand it – or by simply delegating it to women to decide. During a discussion on the role of men in a regional consultation in Eastern Africa, a Somali woman exclaimed: “It is true that men are not there when FGM is done, but in our culture... Is it not the men who are marrying the circumcised girl? So he definitely plays a role.”⁷⁶ Some men are opposed to FGM, while the women want it done. In ascertaining men’s and women’s roles, care should be taken to avoid gross generalizations like ‘men are for’ and ‘women are against’. Men reflect attitudes as non-homogenous as those of women. Aspects of age, class, and education also cut across the male-female dimension.⁷⁷

There are many blind spots as to men’s experience and views about FGM. An increasing number of project evaluations ask for greater male involvement. Yet in his thesis on FGM in Ethiopia, Dr. Simon Rye points out that men’s voices on FGM were muted. Men are easily placed in the category of proponents. He accounts of a boy called Tesfaye who sees his sister undergo FGM. He tries to intervene and stop the circumciser but without success. He is angry with his mother and grandmother for a long time afterwards. For Tesfaye this episode was a traumatic experience and the starting point for critical reflection.⁷⁸ For many men in Ethiopia FGM is an aspect of their culture that they dislike. Usually, it is left in the hands of women, and many men do not know what actually takes place during the procedure. But there are communities where male relatives assist in holding the child, and male medical staff conduct FGM in clinics or hospitals.

The **if, when** and **how** are usually decided by women (negotiated power space) – sanctioned or disapproved of by the male family head. The duty of arranging for the operation lies with the women. Mothers or grandmothers want their girl to undergo FGM to secure her

prospects for marriage, become ‘clean’, protect her virginity, and secure family honor. It is not without reason that **one finds the strongest proponents and the strongest opponents among women**. Another important aspect is the influence of older women over younger: Many mothers – even if they are against it – succumb to pressure to have their daughters undergo FGM.

Control over female sexuality and fertility

“...Even if not put directly, it is **marriage and control over women’s fertility and sexuality which commonly underpins the cultural practice**” says Aud Talle⁷⁹. She argues that there is basic social value attached to women’s chastity in societies where FGM is widespread. A girl’s virginity is seen as an important asset to her family and her husband. Virginity guarantees the man sovereignty, confirms family honor, and secures inheritance rights. Power, economic gain and social status are provided or maintained by controlling the girl’s/woman’s sexuality.⁸⁰

In countries where FGM is practiced, a woman is commonly seen as incapable of controlling her sexuality, therefore, she must be excised or infibulated – or she may disgrace her family. To limit her sexual sensitivity, cuts are made in her genitals, so as “...to keep moral behavior... and assure that women remain faithful to their husbands”.⁸¹ As Dr. Simon Rye points out : “...Because of the link with virginity, marriage and upkeep of moral norms and social relations, the circumcision of girls is a more pressing concern than is the circumcision of boys... The honor or shame of the family is seen to be contingent upon the control of women’s bodies and women’s subjection to the values of chastity and virginity.”⁸² Much is at stake and the female body is placed under control as the ‘property’ of the family or the husband. A woman’s sexual desires are perceived a threat to



status quo, and believed to be controllable through FGM. Women respond by saying that sexual desire is placed just as much in the mind as in the organs. “One does not have to cut and sew to control my morality,” says Safia Yussuf Abdi, a Somali nurse linked to the OK project in Norway. She continues: “...female circumcision does not remove sexual desire ... this desire is placed just as much in the head and in our fantasies...”⁸³

The emphasis placed on a girl's virginity in Afro-Arab cultures was discussed in the 2002 NCA regional consultation referred to earlier. One participant responded that “... If virginity is highly valued, why is the responsibility placed solely on the girl? This is nothing but hypocrisy and places unreasonable pressure on girls. It should apply to both male and female.”⁸⁴ While girls are expected to keep their virginity until marriage, it is ‘permitted’ for a man to have several sexual partners – this is taken merely as a reflection of his male nature. What is immoral for a girl, is not necessarily so for a man.

Another aspect of control is control over the woman's body for the man's sexual enjoyment: In a study in Sudan, the explanations given for infibulation and re-infibulation included “...to please our husbands and tradition.” One man said that “...without re-infibulation, sex will be like falling into a gaping hole.”⁸⁵ Re-infibulation for a man's pleasure reflects the uneven distribution of power in sexual relations.

FGM as rite of passage

Communities mark the transition from one stage of life to another with a ritual held for a whole group of age mates. Female genital mutilation is a rite which marks a girl's passage from childhood into womanhood taking place before, during or after puberty.⁸⁶ FGM carries this particular meaning among groups of people both in Western and Eastern Africa, exemplified by the Pokot, Samburu, Kikuyu, or Masai

in Kenya, the Mende in Sierra Leone, the Dogon and the Senoufou of Mali and Mauritania. Before going through a rite of passage, the girls are considered ‘unfinished’ individuals. The rite gives them membership into secret societies and sisterhoods which last a lifetime. A time of education or ‘initiation’ accompanies the operation – a period of seclusion to receive knowledge about life as a woman. The cutting is done as a ritual which involves the whole community and is accompanied by celebration.

‘Having been cut’ gives legitimacy to be part of the adult fellowship, be married and have legitimate children⁸⁷. Here, FGM is not only about sexual control: The procedure serves as an ‘entry ticket’ which grants social acceptability and the grown woman's rights, duties, and status. Without it she may lose the rights to be part of community life, to own property, to vote or be voted for, to be married, etc. The loss of such rights may bring shame upon herself and her family members.⁸⁸

Professor J.N.K. Mugambi of University of Nairobi relates how the Africans viewed the efforts of the missionaries to ban FGM as an attempt to undermine the entire process of traditional education. To abstract one element and condemn it is unwise, because the community will interpret it as a deliberate insult to their cultural heritage. He refers to how Jomo Kenyatta, anthropologist and former president of Kenya, emphasized the symbolic value of female genital mutilation as part of initiation into adulthood. Kenyatta saw the surgical element (clitoridectomy) as part of a totality consisting of teaching, apprenticeship, physical ordeals and operation. Mugambi quotes Kenyatta: “...this operation is still regarded as the very essence of an institution, which has enormous educational, social, moral and religious implications, quite apart from the operation itself... Therefore the abolition of the surgical element in this custom means to the Gikuyu the abolition of the whole institution.”⁸⁹

If the surgical element that marks the completion of such a ritual is dropped, what will now mark the girl's transition? Fortunately, experience showed that it is possible to introduce alternative rites of passage and adopt the content without physically mutilating the girls.

FGM and religion

The custom of female genital mutilation predates Islam and Christianity. Nevertheless, religion was misused as an intellectual basis for the sustenance of the practice. Patriarchal family structure and ideology of male supremacy (to which FGM is attributable) was supported by religion. Religion and culture stand in a relationship of mutual influence, and people with limited knowledge may not be in a position to distinguish between the two. Although it is a cultural practice, the idea that FGM is prescribed by religion is still widespread. A recent Survey in Mali revealed that 19% of the interviewees thought FGM was a religious issue.⁹⁰

Religion enjoys a more influential position in people's private spheres than do local government and public law – especially in African societies. Interpreters of the Bible and the Qu'ran have vested in them the right and the duty to speak about, and thus influence, people's personal lives.

By remaining silent about FGM or even advocating it, Muslim and Christian leaders contributed to ‘cementing’ the tradition and prevented women from having any choice but to continue practicing it. Also, some religious leaders spoke out against FGM and other forms of violence against women in workshops and international forums to appear politically correct, whereas upon return to their “home arenas” showed little or no commitment, or at best delegated the responsibility to women staff. Fortunately, this is changing as more religious leaders are becoming >>>

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At times resistance to anti-FGM campaigners can be fierce: On several occasions Dr. Amna R. Hassan experienced attacks when speaking about FGM in public occasions in Sudan. In 1985 an old man hit her with a stick. Once people threw stones at her. In 1993 she was thrown out of a village by the local religious leader.

"Clitoridectomy is understood to be a religious obligation by most Muslims all over the country... an uncircumcised individual cannot enter the mosque nor can she pray. Christians say that the Old Testament orders circumcision for both males and females."

Worku Zerai, p. 44.

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aware of the challenge among their own constituencies. Religious leaders comprise a unique potential for changing people's attitudes and behavior.

FGM and Islam

Much of the controversy over FGM in Muslim communities evolves around the understanding of the 'Hadiths' ('narration' or 'tradition') in which Mohammed supposedly said: "If you must cut, be gentle and cut very little." This is taken as a justification for the practice of Sunna (Type I or II). However, this Hadith is considered secondary to basic principles in the Qu'ran or other 'stronger' Hadiths. Moreover, some scholars hold that the above Hadith should be interpreted as "Be merciful and gentle, do not carry out any cutting to damage her..."⁹¹

In her PhD research Dr. Amna R. Hassan, a Sudanese sociologist and specialist on FGM, studied the interpretation of the Qu'ran and the Hadiths relevant to FGM. When consulting scholars in Syria, Jordan, and Saudi Arabia (considered authoritative in doctrinal matters) their response was unambiguous: FGM is not prescribed. They emphasized the general rule that one should not cause harm to the body, but be gentle.⁹² Dr. Amna Hassan argues that if the prophet Mohamed had meant that one should conduct 'Sunna', there would be no ambiguity among scholars. She goes on to reason that the differences in interpretation show that it is a weak tradition and thus not a requirement. Respected scholars assert that all traditions on FGM are weak. Dr. Amna Hassan concludes that "...the removal of a woman's organs so vital for her well-being and fertility is seen as a violation that obliterates the enjoyment and pleasure of legal copulation...The basic thinking in Islam is to make everything good for family life... And God decided a function for every part of the human body, there is no need to change, remove or 'improve' them."⁹³ She quotes the president of Al-Azhar University, Siddique Abd El-Hai: "FGM is not enjoined or mentioned in Al-Sunna. It is not against Al Shari'a to leave the woman uncircumcised. The woman's genitals are to be left as they are – as the Creator made them..."⁹⁴

FGM and Christianity

The Old Testament, the basis for Jewish tradition and religion, prescribes male circumcision. With the coming of Christ, a new era began where the teachings of Christ and the apostles in the New Testament are authoritative for Christian living, whereas the specific prescriptions in the Old Testament, given particularly to the Jews, no longer apply. Some Christians (especially adherents to the Orthodox faith) continue to follow some Old Testament instructions on food, fasting, cleansing, etc. And many Christians worldwide continue to practice male circumcision.

Photo: Bente Bjercke



Sheikh Mohammed in Mandera, Kenya, has joined the ranks of religious leaders who support anti-FGM efforts.



There is no mention, whatsoever, of female circumcision in the Bible. Yet Orthodox Christians in Egypt, Eritrea and Ethiopia and elsewhere practice female circumcision based on the assumption that religion prescribes it or that it is in line with Christian thinking. Although there is ambivalence among the clergy, many followers of the Orthodox church in Ethiopia and Eritrea approve of the circumcision of both boys and girls. Girls' chastity and virginity before marriage carries high value. While male circumcision represents servitude to God, FGM is interpreted as "... a symbol of a girl's 'purity', a seal of procreative capacity and of family reputation."⁹⁵

It is assumed FGM was adopted through cultural influence, since FGM is incompatible with a Biblical view of human beings. Several verses point to how God upon considering his creation was pleased at what he saw (Genesis 1:26-31). A Christian sees the human body as a carrier of the Creator's image and as the dwelling place of the Holy Spirit. "...not causing harm to the body, but caring well for it, because it is the temple of God." 1 Cor. 3: 16-17. The act of FGM expresses discontent with the Creator's work – an insistence that His creation needs manipulation. God wants his children to be good stewards of his creation including the human body (Galatians 3:25). Any act of violence to the body shows disregard for the image of God - in the perpetrator and in the victim⁹⁶. Hence, any practice which violates a human being's bodily integrity should be abandoned.

Jesus Christ introduced a new view of women and children, demonstrating it by the way he approached them. He identified himself with the oppressed and the weak. "Quote...", Matt. 25:40. In the eyes of God, women have equal value and stand on equal footing with their male counterparts.

If God was pleased with his creation, he must have been pleased with the sexual organs, too. A Christian view of sexuality sees it as God's gift, not only for procreation but for men and women to enjoy. In the NCA and partners' regional consultation in Nairobi 2002, a delegate shared how her church is taking up the battle against FGM. She explained that "... In Eritrean culture, it is seen as inappropriate that girls and women are sexually aroused. However, from a Christian point of view there should be no distinction as both man and woman were created to enjoy sexual life."⁹⁷

The misconception that religion demands FGM has persisted for too long. As long the idea survives, religion will serve to sustain the practice of FGM. Religious leaders and scholars must teach people that FGM is not a religious injunction. **Only a religious approach can put an end to a religious misconception.**

Photo: Bente Bjercke



The church strongly condemns FGM, says The Patriarch of the Ethiopian Orthodox Church, Abune Paulos.

"In its annual Synodical Convention in March 2003 The Evangelical Church of Eritrea (ECE) articulately condemned the practice of FGM because of its negative effects to the psychology and the physical situation of the victims. The ECE also declares FGM as a non-Biblical and theologically unapproved practice. Therefore ECE has passed a resolution that its members should not practice FGM."

From circular to the churches, Evangelical Church of Eritrea, 2003.

"It (FGM) is her motherly duty that the society headed by men and decided by men has bestowed on her. The mother is not sure of what she is doing. Some say it is religious obligation, but for her the ultimate goal is to express the greatest love a mother can give to her daughter. I am sure by now you are asking yourself what a way of showing love? Yes it is love, for if she does not perform FGM on her daughter she will not get a husband to marry her, and even if she gets one she will not satisfy him for it is said, "a hole (the size of the virginal opening after infibulation) is better than a well (vaginal opening of an uncircumcised girl) – she will be divorced by the husband on the first day of marriage for not being a virgin. How many of us would want their daughters to be all these things which are not good for men – men the source of power and the only gateway to income and procreation? I see no hands up."

Fautma Abdi Mohammed, Kenyan consultant and anti-FGM activist at NCA Regional Consultation, 2002.

Understanding FGM

Peer pressure

Since 'everybody else' is practicing FGM and this is considered 'the normal thing', a girl or her family feels obliged to do the same. The girl faces pressure from many sides: Her parents and relatives instruct her that it is part of tradition and necessary in order to get married and become respectable. Age mates will undergo it and ask her when it is her turn. A girl who is not circumcised may be teased with comments such as "you who are still a child", "you who are not yet clean" or "not yet made beautiful", etc.

In communities where FGM is a rite of passage, not undergoing FGM may imply exclusion from the fellowship of peers at puberty. By saying no, the girl will miss out on other crucial parts of the ritual – the instruction, the apprenticeship, the secret fellowship, the knowledge, and the feast. **In sum she will not go through the 'proper transition' from girl to woman.** She risks being ridiculed and ostracized as an incomplete person. Refusing becomes extremely difficult.

Parents on their side face pressure from parents, community elders or circumcisers. A grandmother may set up the circumcision of her granddaughter even if the child's mother is against it. Friends may do the 'operation' on the daughter while the mother is away, like Habiba Is-sack and her daughter Ayan experienced (photo p. 21). Ayan was teased by classmates who named her activist mother "Habiba-clitoris". Finally, Ayan had to switch to a different school.⁹⁸

In communities that practice infibulation, there is pressure on the bridegroom to penetrate his infibulated bride by force, even if it is extremely painful for both parties. In Longinotto's film (referred to earlier) a newly married Somali man, whose infibulated wife is advised to be 'opened' by surgery, explains that "...my friends will laugh at me if I cannot penetrate her myself." So he refuses to let her 'be opened' by medical personnel.

The dilemma of immigrant women

African immigrants to the West face new opportunities to leave FGM as they move to new surroundings. Dr. Naheed Toubia, however, relates how many immigrant girls and women become trapped between two cultures – the one of their parents, whom they love, and the new culture, which they want to belong to⁹⁹. Some girls keep it a secret that they are circumcised out of fear that the parents will be arrested, or they fear condemnation by peers. Others resist circumcision and face difficulties with their parents or relatives.¹⁰⁰

Media focus and public debate on FGM does not ease the pressure. Somali women in the UK shared how they disliked all the attention around their 'status'. They felt 'abnormal' in people's eyes and humiliated when seeing a doctor.¹⁰¹ A psychiatrist well acquainted with the situation of circumcised immigrant women used the following words: "When others think you have a problem, you may start believing them. And when you believe you have a problem, you may start to get one."¹⁰²

Immigrant women also find it hard to strike a balance between the positive associations with FGM from their home country (where FGM provides esteem) and the negative experiences abroad (where FGM is condemned). Elise Johansen, a Norwegian anthropologist found that pain associated with FGM seems to lose its meaning when the woman or girl moves from her natal home to the West: "... there is a transformation of the pain experience from ritual to accidental, from necessary and meaningful to unnecessary and even destructive".¹⁰³

A recent study among second and third generation immigrants revealed that living in Sweden and having undergone FGM was problematic. Many of the girls neither dared nor wished to talk about FGM because they felt shameful and

Photo: Bente Bjercke



Somali school girls.



different. Some were reluctant to seek medical assistance for FGM-related complications. They regarded it as impossible to marry someone from a non-practicing culture. Explaining the custom would be too difficult or they would not be accepted as 'real women'... ¹⁰⁴

Understanding is not equal to accepting

It is important to analyze all the aspects of FGM to gain a deeper understanding. For all that, understanding does not lead to acceptance. On the contrary human dignity and bodily integrity are inviolable entities. What is more, FGM is not a religious prescription. All girls and women are entitled to know that FGM violates their basic rights, it is an unnecessary sacrifice and they should be protected from it.

FGM reinforces what runs as the 'theme' in many girls' and women's lives: You are to obey the will of others. Held down by force – with no chance of escape – while being cut in her most intimate body parts, the girl learns her 'lesson': Such is life: Others own and control you – your family, community, or husband. FGM is a powerful way of literally engraining such a 'message' into a girl's mind, body and soul.

Unfortunately the practice of FGM is but one piece in the mosaic of violence against women. Women all over the world belong to the same, unhappy sisterhood of violence, either through battering, sexual abuse, rape, widow burning, early or forced marriage, honor killings or FGM. In the face of this challenge it is very promising that an increasing number of African activists are speaking out. Women – and an increasing number of men – are objecting to oppressive patterns. They have embarked on the quest to safeguard the right to decide over their bodies and lives.

Human rights advocates must turn more of their attention to the barrier that FGM poses with all its bearings on millions of girls and women. And safeguarding reproductive rights through providing adequate pre- and postnatal care for mother and child is one of the urgent

challenges on the road to fulfilling the UN millennium Goals 4 and 5 (reducing maternal and under-five mortality). Goal 3 – to empower women and promote equality between women and men – can only be reached if gender-based violence – including FGM – comes to an end.

Photo: Bente Bjercke



Activist Habiba Issack Barrow and her daughter.

Aspects of change

Inner motivation

Intervening in FGM essentially means addressing underlying attitudes and power structures. Resistance is likely to come from both male and female community members. What individuals and communities have been practicing for generations is being questioned! If a person feels that his or her position is threatened, the more he or she is likely to resist.

People will only change when and if they are convinced that new behaviors are more beneficial than the old. For change to be sustainable, it must be motivated by a new set of interests and emerging social consensus.¹⁰⁵ External agents seeking to enforce change are easily perceived as imposers. That is why agents of change need to emerge from within the target group.

The prospects for change

“A tradition which has been ongoing for thousands of years cannot be abandoned overnight,” says anti-FGM activist Dr. Naheed Toubia. She is still a careful optimist: “In the course of this generation, the number of those who continue the tradition will decrease by 5-10%.”¹⁰⁶ Others are far more optimistic than her.

As long as culture is not genetic, change is possible. *That which was learnt, can be unlearnt.* A child adopts cultural values and learns to behave in accordance with these. This does not automatically imply that a person appreciates all aspects of his/her culture, as the story about Tesfaye on p.16 illustrates. Exposure to the grim physical aspects of the custom and new knowledge, coupled with critical reflection, may create discontent and even behavior of protest.

Another expert on FGM, Agnetha Hejll, found that “... an issue which was considered African, difficult, culturally

sensitive and expensive now begins to show a different face: Experience has shown that it is possible to do something about it.”¹⁰⁷ In many countries, role models are emerging, daughters are questioning their mothers, fathers are using their position to protect the girl from undergoing FGM. The study from Sweden referred to earlier showed that a majority of the young men from the immigrant community said they would prefer to marry an uncircumcised girl.¹⁰⁸

The process of change

Taking FGM as a case, Suzan Izett and Nahid Toubia in their book *Learning About Social Change* describe the process of change¹⁰⁹. They have summarized the process as going through the following five stages:

1. Precontemplation

Decisions on whether or not to abandon FGM are based on existing views acquired through social conditioning.

2. Contemplation

At this stage the person begins to think about changing her (or his) behavior, triggered by a direct experience (e.g. seeing a child bleed or suffer due to FGM), new knowledge (that FGM is harmful and violates women’s rights) or societal change (e.g. moving to new country).

3. Preparation

The person intends to change and plans to do so. Her/his attitude has changed and FGM is no longer an acceptable practice. She/he may, however, face social pressure not to go further with her/his decision.

4. Action

This is a critical stage, where the person acts on the decision. She/he might inform those involved in decision-making of her/his decision, take her/his daughter away during the “FGM-season” in the community, or take her through an alternative rite, etc.

5. Maintenance

Finally, there is a phase where the person has to maintain her/his decision and face the aftermath, including confrontations with family members or community elders, loss of status, ostracism, ridicule, etc. On the other side, her/his decision may have positive effects, such as approval and support of others who follow her/his example. The daughter may also experience exclusion from peer groups.

A study from households in a village in Egypt found that the decrease in the prevalence of FGM was connected to three factors in this particular community:

- One or more persons in the household had been involved in development activities such as literacy classes or income generation.
- The husband had gone to work abroad and the wife had increased decision-making power within the household and in community life. This evidently extended to the area of FGM.
- Christian churches had been speaking out against FGM, including prominent religious leaders¹¹⁰.

The success of the Tostan-project in Senegal was attributed to factors such as:

- Basic education (literacy, including literacy of the female anatomy)
- Public discussions
- A collective decision to abandon FGM culminating in public declarations
- Media campaigns and media coverage (had a knock-on effect)
- Inputs like education, awareness creation, problem-solving techniques empowered women to make bold decisions.¹¹¹



For decades NGOs, governments, national committees, and individuals worked to put an end to FGM. The outcomes of these efforts are not so visible, nor do they stand in proportion to the resources and efforts invested. Nevertheless, years of hard work have begun to bear fruit. FGM now stands higher on the agenda of a wide range of NGOs and professionals. The practice is receiving more media coverage. Twelve African countries reported a decrease in prevalence¹¹². Numerous governments, international agencies and regional bodies (such as the AU) have come up with policies against FGM. More international and local NGOs are supporting projects. New and diverse anti-FGM approaches are attempted. There is evidence of families and whole villages abandoning the practice.¹¹³

Four approaches

Below is a brief presentation of four common approaches to reduce FGM:

The Harmful Traditional Practice approach

- The oldest and most widely used approach
- Emphasis is on health risks
- Religious information is sometimes included
- Didactic delivery of messages often by experts
- Changes seen: Safer practices, medicalization and Increased level of knowledge, but no clear evidence of behavioral change.

Targeting practitioners

- Many different approaches, e.g. training and income generation
- A good proportion of the targeted circumcisers stop practicing
- Some practitioners revert to it later, or other practitioners 'move in'
- Evaluations show limited change in behavior.

Alternative rites of passage

- In communities where FGM serves as a rite of passage it is possible to create rituals that imply "circumcision of the mind, not the body."
- Focus on girls at risk and their families
- Intensive education for the girls, and peer education for parents
- Community sensitization
- Culminates in a public ceremony
- Possible knock-on-effect for those who are not part of the project
- A declared intent to abandon FGM is not the same as real abandonment

The Maendeleo Ya Wanawake Organization (MYWO), Save the Children Canada and other local and international NGOs have introduced alternative rites in Kenya. Community members design the ritual themselves to ensure that aspects of culture are kept when the cutting is left out¹¹⁴. These projects are costly and demanding, but belong to the success stories in FGM-prevention in Eastern Africa.

Where FGM is carried out as a collective ritual, the alternative rite approach is workable. In Mali, the AMSOPT (the Mali national committee on traditional practices) works in 30 communities in a project where all family heads are asked to sign a public declaration. After they have signed, a follow-up committee tries to ensure that those who committed themselves actually abandon FGM.

Representative from AMSOPT, Mali in NCA Consultation.¹¹⁵

The Integrated Approach

- FGM is integrated into other project activities like health, education, income generation or as a sub-component in rural development programs.
- Focus is on women, men and their daughters in risk age groups.
- Assumes wide involvement of the community (men, community and religious leaders, practitioners, youth, etc.)
- Group decision to abandon FGM – declared publicly
- **Documented evidence of substantial behavioral change, possibly long-lasting.**

Photo: Bente Bjercke



Fathers can play a crucial role in protecting their daughters. This father in Mandera, Kenya promised that his daughter would never undergo FGM.

Responding to the FGM challenge

Norwegian Church Aid and partners

Norwegian Church Aid is involved in a long-term program for FGM-prevention in Eastern and Western Africa funded by NORAD. NCA supports 18 projects in Kenya, Somalia, Ethiopia, Eritrea, Sudan and Mali, and recently also Mauritania and Egypt. Except for Somalia (where NCA is operational), the projects are implemented by local partner organizations.

NCA and partners' strategy has been three-tiered:

1. Awareness creation on FGM and other harmful practices among own staff and partners' staff over the past four-five years (as part of gender sensitization).
2. Community-based approaches primarily focusing on awareness creation among local leaders, development agents, priests, imams, women groups, men, school pupils and teachers, health personnel, and traditional birth attendants. The message is conveyed through workshops, campaigns with drama, poetry, songs, and video shows. The activities are usually built in as sub-components in wider community development programs. A few projects focus only on FGM.
3. Advocacy vis-à-vis local, regional and national policy makers, religious leaders government institutions and civil society (NGOs, media, religious institutions, etc.). The main activity has been to facilitate sensitization of religious leaders and to take part in NGO networks.

The following are examples of the type of activities NCA supports:

Somalia

The NCA-Somalia program for FGM came into being due to an initiative by local women. NCA had been involved in the Gedo region of southwestern Somalia for more than ten years in water, health,

education and income generation even during times of civil war. Hence, the project had the trust of the communities. Local women had benefited through income generating schemes, literacy classes and schools for their children. Some of these women came to NCA with a request for support to do something about FGM. NCA hired consultants to facilitate participatory assessment of local perceptions of FGM. The findings were discussed in workshops with cluster groups for men and young boys, women and young girls, religious leaders and finally in plenary sessions.

With the support of NCA the active women have formed change agents teams. They arrange public meetings and seminars in coalition with local administrative and religious leaders in the Gedo region. Personnel from education, health and other sectors participate. The team members spread information, teach in villages, engage more women, train instructors and seek to include men and former circumcisers in their efforts. Anti-FGM messages are spread through T-shirts, pins, videos and posters. NCA supports the women groups through building the capacity in fields of management, health, accounting, income-generation, exchange visits, etc. The women are backed by the support of local Muslim leaders, who preach against FGM on the basis of Islam. Literature about the Islamic view of FGM is translated and made available to local religious leaders.

- The NCA Somalia project has already had an impact and is expanding to surrounding areas, presumably because of the following factors (not yet assessed by research):
- The local women themselves came forward showing strong commitment against FGM.
- The project has a solid, broad community base.
- A trusting relationship between NCA and the communities.

Photo: Bente Bjercke



Consultant Fatuma Abdi Mohamed explaining FGM to men and women in Mandera, Kenya using wooden models produced by the Maendeleo Ya Wanawake organization (MYWO).

Anti-FGM button used in the NCA/Somalia programme.





- Other project components provide access to a wider audience.
- Many Somalis are committed Muslims, and the involvement of the religious leaders from the onset has proven very constructive. Husbands and wives are now able to deny FGM on the basis of Islam.
- Some role models declared that they will not circumcise their daughters. One of the activists is the daughter of a local imam. She was formerly a circumciser.
- The change agents have made it clear from the onset that they want total eradication (not even the “mildest” forms of FGM are tolerated).
- The BBC had been broadcasting programs on FGM and its harmful effects on the national radio for many years.

Eritrea

– With financial support from NORAD, NCA conducted a survey in 2002-2003 on FGM among 3000 women from nine ethnic groups in Eritrea.¹¹⁶

– In the Zula and Sheba Demaz districts, training is given to police, local leaders, health workers, teachers and the local population.

Sudan

Some South Sudanese refugees have begun to adopt the practice of FGM. A program for awareness creation involving the Sudan National Committee (SNCTP), the Sudan Council of Churches (SCC) and NCA, is about to start in selected schools in the Khartoum suburbs. Trainers will be recruited and trained locally. The project will educate headmasters, teachers, parents, girls and boys.

Mauritania

Through the Lutheran World Council and the local organization SOS Peers Educators, NCA supports a program which instructs 15 girls in how to train their peers. The focus is on mothers-to-be. The initiative is supported by key muslim leaders.

Kenya

– NCA and BEACON (Building Eastern Africa Community Network) arranged a workshop for more than 20 religious leaders aimed at creating a platform for inter-faith dialogue on FGM.

– In Mandera in the Northeastern part of Kenya the local NGO Habiba International seeks to create awareness and behavioral change through information, home visits, and by influencing local religious and administrative leaders. Approximately 620 trainers have been trained to promote the abolition of FGM.

Mali

– NCA supports a theatre group which visits Bamako and environs with the anti-FGM play “Lay down your knife”. The play will also be aired on TV.

– Musow Jigi, a local NGO, supports the socio-economic development of women in 17 villages. Circumcisers are retrained to become health instructors. The plan is to incite the villages to make public declarations against FGM.

Africa – Regional level

– In 2002 a consultation in Nairobi gathered the partners of NCA involved in FGM prevention in Eastern and Western Africa to share experiences and look ahead. Such consultations will take place on a yearly basis, as they were found to be most useful.

– NCA/Eastern Africa supported the All African Council of Churches (AACC) with the publication of a training of trainers manual on violence against women in which FGM and other harmful practices are presented. The manual will be used for training in AACC’s member churches across the African continent, including NCA’s church partners.

Norway

NCA coordinates a network of humanitarian organizations and researchers initiated by NORAD for sharing of information and experiences and for strengthened efforts.

Photo: Ken Opprann



Drama and dance in FGM sensitization, Mali.

Agenda for advocacy and continued action

The sections above described Female Genital Mutilation and the socio-cultural web surrounding the phenomenon. Past and present efforts were also sketched. As we look ahead, what are the core messages to be communicated? Who has what kind of responsibility? Which factors are essential for projects to succeed?

FGM is about advocacy

Actors that are involved in FGM prevention are not a homogenous group, nor are the strategies they employ. And **no single approach can eliminate FGM alone**. But common to all actors is that preventing FGM involves targeted **advocacy action**.

Advocacy is putting the problem on the agenda, providing a solution and building support for action. It is to **influence decisions** at individual, family, community, organizational, national and international levels in support for a cause or issue. It is also to **provide a voice for the voiceless and draw attention to injustices**.¹¹⁷ Advocacy work is critical in FGM prevention, because it is about mobilizing those with power to make a difference.

Four advocacy messages

Context, targets and approaches will vary, but the key messages remain the same:

1) FGM is a human rights violation

Anti-FGM efforts used to have health as the primary focus. Even today the majority of programs focus on reproductive health and family planning¹¹⁸. Emphasizing only the physical aspects of FGM, however, reduces the practice to a matter of “safer methods”. Minimizing health risks may then be considered a solution, while the continuation of the practice is left unquestioned. The Convention on the Rights of the Child (CRC), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the new protocols to the African Charter on Human Rights **explicitly recognize that practices harmful to women are violations of human rights**.¹¹⁹

FGM violates the following human rights of women and girls:

The rights to bodily integrity: Where FGM involves removal of tissue necessary for the enjoyment of a satisfying and safe sex life, a woman’s “right to the highest attainable standard of physical and mental health” (CEDAW) has been compromised.

The right to a) health and to b) reproductive health: FGM often causes physical and psychological harm affecting the well-being of girls and women.

The rights of the child: The Convention on the Rights of the Child requires state parties to abolish practices harmful to the child’s health, guarantee health and protect children from all forms of abuse.¹²⁰ FGM comprises a violation of all these rights.

The rights to life, liberty, and security. FGM may be life-threatening to girls and women. Some died due to FGM-related infections, obstructed labor, or severe bleeding.

The right to non-discrimination on the basis of gender: Girls and women undergo FGM because they belong to the female sex. (Male circumcision is incomparable).

Photo: Bente Bjercke



Ayan Abdalla Hashi, staff of Ogaden Welfare and Development Association, NCA's partner in Ethiopia.



“To cut off healthy sexual organs for non-medical reasons is in its essence a basic violation of girls’ and women’s right to physical integrity. FGM is carried out primarily on girl children who do not have a say...” – Agnete Strøm.

Afrikanske kvinner i kampen mot kjønnslemlestelse.
www.fokuskvinner.no 1999 (translation by E.S.)

“From a human rights perspective, FGM cannot be viewed in isolation from other forms of violence against women, from the vulnerability of children to abuse, and from issues of access to education and economic development.”

Amnesty International, ACT/77/16/97
www.amnesty.org

Photo: Bente Bjercke



Staff of the Ethiopian Women Lawyers’ Association (EWLA), Yetnayet Andarge. The EWLA is one of several actors who speak out against FGM in Ethiopia.

The right to protection and a life free from violence: Although FGM is not done to harm intentionally, it is still an act of violence (use of force, causing health damage).

Economic and social rights: FGM impacts women’s and girls’ ability to exercise these rights. The right to education may be impeded by FGM. When a girl reaches puberty or is considered ready for FGM, she may be taken out of school permanently or temporarily. She is then bereft of the right to fulfill her education. Gender-based violence contributes to maintaining women in subordinate roles with low levels of participation, education, skills and fewer work opportunities.

The rights to culture and religion and the rights of minorities have been invoked in defense of FGM. This, however, contradicts the Universal Declaration of Human Rights which protects women’s equality without exemption for cultural practices.

“Human rights imply the obligation on the part of someone else to safeguard those rights.”¹²¹ Those who own the rights have the right to know, and those who are responsible have the duty to inform and to ensure that rights are implemented. Women must learn that they have an internationally ratified right to say no to FGM and that international treaties are **legally binding** for those countries that ratified them.

2) FGM is based in culture, not religion

There are no grounds either in Islam or Christianity for promoting FGM as a religious prescription. On the contrary, both religions advocate good stewardship of God’s creation and for not causing harm to what the Creator made perfect. Even so, large groups of people and communities are ignorant of this fact or misled to think that they must continue FGM.

In high-prevalence countries such as Sudan, Ethiopia, and Eritrea there is

a tendency to move from infibulation (type III) to the ‘Sunna’ (types I or II). To go from some to no cutting, however, seems a more drastic step, which fewer dare to take. Such a step represents a total breach with an age-old tradition and with the deeply engrained idea that female genitals must be manipulated and girls ‘purified’. Before complete abandonment, some communities might go via the ‘Sunna’. In the Harar region of Ethiopia, activists were happy that the girls underwent clitoridectomy ‘only’ (no sewing): “In this generation, we will see many turn to ‘Sunna’. We hope that in the next generation there will be no FGM at all.” But to practice ‘Sunna’ should not be promoted as an alternative – a complete stop should be the only acceptable solution.

Sadly, many Muslim leaders in countries where FGM is practiced support the idea that ‘Sunna’ is prescribed by Islam. A strong argument against this is the fact that FGM is not found in Saudi Arabia, which hosts the seat of Islamic law and teaching – nor in many other Muslim countries like Algeria, Morocco, Iran, Iraq, or North Yemen.¹²²

It is time that religious leaders seize their responsibility in addressing the practice of Female Genital Mutilation and in clarifying the Koran’s or Bible’s position on FGM. Not only is it their **responsibility** – given their influential position in African communities, they also possess a **unique potential** to make a difference. Their word is respected and they have access to large audiences as they teach weekly in mosques and churches. Anyone who wants to address FGM in a community must secure the approval and support – and ideally the cooperation – of these.

In a newspaper interview in Norway young Somali men expressed that people still consider FGM as a part of Islam, even if it is not mentioned in the Koran or in ‘Al- Sunnah’ (tradition of the Prophet). >>>

»»»

"We should be discussing this, also with the scholars. Only religion will change the Somali people's attitudes towards FGM."¹²³

Sima Samar, the head of the human rights commission in Afghanistan, was asked about the oppression of women and the potential for change. She replied: "When the mullahs teach that it is culture, not Islam, which oppresses women... women are relieved, because culture may be changed – not religion."¹²⁴ As long as religion plays a significant role in most

Africans' lives, her statement applies to the case of FGM, too. Upon realizing that Islam does not prescribe FGM, the women in the Gedo region of Somalia exclaimed with anger: "Why didn't you tell us this before?"¹²⁵

3) FGM may have serious health consequences and increases the risk of HIV-transmission

After years of information campaigns there are still many knowledge gaps about FGM. FGM-practicing communities do not necessarily associate the health problems that FGM-affected girls and women develop later in life with the fact that they underwent the 'operation'. They may be unaware of the complications that arise during pregnancy, delivery and in the daily lives of girls and women. The need for basic information - about the procedure, which organs it affects, which health risks it implies – is enormous.

FGM increases the risk of HIV transmission. This is particularly the case in communities where FGM is carried out as a group ritual and as a rite of passage. The same knife or blade may be used on a batch of girls ready to become 'women' without any form of sterilization between each cut.

A study of 1300 women in Gambia revealed higher levels of the herpes simplex two virus (HSV2) in women who had undergone FGM. This virus is a known co-factor for HIV transmission. The higher prevalence of HSV2 in cut women suggests that they may be at greater risk of HIV infection.¹²⁶ Transmission of HIV is also related to the scar tissue which forms after the FGM operation. Such tissue is less flexible than normal skin and prone to tearing during intercourse, causing surface openings and bleeding – making the woman/girl (and the man) more vulnerable to HIV. The fact that many Muslim communities (e.g. in Somalia) are in the denial phase

as to the existence of HIV amongst themselves makes the situation even more dangerous.

When giving birth, a woman who has undergone FGM may experience tearing of tissue followed by excessive bleeding, which heightens the risk of mother-to-child HIV transmission. What is more, the 'reopening' before and the suturing (stitching) after delivery means that a girl/woman may get infections and is likely to visit clinics and hospitals more often than an uncircumcised woman. Sixty-five percent of the women in Eritrea confirmed that they needed to be re-sutured after delivery.¹²⁷ Non-sterile needles and instruments in poorly equipped hospitals or clinics increases the risk of exposure to HIV. Loss of blood during the initial cut and later during suturing and 'reopening' may lead to the need for blood transfusions, another risk in countries which cannot guarantee only HIV-free blood.

4) The long-term solution to ending FGM is empowerment

As long as women have limited access to knowledge, participation and decision-making – and as long as men remain indifferent or wish to maintain the status quo – female genital mutilation will go on. FGM is a manifestation of women's subordinate position in marriage, family and community. The only sustainable way of ending it is to address the structure that sustains it – the underlying values and attitudes and the male-female power imbalance.

Girls and women who are at risk of undergoing FGM are often portrayed as victims only. This may contribute to cementing the stereotype that women are weak and lack control over their own lives. Indeed they are victims, but they are also individuals with an ingrained ability to stand up against discrimination – if given the chance. Focus should be on how women and girls can be empowered to take charge.

FGM and HIV/AIDS

Somalia

Among the Somalis in Mandera, women normally take few precautions to protect themselves. As one participant in the NCA regional workshop put it: "Somali women refuse to use condoms completely".

Girls undergo FGM at ages 3–9, and their mothers agree to do it on the girls together. The practitioner does not use gloves, but usually new blades for each girl.

Most girls were stitched up when they underwent FGM. But due to poverty and desperation, they indulge in anal sex for commercial purpose, while still keeping their 'virginity'. Anal sex increases the risk of HIV transmission.

Sudan

Group circumcision occurs occasionally for both men and women. The same cutting tools are used on several people. The same is true about re-infibulation after delivery: The midwife does it for groups of women and the stitching instruments are not sterilized.

Divorced women go through 'preparation' for a new marriage (they are re-stitched to become 'tight' for their new husband).

There is also lack of clean, screened blood for transfusion in rural areas.

Report on NCA Regional Consultation, 2002, p. 48.



“The long-term solution to the issue of FGM is empowering women,” says Dr. Toubia. Women are often the strongest proponents of the tradition: In societies where women have little or no status, FGM is an arena where they can exercise what little power they have. “We must change their self-awareness... They must get access to alternative sources of power, so that they do not have to sacrifice body parts to gain social mobility,” maintains Dr. Toubia. “Sometimes it is not even necessary to speak to them about the practice. Through increased awareness and new economic strength village women... conclude that they wish to abandon the practice”.¹²⁸ While knowledge is power and women need to know their right not to be forced to undergo FGM, it is not enough in itself. Real empowerment is possible only if knowledge is accompanied by the financial capacity to bear the consequences of a choice. Refusing FGM traditionally made a girl less eligible (or not eligible at all) for marriage in societies where a woman is to be provided for by the husband. Hence, if a woman lacks economic independence, the cultural norms attached to FGM will prevail.¹²⁹

All too often men see FGM as “women’s business”. This is understandable in societies that segregate the sexes and where men and women seldom discuss sexuality.¹³⁰ Women also keep men out of the matter. The involvement of men in FGM prevention has been limited. For all that, the gains toward ending FGM are less evident to men. That is why men are in need of empowerment by way of new knowledge, increased awareness and a new perception of their own role as men.

Women should play a greater role in religious forums where the Koran and the Bible are interpreted -- a task historically reserved for men. When women become involved in understanding, interpreting and re-interpreting Christian and Muslim scriptures, they may bring in important new perspectives and help see the scriptures in new ways. Dr. Amna R. Hassan is an excellent example. This may in turn create room for increased female involvement in similar arenas at the grassroots level.

Photo: Bente Bjercke



Men can play a key role in ending FGM.

Photo: Bente Bjercke



Habiba discussing FGM with women in Mandera, Kenya.

Target groups and recommendations for action

“We should not indulge in explaining the various [human rights] conventions, but try to contextualize them by building on local values, use traditional ways of solving conflict, honoring, etc. ... After carefully initiating dialogue by discussing health issues, you suddenly find yourself talking about leadership, gender, ways of solving family conflicts, avoiding violence, and ultimately also FGM. This is human rights in practice.”

Dr. Amna Hassan of SNCTP,
Sudan in NCA Regional Consultation, 2002

Girls and women hold a legal entitlement to have their rights secured. **The duty bearers – those responsible for delivering these rights – must be held accountable. So who should be challenged about FGM – to do what?**

The direction of attention in the following is bottom-up, starting with the household, within which women and girls, men and boys are placed. From here the focus moves to roles and responsibilities of different actors, such as community leaders, governments, NGOs and civil society, and the international community. What are the responsibilities of each actor? Which actions should they take?

Girls and young women

The girl or young woman is the one whose rights are violated by FGM. Her vulnerabilities (need for protection or support) and strengths (ability to learn, decide, etc.) must be taken into consideration. She must learn about her own anatomy and her rights. Education, however, seldom suffices for a girl to be able to say no, because adults around her make decisions on her behalf.

Adult Women

Women – mothers, grandmothers, aunts or other women – are the most important target group for FGM prevention.

Photo: Ken Opprann



Women in Mali use drama and dance in the efforts to prevent FGM.

They have personal experience with the procedure, and have vested in them power to bring change, as exemplified by women of the Gedo region in Somalia. Women’s participation is crucial for understanding FGM and for finding the best solutions. Extra care should be taken to reach women who rarely go out of their compounds. And as individuals responsible for raising children, mothers should be encouraged to raise their boys and girls in a way which promotes gender balance.

It has been said that illiteracy is a woman’s face in the developing world. Women lack exposure to other cultures and thus believe that “everybody” undergoes FGM. They need to learn about the genital organs and functions. Many women do not realize that FGM may have caused some of the health complications they face. What is more, women – young and old alike – are entitled to know that they have rights, and that their opinion counts. New knowledge about human rights can create a basis for going against other harmful practices. And the very same rights apply to other areas of life – be

it in the choice of education, marriage partner, career, number of children, and the like.

Information should be presented in a contextualized way. The Sudan National Committee on Traditional Practices (SNCTP) runs training programs for women which include “four literacies”:

- Literacy of Words
- Bodily and Environmental Literacy (including health, FGM & HIV/AIDS)
- Economic Literacy
- Literacy of Human Rights

Men and boys

Raising the issue of FGM among women only is not enough. Moreover, when women alone are addressed, there is a tendency to trivialize the issue¹³². Dr. Simon Rye, who studied the male perspective on FGM in Ethiopia, made three important observations that seem to apply in most contexts where FGM is an issue:

1. Men and boys are seldom encouraged to speak their minds and relate to their experiences with FGM.



2. FGM and other reproductive health issues are commonly misconceived as “women’s issues” that do not affect men.
3. People believe that men generally support the practice of FGM while in fact many men find it a problematic part of their culture.¹³²

These three points constitute important challenges in mobilizing men in anti-FGM work. Local arenas must be found where men and women can meet, both separately and in plenary to present and discuss their views respectively.

Since FGM is considered a women’s issue, boys and men may not know what their sisters, daughters, and wives actually undergo during FGM. Many of them did not receive education about the female organs in the first place. SNCTP arranged a training session for top Muslim scholars in Khartoum. Their knowledge of the female anatomy and the functions of the sexual organs was minimal.¹³³ In Ethiopia NCA and partners arranged workshops for development staff, church leaders and government representatives, most of them men. Upon seeing a documentary of a 9-year-old girl undergoing FGM, not only were the men shocked by the brutality of the procedure, but suddenly fully realized what takes place physically.

Men need to realize the **gains of abandoning FGM**, such as happier and healthier daughters, a healthier wife and more enjoyable sex life for both, less complications during childbirth, and less money spent on medical care. Change in behavior comes when a person sees it as **necessary or beneficial** to himself or his family.

Beyond receiving information, men need to realize the **responsibility** they bear, given their position and power. They make decisions on behalf of their daughter or consent to the wife or the grandmother’s decisions. They transmit attitudes to their

sons. Young men contribute either to the status quo or to change by expressing that they are willing to marry uncircumcised girls. At times the issue of FGM turns into a matter of serious controversy between husband and wife (see story of Helen Nettey from Ghana this page) or between generations. A woman or daughter who has a supportive husband or father has a great advantage. The story from the NCA-supported project of Kembatta Women’s Self-Help Centre in Kambatta, Ethiopia, is a touching story of how a wise father, a considerate boyfriend and sufficient courage to trust her gut feeling helped Belaynesh avoid FGM:

Today, Belaynesh and her husband Tekeyel are married... “I did not know much about circumcision... to me this was just something ‘we all did’”, says the 17-year-old. In the Kembatta region, tradition demands that girls are circumcised when they are in their teens, as a rule just prior to marriage.

It was her father who first became alerted to the dangers of FGM. Along with some co-villagers he took part in a seminar arranged by the Kembatta Women’s Self-help Centre. Enraged by this new information, he sat down to speak to his daughter.... Her father and boyfriend agreed that Belaynesh would not have to be circumcised unless she wanted so herself. Her mother, on the other hand, was firm in her intention to make the daughter “pure” before marriage. “Papa and I discussed it, and we agreed that it would be better if I moved away from home. Stopping my mother could prove difficult.” They got married some months later. Neither of the parents came -- the mother because she still was enraged by the daughter’s choice, and the father because he did not want to add fuel to the fire. “I’m sure papa would have liked to come, but I understand his reasoning. We meet discretely. He is a brave man...”

Tekeyel agrees.

NCA Magazine p. 12, January 2004

A vulnerable position

Dear What’s The Problem,

I am a 19-year-old student in Accra. I ran away from home when I was seventeen years old because my father tried to force me to have a circumcision and I refused.

My mother who supported my decision, managed to persuade a friend of hers to take me into her home. This lady has been very good to me for the last two years and has financially assisted me in my studies. But recently my father found out I was living with her – and started to harass and intimidate this lady. Although She pleaded with my father to leave us in peace, and let me stay with her until I had at least finished my studies, he refused and continued the harassment, so I left.

I am now living in a hostel but can’t really afford the rent – nor can I continue with my studies, and to make matters worse, my father has now divorced my mother, all because of me. My whole life is a mess. I feel all alone and unable to cope. Out of desperation I have even tried to return to my father’s house but he said I’ve disgraced the family and he will only take me back if I agree to the circumcision. I really don’t know what to do, please advice me.

Helen Nettey, Ghana.

Photo: Bente Bjercke



Belaynesh and her husband Tekiyel in Kambatta, Ethiopia.

Target groups and recommendations for action

“Being a young man interested in youth, gender, and women’s empowerment, the primary challenge is to get people to respect me and my ideas even before accepting them. Most of my fellow young men think I am advocating impossible ideas, which ... cannot be implemented in The Gambia. They accuse me of being a “womanizer.” Nevertheless, this never discourages me. Instead, it adds more fuel to my fire... Resistance to change or new ideas just means you have more work to do in sensitization.”

Ebrima Saidy, The Gambia Youth Coordinator at the Foundation for Research in Women’s Health Productivity and the Environment (BAFROW), Equality Now website, Awaken Campaign.

Durame (ENA): “More than 500 community and religious leaders as well as women in the Kembata zone of Ethiopia gathered Tuesday to voice their determination to fight Female Genital Mutilation (FGM) which hastens the spread of HIV/AIDS particularly in rural areas. They said they would join forces to eliminate this brutal practice being exercised on girls, which contributes to the spread of HIV/AIDS where FGM is rampant.”

Ethiopia News Agency, 2002.

- Circumcisers are not difficult to find. Parents have to be sensitized not to request the “service”.
- We need to focus on both parents and circumcisers. We cannot leave out the practitioners.
- In Somalia many of the circumcisers do not know that they are doing something harmful. Even if they become aware...it becomes a problem when it is their only source of income...
- In Mali there are two kinds of circumcisers – those who live within the community and those who travel around. If she lives in the village, our projects give her income-generating activities. But for those who go from village to village there is little we can do ... except sensitize the communities not to accept their ‘service’.

Participants in NCA Regional Consultation on FGM, 2002

Group support and role models

To be different from “everybody else” is not easy. That is why people may be against the custom, but still practice it. If people can join in a fellowship of like-minded boys or girls, or men or women, however, it can give the needed backing to break a convention. The Kembatta Self-Help Centre in Ethiopia facilitates the formation of support groups around girls who wish to break away from the custom.

A convention can only be broken when a “critical mass” of people do so simultaneously¹³⁴. Aud Talle says: “Decisive for breaking a convention like FGM (besides information and education) is a **public declaration** from a sufficient number of members and/or powerful members of the group.”¹³⁵ Such public statements were made in the Tostan village of Senegal, a much cited example of how a whole community denounced FGM.¹³⁶

Role models are individuals, families, groups, leaders or communities that break a convention. They demonstrate

that the “impossible” is possible, and may inspire individuals on the brink of change to take the next step. The young girls in Kenya who fled their villages to escape FGM are role models – as are the pastors who received them. Belaynesh’s father and husband are role models, whose examples have had multiplying effects in that particular community¹³⁷.

Community leaders

Community leaders are elders or political administrators, priests or sheiks/imams, traditional healers, members of traditional judicial institutions, most of them men, but also some influential women. They **influence opinion and decisions** at the community level. The **interplay** between these **bearers of tradition** and **FGM activists** (local women and men, role models, development personnel, local staff of the national committees, etc.) lays an important foundation for change. Local leaders should be encouraged to raise the issue of FGM in various traditional, political, administrative and public forums. (For the role of religious leaders, see section below).

Photo: Ken Opprann



Community awareness creation on FGM in Mali.



The Circumcisers

Circumcisers need to be made aware of the harmful effects of FGM. When realizing their role in inflicting harm, some circumcisers were “converted” and became change agents involved in health promotion. Their involvement in anti-FGM work can be an asset, whereas resistance may hinder other efforts. Addressing circumcisers, however, is a complex matter. They may be reluctant to give up the practice, as they may lose income and/or the status they might have had. Moreover, it is difficult to monitor whether a circumciser actually ceased ‘operating’. She/he may find new ‘markets’ elsewhere. Arranging for alternative means of employment may seem an effective strategy, but demands extra resources. What is more, such economic schemes may unintentionally become “rewards” for having circumcised girls, as circumcisers receive special attention and even financial support. If parents wish to circumcise their girls, they will continue to seek out circumcisers till they find one or do it themselves. Hence, **focus should be on reducing the demand for FGM** rather than restricting the circumcisers¹³⁸.

Governments

Most African states have ratified international conventions like the CRC, the CEDAW and the African Charter, which all clearly state that governments have a responsibility to protect the girl and make sure women’s rights are safeguarded. However, except for a few countries, governments either remained silent or hardly addressed FGM.¹³⁹ The contributions of local and national NGOs far outweigh those of governments. It is high time that national governments back their pledges with action. They should:

- implement the protocol “The Rights of Women in Africa” to the African Human Rights Charter ratified by the AU in 2003. Articles 5, 14 and 20 deal with FGM/harmful traditional practices and women’s reproductive rights.
- develop national and regional policies and action plans to eliminate FGM and other harmful traditional practices.
- increase national funding for FGM prevention.
- create public awareness by using all channels of information (media, IEC-materials, art/culture, etc.) and

educate communities on human rights, reproductive rights and legislation that provides protection from FGM.

- create favorable conditions and provide technical/financial support to organizations involved in community-based initiatives.
- mainstream FGM into education and health sectors, and where relevant, bridge FGM- and HIV/AIDS-sensitization programs.
- build the capacity of their own staff and organization.
- provide training/resources to the police and judicial sector for reporting and prosecution of FGM/other forms of violence against women.
- establish or support shelters/transitional solutions for girls who flee FGM
- provide technical, logistic and financial support to research on FGM and facilitate networking and coordination among governmental and nongovernmental organizations.

At the **local** level, governments should ensure that national policies and laws concerning FGM are enforced. This could mean that line ministries cooperate locally with NGOs, women’s/ youth groups, and religious communities/leaders on information sharing, campaigns, training, provision of “safe havens” and appropriate social services to affected girls and women, etc.

Photo: Bente Bjerkke



School girls in Kambatta, Ethiopia.

In the Gondar area in Ethiopia, Save the Children Norway and the Ministry of Labor and Social Affairs, the Ministry of Justice, the Ministry of Education and the police have cooperated for years in an awareness creation program for professionals on FGM, and formed CRC-committees to monitor possible violations of the Convention of the Rights of the Child locally. They also broadcast information on FGM and early marriage on the local radio and have dialogues with listeners’ groups.¹⁴⁰

Target groups and recommendations for action



It should be added that top-down approaches based on governmental intervention are limited in scope and impact. Most effective are programs with a strong community base.¹⁴¹ Governments should realize their limitations and facilitate local, voluntary initiatives.

Education sector

“...Education by itself has the potential for initiating the analytical ability of the individual... It enhances the individual’s self esteem...self-confidence. It thus provides a huge impetus for change.” This is how Worku Zerai, who conducted research on FGM in Eritrea for NCA, describes the link between education and the elimination of FGM¹⁴². Not only does general education – especially secondary and tertiary – in itself contribute to a decrease¹⁴³. The education sector (including literacy courses and non-formal education) also has the potential to become arenas for learning about FGM and for building attitudes against it. This potential has yet to be exploited.

Information about the female-male sexual organs in general, and the procedure of FGM in particular, is still scarce in many school curriculums in countries where FGM is practiced. The Sudan National Committee reports that after ten years of lobbying and awareness creation, they now cooperate with the Minister of Education to bring FGM into the curriculum and produce educational materials¹⁴⁴. Another challenge is that some teachers advocate for the practice. In the mentioned Eritrea-study, almost all the male and female teachers were against infibulation but **in favor of clitoridectomy!**¹⁴⁵

FGM affects girls’ school attendance. After undergoing infibulation, it may take a month or more before a girl can return to school. Many circumcised girls stay away from school due to urinary tract infections or problems during menstruation.¹⁴⁶ In countries like Kenya many girls are taken out of school after undergoing

FGM, as they are considered ready for marriage.

The following are examples of how FGM can be integrated into education:

- create awareness among teachers and train them to train their pupils
- encourage teachers to raise matter with pupils, colleagues, and parents
- form anti-FGM clubs among pupils and participate in local public campaigns
- raise the issue in PTA meetings
- invite local religious leaders to ascertain that FGM is not a religious demand
- keep records of female students’ absences and their problems related to FGM
- spread IEC- materials on FGM and other harmful practices

Health sector

In the health sector, governments should

- continue to train health personnel on FGM and its effects, on prevention, and management of FGM complications. Several countries have documented lack of competence in treating FGM-related complications, especially with infibulated women, or counseling for FGM-affected women.¹⁴⁷
- involve circumcised women in FGM-prevention programs
- cooperate with traditional healers and TBAs, drawing on their knowledge and offer them training to become local agents of change
- improve data collection, documentation and reporting on prevalence, types of FGM practiced, complications, etc., in clinics and hospitals
- take measures to prevent/ punish medicalization and the involvement of medical personnel in FGM
- establish and strengthen ties with HIV-AIDS programs
- integrate FGM as a component in sex- and HIV-AIDS education among youth

- provide appropriate care for affected girls and women, such as reconstructive surgery, treatment of fistulae and psychosocial care.

Anti – FGM laws – necessary but with limited reach

“Governments should be guided by treaty provisions requiring them to modify customs that discriminate against women, abolish practices that are harmful to children, and ensure a social order in which rights can be realized.” says Anika Rahman.¹⁴⁸ All African countries have provisions against FGM in the law or constitution, if there is willingness and interest to find them¹⁴⁹.

The legal aspect of FGM is a complex one. A law is a message about what is unacceptable. It is a tool, among other things, for taking circumcisers to court and giving the work of activists legitimacy. The reach of the law is limited, however, as issues concerning sexuality and marriage belong to the domestic sphere. A law may at worst cause the practice to go underground, making prevention more difficult. If a girl is bleeding heavily after being cut, her parents may not take her to the clinic for fear of being reported, thus risking the girl’s life. Punishing such parents is a double-edged sword, because it may lash back at the girl. Nevertheless governments need to:

- make legal provisions against FGM and enforce these
- when a law is passed, put an equal amount of resources into awareness creation and sensitization among practicing communities
- create favorable conditions for lawyers’ associations and activists from civil society to give input to the formation or amendment of legislation.

The Norwegian government

The Norwegian government has committed itself to the **Norwegian**



Government's International Action Plan (launched in 2003), which presents the measures it will take to prevent FGM. The Norwegian government has a key role to play not only by means of financial support to programs. It should:

- put political pressure on other governments, especially countries of development cooperation (Eritrea, Ethiopia, Uganda, Tanzania, Mali, Sudan) to implement what they already pledged: to protect women/girls from FGM
- put as a condition that FGM is integrated into health and education sector programs in the countries of development cooperation
- monitor the use of Norwegian funds channeled through the UN agencies so that these help strengthen grassroots activities to prevent FGM
- help build the capacity of government and NGO staff, and own embassy staff
- contribute to more documentation about FGM and support research and the development/refinement of tools to monitor and evaluate FGM-programs.

The role of Non-Governmental Organizations

Vis-à-vis governments and international bodies such as the AU and the UN, local, national and international NGOs should be intermediaries between rights holders and policy makers/duty bearers. They should:

- monitor governments' commitment to and implementation of the African Charter as ratified by the AU and lobby for increased attention to FGM within various public sectors; advocate for inclusion of FGM/other harmful practices in Poverty Reduction Strategy Plans (especially in health and education sectors)
- advocate for development and implementation of FGM-policies and plans

- develop own advocacy skills and identify channels to reach policy makers
- give input to legislation processes on FGM / harmful traditional practices
- keep governments informed of the "situation on the ground".

At community level, local and international NGOs intervening in FGM should:

- ensure systematic quantitative and qualitative documentation of local FGM-prevalence, attitudes, effects and possible impact in project communities
- draw on the expertise of organizations such as RAINBO and others, and employ indicators and other tools to monitor attitudinal/behavioral change in project areas
- use their dual access to national and local levels and help create synergy between the two, for example by facilitating forums where top religious leaders meet local imams or priests to discuss FGM and religion
- where relevant, link anti-FGM activities with HIV-AIDS programs
- support and encourage role models to sustain their decisions.

The role of Faith Based Organizations

Many of Norwegian Church Aid's partners in Eastern and Western Africa are churches or faith-based organizations. They have unique access to the grassroots level through their constituencies and village level churches and mosques. In rural communities in Africa, there is suspicion against governmental interference in family and community. Religion, however, by nature addresses the private area as it deals with morality and sexuality, faith, family life and gender. Women and men turn to the local imam or priest or pastor for advice. Religious leaders are a potential force in anti-FGM campaigning.

Photo: Bente Bjercke



Men and women joining in the efforts to end FGM, here represented by staff of BEACON, Kenya, Rebecca Tanui and Akattu Enoch.

By way of their position (in African societies), religious communities and their leaders are duty bearers vis-à-vis girls and women at risk of FGM for two reasons: First, they are in a position to influence people's life choices in a direct way. Second, Muslim and Christian leaders who know that FGM is not based in religion are obliged to speak about it. To not make use of the opportunity is to fail in one's duty towards the female child and women.

Faith-based partners of NCA should speak in a unified voice across religious and dogmatic differences to present a clear no to FGM. NCA is already facilitating inter-religious dialogues in Eritrea, Kenya, Ethiopia, and Sudan on issues like peace, HIV/AIDS, small arms etc. They should bring up the topic in general assemblies, >>>

Target groups and recommendations for action



workshops, leadership training, women's groups, youth groups, and take part in anti-FGM campaigns.

Evangelical churches both in Ethiopia and Eritrea have issued public statements, articulating that FGM and other forms of violence against women is incompatible with a Christian view of human beings and should not be practiced by its members.¹⁵⁰ In an NCA-supported project in Northern Ethiopia, local priests will be involved in anti-FGM education. The Coptic Church of Egypt runs development projects where local leaders, midwives, health workers, priests and sheikhs receive training about FGM. Church members visit homes and schools, trying to change attitudes.

There are limitations to a religious approach to FGM also. Some muslim scholars mislead their people by saying that infibulation should stop, but 'Sunna' may continue. Moreover, a situation where religious leaders decide everything is not an ideal situation. In principle, people should decide for themselves. "We should involve local religious leaders, but it is essential that women can think and decide for themselves", says Dr. Nahid Toubia.¹⁵¹

The role of the media and other civil society actors

The role of media has become increasingly important as more people have access to a radio or a TV set in Africa. As mentioned earlier, the BBC has broadcast programs on FGM to Somalia for more than ten years. In Northern Ethiopia, Save the Children Norway used the radio as a tool to prevent FGM. Local women's group discussions are broadcast weekly and the listeners give their feedback the following week¹⁵². Many local and international NGOs produced films and videos on FGM of varying quality. It is important that such materials communicate clear messages (e.g. that no form of FGM is acceptable) and keep certain ethical standards when

it comes to respecting the integrity of persons portrayed. An NCA partner in Kenya, the Africa Woman and Child, trains journalists and others in handling issues of gender, FGM and violence against women in the media. Media's role can be that of educator, provocateur, host for debates, or advocate – and NGOs and government should build strategic alliances with the media and learn to use them consciously. The media can make an important contribution by portraying positive role models and best practices so as to communicate that change is possible and change is under way.

Other civil society actors that could take part in FGM prevention are trade unions, women's unions, youth organizations and other associations and interest groups.

Networking – local and international

The Inter Africa Committee has played an important role in bringing together NGOs and other actors involved in FGM prevention. On a general note, however, there is great need for building more common platforms and for better coordination. Interregional experience sharing between Western and Eastern Africa should be strengthened. UN and other agencies should continue to collect and synthesize the experience of governments and NGOs, (cf. The 1999 joint review by WHO and PATH), and oversee that international human rights instruments are interpreted into local and national implementation.

At the national and local levels NGOs should cooperate on:

- common agendas for advocacy, e.g. vis-à-vis the government
- creating forums for mutual experience/information sharing and coordination
- research and documentation and materials production to avoid overlap
- identifying and covering "dark spots" where FGM is still rampant.

At the international level NGOs, UN agencies and activists should cooperate on research, and continue to place pressure on governments to implement ratified conventions/treaties and work towards reaching the Millennium Goals.

For NCA it will be important to make better use of the extensive contacts within religious structures such as the All Africa Council of Churches, the Lutheran World Federation, the World Council of Churches, the World Conference on Religion and Peace, etc. The opportunities for religious and inter-religious action against FGM are many.

Research and improved monitoring and evaluation

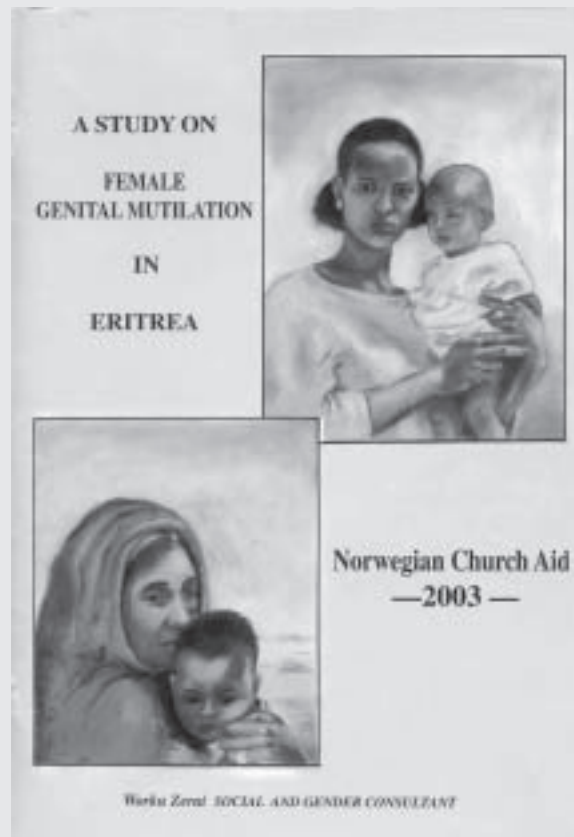
In order to be reality- and needs-oriented and to have credibility, governmental as well as non-governmental actors must build their interventions on a solid knowledge base. FGM, however, remains an unexplored field of study in many countries. Various national figures contradict each other, or are based on narrow-scope studies. Aspects of FGM concerning prevalence, perceptions and attitudes, and even health effects, remain undocumented.

Interventions on FGM are numerous, but the number of studies and documentation of change are few. We should keep asking: Did our interventions bring change? If so, what triggers change, what does not? How can change in perception, attitude and behavior be measured? What happens in the process that brings a person to the decision to go against FGM? Answering such questions is necessary and provides much needed insight for designing effective strategies¹⁵³. Organizations like RAINBO, PATH, the Population Council, and others are doing important work in this field. Yet there is need for far more quantitative and qualitative research on:



- the effects of FGM on physical and psychological health
- characteristics of attitudinal and behavioral change
- the use of indicators to assess, monitor and evaluate the process of change in a) knowledge b) attitude c) behavior d) vis-à-vis input of efforts and resources e) sustainability of change over time (e.g. villages who publicly proclaim no to FGM, what is the status after a certain time? If there is backlash, why so?)
- human rights monitoring regarding FGM
- best short- and long-term strategies
- the male perspective and the male experience regarding FGM
- negative/unintended side-effects of anti-FGM interventions
- economic factors/aspects of FGM
- role and impact of religious leaders and structures in anti-FGM efforts.

When knowledge is in place, it should give direction to the activities. Research on FGM has a value only to the extent that its findings come to use in project planning and implementation.



On behalf of NCA/Eritrea, Worku Zerai and colleagues have surveyed the extent and variations of FGM among the nine main ethnic groups in Eritrea. The study was funded by NORAD. More than three thousand women participated. The study concluded that approximately 98% of all the women had been exposed to the custom.

Photo: Bente Bjercke



Abdullahi Abdi, Agnes McAntony, and Ollo Habil, representatives of the National Focal Point in Kenya, a coordinating network for agencies involved in FGM prevention.

Connecting FGM interventions with HIV-AIDS programs

As pointed out earlier, FGM increases the risk of HIV-transmission. In this sense there is a direct link between the two. However, there is also a connection in another sense: The issues and challenges regarding HIV-AIDS have a high degree of transferability to anti-FGM work.

FGM and HIV/AIDS went through similar stages during the recent past. Efforts to prevent HIV/AIDS started from a health risk perspective, moved on to focus on behavioral change, to mobilizing men and now to empowering women, fighting stigma and safeguarding the rights of people living with HIV/AIDS. In a similar way, FGM was initially addressed primarily as a threat to health. Gradually it also came to be seen as a violation of human rights. FGM and other harmful practices such as abduction, wife inheritance and early marriage gained attention as issues of gender discrimination.

As development issues, FGM and HIV-AIDS share many other common traits: They both concern attitudinal and behavioral change, sexuality and gender, marriage and issues of virginity and control over girls' and women's bodies, ostracism and stigma, gender discrimination, and violence against women and children. Both challenges demand effective information, communication and education strategies, and support to men and women who choose to behave differently. Anti-FGM activists, therefore, can draw on the wealth of knowledge and experience that HIV-AIDS campaigners have accumulated over the years, and vice versa.



Some guiding principles for action

- The entry point for anti-FGM activities should be a broader, **integrated developmental approach**. This presupposes confidence between communities, activists, NGOs and religious communities.
- Ending FGM demands multifaceted approaches. **A complex issue takes a complex approach**.
- Strategies should be **culturally appropriate**. The emphasis on the collective identity and the importance of family in African communities suggests that FGM is addressed in a way which involves the whole community.
- Communicative approaches should be non-judgmental and encourage **dialogue, not confrontation**¹⁵⁴. Avoiding emotional reactions when addressing FGM completely may be impossible. But one should try to lessen their effects and minimize harm by addressing people with respect, and as far as possible, avoid offense¹⁵⁵. Some people may believe that FGM activists come to promote girls' promiscuity by abolishing FGM.¹⁵⁶ The messages should be clear and based on terms that have been tested and are locally understood. Often the focus has been on the horrific aspects of FGM. People must realize that the **gains** of ending FGM outweigh the losses. This is the only way to challenge a culture from inside.
- Effective intervention takes **personal commitment and ownership** of FGM as a challenge, also among men.
- The fact that approximately 6000 girls are mutilated each day creates a sense of urgency to take quick action. And current development practice is characterized by a demand for efficiency and visible results in a short range of time. This mode of thinking may underscore the **importance of time and patience** in the quest to put an end to Female Genital Mutilation. A growing focus on the practice of FGM in Kenya, for example, caused many NGOs to take up the challenge. After two or three years of effort, however, little impact could be seen, and implementers ran short of either money or patience and gave up. This was detrimental to the cause, because it reinforced the perception that FGM is an insurmountable challenge not worth investing in¹⁵⁷. The basic mode of thinking in FGM prevention must be long term and should have implications for policy and planning, for resource allocation and recruitment.
- People need to have an **intrinsic motivation to change**. It is necessary to find local actors who have an internal understanding of the culture.
- There should be **gender balancing** in all steps, phases and levels in anti-FGM work, including increased involvement of men and building the capacity of local women to take charge. Actors should work, not only to prevent FGM from the point of interest of health, but to see it as a step towards greater empowerment for women in a general sense. As stated earlier, the male perspective on FGM needs more attention/documentation. In communities where women do not speak in public, special measures must be taken to ensure their participation.

Conclusion

Understanding Female Genital Mutilation is not accomplished overnight, but a necessary step which lays the foundation for any action to stop the practice. However, understanding is not accepting. The fact that girls from age zero to twenty (or more) are forcefully held while others cut in their most intimate body parts against their own will -- and for no medical reason -- and even in the name of religion -- invokes anger and constitutes a strong call for action. Where culture violates human rights, we are **obliged** to affirm that human rights stand above culture.

A traditional practice does not exist by itself. It is a manifestation of **underlying values and attitudes**. FGM is like a mirror that, when held up in front of women and men, gives an opportunity to analyze such values and attitudes. Being more than a physical issue - just like sex is not only a physical issue but an issue of the mind -- addressing FGM can allow for reflection and change in the image of oneself and others.

Because of its complex nature and deep roots in culture, ending FGM demands **a holistic, integrative approach**. It requires that members of the practicing community themselves reject the custom. Hence, more effort to mobilize local opinion leaders, religious leaders and men is needed. The **personal commitment** of individuals and groups is also vital for sustaining activities over time and having the patience needed before change comes. Another key factor is the enhancement of **role models**. When victims themselves start to tell their stories, things can begin to happen. In this paper, the reader met people like Habiba, Belaynesh, her father, and others.

"I believe communication, compassion and showing humane consideration will lead to change," says Said Salaheldin Al-Said, a young doctor involved in targeting men about FGM in Norway¹⁵⁸. We owe any human being respect -- even those

Photo: Bente Bjerkce



Young girl from Mandera, Kenya.



who advocate for continuing the practice. Cultural tact and sensitivity should mark the way of approach. People may fear that abandoning FGM will lead to the disintegration of culture. The **advantages** of abandoning FGM should thus receive/realize stronger emphasis. “For every girl that escapes FGM, it means a chance for a better life”, says Mershaye, a trainer in the Kambatta Women’s Self-Help Centre in Ethiopia.¹⁵⁹

The motto of the international conference on FGM in Addis Abeba in February 2003 was “Zero tolerance against Female Genital Mutilation” – implying no compromise, not even for the “mildest” types of cutting. This should be the stance of anybody involved in putting an end to FGM. It is also important to stress that there is a radical difference between male circumcision and FGM. One person said that “...if boys and men were subjected to such a practice, there would be an international outcry...”¹⁶⁰ Unfortunately, FGM is seen as “less urgent” by many actors in the development sector or it is sidelined as a “woman’s issue”.

Why are we involved? As faith-based organizations, NCA and her partners have a mandate based on our Christian faith: As God’s creation every person has a non-negotiable right to bodily integrity, to human dignity and to equal treatment. Preventing FGM is a move towards a more just world where neither girls nor boys face oppression because of their gender. Ending FGM is part of the struggle for equality between the sexes, for the right of girls and women to control their own lives - for the implementation of human rights. “Women are recognized as a fundamental force in the quest to eradicate poverty and maintain the stability of families and societies. Without improving the status of women, we cannot expect any real progress in society...” says staff of the Afrol News website.¹⁶¹ All barriers to women’s development must be removed to reach the UN Millennium

Goals – including FGM and other harmful traditional practices. **In other words, we are targeting not only the practice itself, but the underlying values that are detrimental to the empowerment of women.** African women must continue to speak out and act – with a view to a future free from FGM and any other form of discrimination. Governments, development agents and society have a collective responsibility to respond with action.

One of the greatest challenges ahead will be the poor and illiterate girls and women in remote, rural areas¹⁶². When will they learn that they do not have to give up a body part to become worthy of respect?

Most of us associate words like “home” and “culture” with a positive, safe environment which gives value and human dignity to a person in a given community. Millions of girls all over the world, however, learn all too early that the world is not a safe place. As long as this is the reality, we cannot remain idle. To use the words of the World Council of Churches’ Decade to Overcome Violence: We are “... **called to empower those oppressed by violence, and to act in solidarity with those struggling for justice, peace and the integrity of creation.**”¹⁶³

More information on FGM

NCA – Norwegian Church Aid

www.nca.no

OK – Omsorg og Kunnskap mot kvinnelig omskjæring (Care and Knowledge)

(The Norwegian Government's project to Implement the Action Plan)

Information on FGM, the practice, reasons, prevalence, ways of preventing it, etc.

www.okprosjekt.no (English version available).

IAC – Inter-African Committee on Traditional Practices

is a network of 29 national committees in African countries working to prevent FGM. www.iac-ciaf.ch

SNCTP – The Sudan National Committee on Traditional Practices

www.snctp.org

NFP – National Focal Point – Kenya

Focal point and coordinating agency for 19 member organizations who are involved in FGM eradication in Kenya.

Hosted by Northern Aid, Kenya. naid@africaonline.co.ke

NCTPE – National Committee on Traditional Practices in Ethiopia

P. O. Box12629, Addis Abeba, Ethiopia. www.crdaethiopia.org

FOKUS

Forum for kvinner og utvikling

(Forum for women and development, a Norway-based resource organization on women's issues)

Information about FGM, articles, etc. www.fokuskvinner.no/ism/inthel/foko

FOKO

'Forskning om kvinnelig omskjæring' (a Scandinavian network for Research on FGM) Extracts from various researchers' studies, projects and their contact address can be found here. www.med.uio.no/ism/inthel/foko/

Amnesty International

Information pack on FGM, describing the phenomenon, why it is practiced, human rights, etc. www.amnesty.org

CRLP – The Center for Reproductive Law and Policy

Resource page on legislation and other aspects of FGM. www.crlp.org/worldwide.html

WHO – The World Health Organization

Information, articles, links, etc. On FGM and gender-based violence, reproductive health, etc. www.who.int/docstore/frh-whd/FGM

UNFPA – United Nations Population Fund Information, articles, links, etc. On FGM and gender-based violence, reproductive health, etc.

www.unfpa.org

RAINBO – Research, Action and Information for the Bodily Integrity of Women

A resource organization on FGM working to promote and protect the reproductive and sexual rights of women and girls

www.rainbo.org/

FGC Education and Networking project

On-line and offline dissemination of materials related to female genital mutilation. www.fgmnetwork.org

CEDPA – the Center for Development and Population Activities

A resource centre focusing on reproductive health, reproductive and human rights, women in leadership, etc. www.cedpa.org

Religious Tolerance

website focusing on FGM from an Islamic perspective. www.religioustolerance.org



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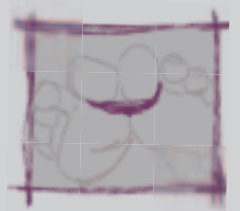
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- ¹⁶³ World Council of Churches. Dec. 2003. www.overcomingviolence.org





Female Genital Mutilation



Norwegian Church Aid is an independent and ecumenical organisation working for people's fundamental rights and based on God's love for all humans. Norwegian Church Aid works in a comprehensive way, through church-based and other local organisations in order to save and protect lives and develop sustainable living conditions. Norwegian Church Aid also works to influence attitudes and decisions for the benefit of the poor, needy and oppressed – regardless of gender, political convictions, religion and ethnicity.



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