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# Female Genital Cutting, Women's Health, and Development

*The Role of the World Bank*

*Khama Rogo  
Tshiya Subayi  
Nahid Toubia  
Eiman Hussein Sharief*



THE WORLD BANK



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Africa Region Human Development Department



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Washington, D.C.

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# Preface

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This paper is intended to give information on the issue of Female Genital Mutilation/Cutting (FGM/C)<sup>1</sup> and to highlight opportunities for the Bank to address the issue of FGM/C within its overall development agenda and poverty reduction strategy. The preparation of the paper was commissioned by Khama Rogo and Tshiya Subayi of the World Bank as part of the broader focus on neglected Gender and Reproductive Health challenges in the Africa Region. The writing was done by Rainbo's Nahid Toubia and Eiman Hussein Sharief. That broader focus led to the successful meeting of all African ambassadors in Washington, D.C. and the seminal publication of the *Background Paper on Harmonizing Approaches to Women's Health in Africa*.

Overall, the Bank has been rather conservative in dealing with the issue FGM/C. To date, there are no specific guidelines, nor strategic plans focusing on FGC work, despite a strong consensus in the Human Development sector that FGC requires a multisectoral approach, integrated into the reproductive health, education, social protection, and rural development strategies of the Bank.

The Bank has been supporting efforts against FGM/C for several years. The Development Grant Facility (DGF) which has provided much needed funding to several international NGOs such as the Inter-African Committee on Eliminating Harmful Traditional Practices (CIAF) and Rainbo. Through DGF, to date, more than 19 million dollars has been disbursed for adolescent reproductive health grant programs, FGM and other neglected reproductive health areas, but these steps are not enough to tackle such a monumental problem.

In the last six years, there has been a shift in the Bank's policy dialogue particularly in the Africa Region, where FGC has been the focus of several discussions with strong support from the vice president of the Region. In addition to this shift, the Bank has also been playing a more prominent role in coordination efforts at the international level. The Bank is an active member of the Donors Working Group on Female Genital Mutilation/Female Genital Cutting and will be chairing the technical discussions for the next two years. UNICEF, as a specialised agency for children and adolescents is the permanent secretariat of the Group. Other members of the Donors' Group on FGC/FGM are: WHO, UNICEF, USAID, UNFPA, Ford Foundation, the Dutch Development Agency, GTZ, CIDA, SIDA, Wallace Global, EU, and other donor NGOs. The purpose of the Donor's Group is to harmonize funding for FGC activities. More specifically the group brings together donor agencies from around the world with wide-ranging approaches to eliminating FGC, but shares the common desire to enhance donor effectiveness.

There also have been more specific efforts undertaken through lending projects such as the Population and Reproductive Health projects in Guinea, Burkina Faso, Djibouti, and Mauritania. Although these are positive initiatives, they are far from adequate in terms of coverage and impact. Many such program focus on urban areas whereas the practice is more often undertaken at the rural level where communities are ill informed about effective ways

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1. We are using FGM/C and FGC interchangeably inside this paper.

to eliminate the harmful practices. In addition, most of the interventions have been vertical, while experience shows that broader, more comprehensive approach yield better results. There are more opportunities through classic World Bank lending instruments such as SIL, LILs, SWAPs, and through the poverty reduction strategies to address the issue of FGM from a broader women's health and economic development angle.

\* \* \* \* \*

The Bank teams wish to thank their colleagues who have reviewed this report and Rainbo for the writing. Special thanks go to Layla Shaaban, Sandra Jordan (USAID), Guggi Laryea, Maurizia Tovo (AFTH2), Mark Blackden, and Nami Kurimoto, all from the Africa Region, for their collegial facilitation and much appreciated advice, and feedback on the drafts. This paper would not have been possible without their invaluable inputs.

Our thanks and appreciation for the time given for research and consultation from Kei Kawabata (Sector Manager, Health, Nutrition and Population, Human Development Network), Dzingai Mutumbuka (Sector Manager, Human Development 1, Eastern and Southern Africa), Laura Frigenti (Sector Manager, Human Development 3, Africa Region), John F. May (Senior Population Specialist Human Development II), Wafaas Ofosu-Amaah (Senior Gender Specialist), and Eija Pehu (Advisor, Agriculture and Rural Development).

We also thank Bank staff and guests who attended a lunch presentation of the first draft paper, and gave valuable insights and raised important questions. Further, we thank the participants from Nairobi, Brussels, and Washington for their time and active participation at the VC on April 25, 2006. The discussions from both meetings, helped shape the final version of this position paper.

Our thanks also go to the World Bank staff in the Nairobi office and their guests who participated in the video conference on FGM in Somalia and Priya Gajraj from the World Bank's Nairobi office who met further with Rainbo staff to help guide the process.

We gratefully acknowledge the important role being played by the Donor's Working Group on coordination of funding to support the fight against FGM/C and the struggle to end this harmful practice across the globe.

Khama Rogo and Tshiyi Subayi



# Acronyms and Abbreviations

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CDD	Community-driven development
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CBO	Community-based organization
DHS	Demographic and Health Survey
FC	Female circumcision
FGC	Female genital cutting
FGM	Female genital mutilation
ICPD	International Centre for Population and Development
IEC	Information, Education, and Communications
IK	Indigenous Knowledge Notes
LIL	Learning and Innovative Loans
MDG	Millennium Development Goals
NGO	Non-governmental organization
PRSC	Poverty Reduction Strategy
SIL	Sector Investment Loans
SWAP	Sector Wide Approaches
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNIFEM	United Nations Development Fund for Women
USAID	U.S. Agency for International Development
WHO	World Health Organization



# Executive Summary

Female Genital Mutilation or Cutting (FGM/C) is a customary practice indigenous to 28 African countries and is also reported among African immigrants in countries in Europe, North America, Australia, and New Zealand. FGM/C is also found in some Muslim communities in the highlands of India.

## Box A. WHO Classification

**Type I:** Excision of the prepuce with or without excision of part or the entire clitoris

**Type II:** Excision of the clitoris with partial or total excision of the labia minora

**Type III:** Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)

**Type IV:** Unclassified: includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above.

It is estimated that 130 million girls and women are affected worldwide by this practice. Every year, 2 million girls undergo FGC, with 600 cases occurring every day. The practice involves an enormous cost in human suffering, which in turn has a detrimental effect on the household economy. Complications resulting from FGC put an additional burden on health systems. FGC is associated with complications during childbirth from keloids that occur due to an overgrowth of scar tissue. Reconstruction surgeries for young girls who have suffered vaginal visceral fistulae also increase the burden on health systems.

FGC has been found to adversely affect school performance, leading to higher rates of absence and drop outs among girls. It is also clear that FGM/C directly affects women's ability to contribute to a country's economic and social development. FGC is considered one of the most serious violation of gender rights and has far-reaching implications for not only individual women's health, but also for the communities and the country as a whole.

Although, much has been done in the past twenty years for rallying international support for putting an end to FGM/C and to encourage governments to denounce this practice, the degree to which laws have been implemented or enforced varies from country to country. Prohibitive legislations have been passed in 11 African countries and almost all host countries in Europe and North America, but their impact has been limited.

The World Bank has been rather conservative in supporting activities against FGM/C. While there is a strong consensus in the Human Development sector for integrating FGC activities into reproductive health, education, social protection and rural development strategies of the Bank through multi-sectoral approaches, no specific institutional guidelines have been developed nor is there a strategic plan for implementing these activities.

Recently, however, there has been a shift in the Bank's policy dialogue particularly in the Africa Region and FGC has received a greater focus in several discussions. The Bank has also been playing a more prominent role in coordinating FGC-related initiatives at the international level. The Bank is an active member of the Donor Working Group on Female Genital Mutilation/Female Genital Cutting.<sup>1</sup> The Donor Working Group seeks to harmonize funding and interventions against FGC at the international level by improving communication, fostering collaboration, and increasing resources for FGM/FGC-eradication efforts.

The Bank also directly supports efforts against FGM/C by NGOs through the Development Grant Facility (DGF). Several international NGOs such as the Inter-African Committee on Eliminating Harmful Traditional Practices (IAC) and Rainbo have been recipients of this grant. To date over US\$19 million has been disbursed through the Capacity Building Program towards neglected areas for Reproductive Health including FGM/C. These steps, however, are not sufficient for addressing such a monumental problem.

Specific contributions have been undertaken through lending programs such as the Population and Reproductive Health projects in Guinea, the health and population project in Burkina Faso and more recently in Djibouti and Mauritania Multisectoral HIV/AIDS projects (MAP). Although these are positive initiatives, their coverage has been limited. One limitation has been that most programs tend to focus on urban areas whereas the practice is more prevalent in the rural areas. In rural communities, where the problem is most acute, FGC interventions have had negligible impact. Moreover, most interventions have had a narrow focus and therefore are less likely to yield desired results.

Most recently, the Bank has carried out analytical work on FGM/C. One such initiative has been covered in the report on Somalia written in collaboration with UNFPA. In Somalia, WHO reports a 98 percent rate of FGM/C (infibulations, type III, is mostly practiced). The report documents the extent to which FGM/C is perceived as a public health issue. The social and political situation in Somalia in light of the civil unrest is likely to be a challenge in expanding the reach and effectiveness of FGC interventions particularly in rural communities. The experience of Kouroussa in Haute Guinea through the Population and Reproductive Health Project presented at the Development Marketplace 2000 competition with the project Ending Female Genital Cutting also gave the opportunity to the Bank to address FGM/C in a more systematic way, using all available resources (the initiative which is described later in this paper, combines learning with micro-financing and couples all this with strong public information of the issue of FGM/C). Other opportunities for supporting FGM/C programs include classic World Bank lending instruments such as SIL, LILs, SWAPs, and poverty reduction strategies. These operations can address the issue of FGM from broader women's health and economic development angle.

This position paper defines the scope of the problem in the region, suggests options for interventions, reviews constraints and identifies areas of interaction for the Bank. It also gives options for future actions within the different sectors of the World Bank Group.

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2. UNICEF as a specialised agency for women and children is the permanent secretariat of the Group. Other members of the Donors' Group on FGC/FGM are: WHO, UNICEF, USAID, UNFPA, Ford Foundation, the Dutch Development Agency, GTZ, CIDA, SIDA, Wallace Global, EU, and other donor NGOs.

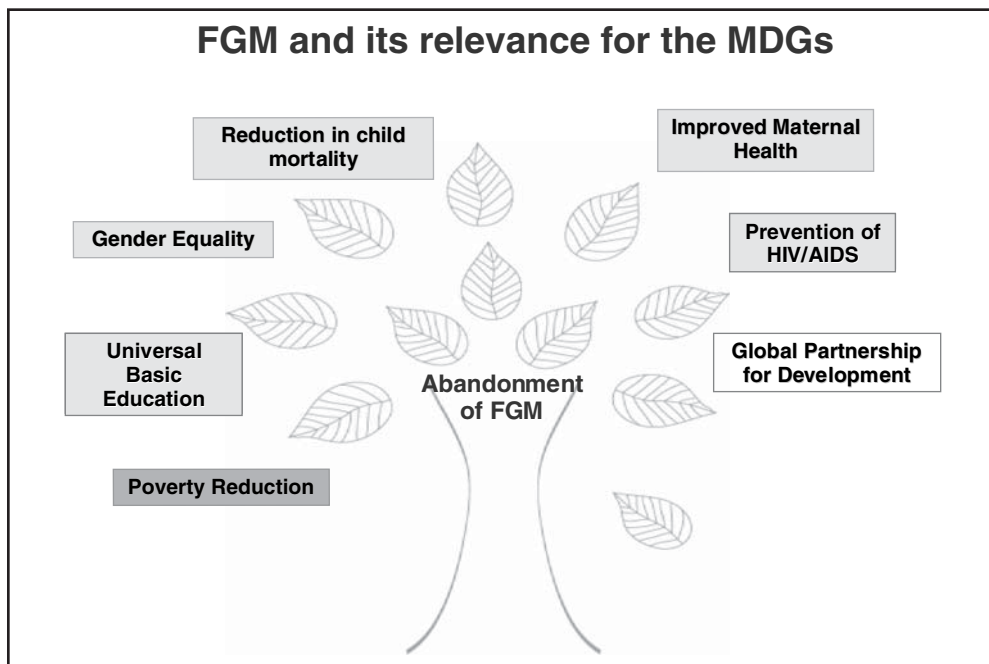
# Why Should the World Bank Be Concerned with FGM/C?

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The landmark paper “Integrating Gender into the World Bank’s Work” (January 2002) makes an eloquent case for why the World Bank should invest in improving gender equity. The rationale for investing in FGC particularly can be derived from for the Bank’s overall commitment to economic growth and inclusive development. In addition, the Bank is committed to implementing international agreements which promote women’s rights and health, including the ICPD Conference (Cairo 1994), the World Conference on Women (Beijing 1995), the Millennium Development Declaration and its Goals (2000) as well as UN Conventions (CEDAW and the Child Rights Convention or CRC).

Regardless of the form or severity FGM/C is a health and human rights violation. It is not only detrimental to women’s health but also has a negative impact on women’s education and other opportunities for growth and development. FGC has several other costs which include the expenditure involved in getting the procedure done, the physical pain and emotional trauma for children who undergo this procedure as well as the cost to health systems for treating complications that result from this procedure. Several consequences of FGC have not been documented systematically but are widely prevalent in light of the fact that around two million procedures are performed a year.

Girls who have undergone FGC are more vulnerable to complications during delivery. The risk of mortality and morbidity is heightened by the fact that fertility is high and women deliver several times over their reproductive years. A recent WHO study published in the *Lancet* has confirmed that women who have undergone FGM/C are more likely to have serious complications during child birth than women who have not undergone FGM/C. FGC has also been found to be associated with increased risk of contracting HIV/AIDS according



Source: GTZ, 2004.

to a study in Kenya (report from Maendeleo Ya Wanawake, Nairobi, Kenya). In most communities, a single knife is used to cut more than a 100 girls in one ceremony. As a result of the link to HIV/AIDS or “slim” disease, some communities now perform FGM/C on young girls who supposedly have not yet been sexually active. Now girls as young as three years of age are being cut.

# Background Information about FGM/C

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*Globally, over 130 million girls and women are estimated to have undergone a form of genital cutting with two million at risk every year. Everyday 600 girls of various ages suffer the pain and trauma unless we take concerted and serious action.*

—Dr. Nahid Toubia, Rainbo

## World Health Organization Classification and Definition

Female genital mutilation comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons. It is estimated that around 130 million women worldwide have undergone procedures involving removal of female genitalia and that these procedures are performed on a further 2 million girls and women every year (WHO 1998).

In 1995, the World Health Organization (WHO) recommended a standardized typology of Female Genital Mutilation/Cutting (FGM/C), which provided a broad framework designed to include all procedures, both common and uncommon. Although different classifications of the practice have been used, it is strongly recommended to use the standardised WHO classification as it stands in 2004.

## Terminology

Several debates surround the use of terminology. The term Female Circumcision (FC) was used in the international literature until the early 1980s when the term Female Genital Mutilation (FGM) was introduced and became more widely used particularly in U.N. declarations and other policy documents. In the late 1990s, other terms began to be used such as Female Genital Surgeries (FGS) and Female Genital Cutting (FGC). Female Genital Cutting was formally adopted as the official term for the United States Agency for International Development (USAID) and its cooperating agencies during in the late 1990s. Some UN agencies are increasingly substituting FGM with FGC in its official documents. In this document the terms

### Box 1. WHO Classification

**Type I:** Excision of the prepuce with or without excision of part or all of the clitoris

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used will be female genital mutilation/cutting to reflect the transitional state of the terminology in the field. Female circumcision will be used as a verb or an adjective to pay respect of the views of practicing communities and affected women.

## Prevalence Rates

FGM/C is practiced predominantly and in various forms in 28 countries in Africa, amongst few groups in Asia, and among some African immigrants in North America, Australia and Europe.

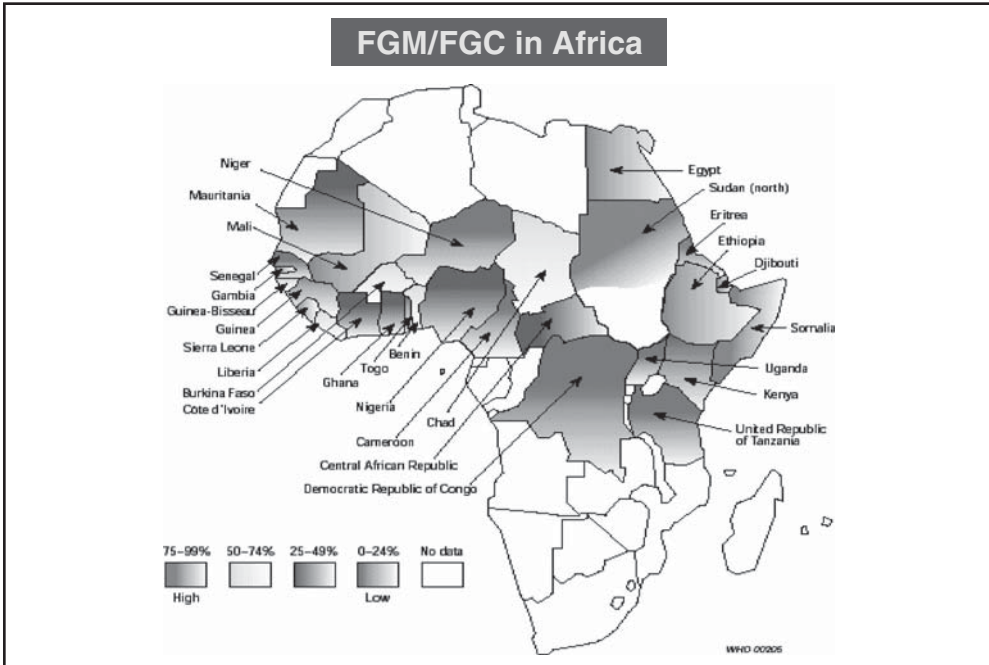
The practice started getting documented in the early twentieth century in reports of European travelers and missionaries. In the 1950s, 1960s and 1970s clinical studies by physicians, hospital records, and direct interviews in a few countries provided evidence for the existence of this practice.

In 1979, a national survey was conducted by the University of Khartoum in Sudan followed by the Sudan Fertility Survey in 1980. Both surveys measured prevalence of FGC in Sudan. The prevalence rates were first published in the “Hosken Report” of 1979. The rates have been updated by Dr. Nahid Toubia in the report “Female Genital Mutilation: A Call for Global Action” (1993 & revised in 1995).

Since 1993, the Demographic and Health Surveys (DHS)<sup>2</sup> included a questionnaire on FGM/C that has been used to collect data in several countries in Africa. DHS data on FGM/C have since become available for 16 countries in Sub-Saharan and North Africa. The CD-ROM “FGC Data from DHS Survey 1990–2002” summarizes these findings (Measure DHS+ April 2003).

2. For more than 15 years, Demographic and Health Surveys (DHS) have become established and reliable sources of demographic and health research. DHS are nationally representative household surveys with large sample sizes of between 5,000 and 30,000 households. They provide data for a wide range of monitoring and evaluation indicators in the areas of population, health, and nutrition. The national Demographic and Health Surveys are prepared and organised by Macro International Inc. USA.





There are no comprehensive, country data on FGM/C in countries where the DHS has not been conducted. The data available for non-DHS countries is either from national surveys or smaller scale studies conducted by local organizations. In other countries where no surveys have not been carried out, prevalence estimates have been compiled by the WHO or from the U.S. Department of State through a compilation of anecdotal evidence. See Table 1.

**Table 1. Showing Prevalence Rates & Types of FGM/C**

DHS Data			
Country	Prevalence	Year	Types practiced
Benin	17%	2001	II
Burkina Faso	72%	1998/99	II
Central African Republic (CAR)	43%	1994/95	I and II
Cote d'Ivoire	45%	1998/99	II
Egypt	97%	1995 and 2000	I, II and III
Eritrea	95%	1995 and 2002 (ongoing)	I, II and III
Ethiopia	80%	2000	I and II {type III in borders with Sudan and Somalia}

(continued)

**Table 1. Showing Prevalence Rates & Types of FGM/C (Continued)**

<b>DHS Data</b>			
<b>Country</b>	<b>Prevalence</b>	<b>Year</b>	<b>Types practiced</b>
Guinea	99%	1999	II
Kenya	38%	1998 and 2003 (ongoing)	I and II {type III in borders with Somalia}
Mali	94%	1995/96 and 2001	I and II
Mauritania	71%	2000/01	I and II
Niger	5%	1998	II
Nigeria	25%	1999 and 2003 (ongoing)	I, II, III and IV
Sudan	89%	1990	I, II and III
Tanzania	18%	1996	II and III
Yemen	23%	1991/92 and 1997	II and III
<b>Non DHS Data</b>			
<b>Country</b>	<b>Prevalence %</b>	<b>Year</b>	<b>Types</b>
Cameroon	5–20%	1994	I and II
Chad	60%	1990 and 1991	II
Democratic Republic of Congo	5%	N/A	II
Djibouti	90–98%	1991	II and III
Gambia	80%	1985	II
Ghana	9–15%	1998	II
Guinea-Bissau	50%		I and II
Liberia	60%	1984	II
Senegal	20%	1990	II
Sierra Leone	80–90%	1987	II
Somalia	96–98%	1982–1993	III
Togo	12%	1996	II
Uganda	< 5%		I and II

Sources: WHO: <http://www.who.int/docstore/frh-whd/FGM/FGM%20prev%20update.html>

US State Department: <http://www.state.gov/g/wi/rls/rep/crfgm/>

# Review of Programs, Interventions and Legislations

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## History of National, Regional, and International Efforts to End the Practice

Various efforts to prevent FGC can be traced back in history to the colonial era. Colonial administrations and missionaries tried to enact laws and church rules to stop the practice in countries such as Burkina Faso, Kenya, and Sudan. The documented evidence of these efforts dates back to the early twentieth century. These efforts were strongly resisted and perceived as a colonialist attempt to destroy the local culture.

In the 1960s and 1970s, activism against FGM/C developed in many countries in Africa. In these countries, women's groups led intermittent campaigns to educate people about the harmful effects of FGM. In Sudan, Nigeria and Somalia, the practice came to light when doctors reported about its clinical complications in medical journals.

The World Health Organisation held the first international conference on female circumcision in Khartoum, Sudan in 1979. The historical significance of that conference was its recommendation that this practice be totally eradicated. The conference marked the official involvement of the international health and development assistance community in supporting programs designed to stop this deeply imbedded cultural practice. These developments also meant that milder forms of FGC could no longer be performed within medical facilities as was the case earlier.

The next twenty-five years witnessed increasing support for FGM/C. Most of these efforts focused on the physical harm caused by the cutting. During the 1990s, women's right as human rights and prevention of violence against women emerged as major themes. This

led to FGM/C being addressed as a violation of women's and girl's rights, rather than only a health or medical issue. The events that led to this change were:

- The Vienna Conference on Human Rights in 1993, where all cultural practices that affected the health and rights of women were considered a violation of human rights.
- The International Conference for Population and Development (ICPD) in 1995, Cairo where FGM/C was mentioned specifically for the first time in an international document as a violation of women's reproductive health.
- The Fifth World Conference on Women in Beijing in 1995, where FGM/C was further considered a violation of women's rights.
- All relevant UN bodies namely UNICEF, UNFPA, UNIFEM and the WHO developed policies condemning FGM, which they defined as violence against women and girls.
- In 2003, The African Union introduced the "Protocol To The African Charter On Human And Peoples' Rights On The Rights Of Women In Africa."
- USAID policy in 2000.

Article 5 states:

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

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

In 1995, the ICPD raised the issue FGM/C in an open debate, making this a watershed event for FGM/C, as it encouraged debates at the international level and mobilized support for efforts at the national and regional levels.

A major success of the ICPD was to provide a platform for mobilizing NGOs which led to changes in national policy and legislation for FGC. Behind these changes in legislation lay substantial efforts put in by women's groups, other civil society institutions and international organizations that shared a common vision for putting an end to FGM/C.

At the United Nations Millennium Summit in 2000, the Millennium Declaration was signed by 147 heads of state and passed collectively by the members of the UN General Assembly. By 2002, the agenda was refined into eight Millennium Development Goals (see Box 3). Of these eight goals, three of them directly support sexual and reproductive health and rights, including FGM/C (goals 3, 4 and 5). FGM/C is also specifically addressed under the third Millennium Development Goal.

#### **Box 2. The Millennium Development Goals**

1. Eradicate extreme poverty and hunger
2. Achieve Universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

The 2001 Report of the UN Secretary General "Roadmap towards the Implementation of the UN Millennium Declaration" (paragraph 209) states that:

Harmful traditional practices such as Female Genital Mutilation remain common forms of abuse

At the *regional* level, two seminars were organized by the UN in Burkina Faso (1991) and Sri Lanka (1994) to assess the human rights aspects of FGM/C and other traditional practices affecting women and children. The seminars were a forum for discussion between national officials, UN specialized agencies and NGOs. It led to the development of the 1994 Plan of Action for the Elimination of Harmful Traditional Practices Affecting the Health of Women and Children.

In June 2003 a European Union funded "Expert Consultation on Legal Tools to Prevent Female Genital Mutilation" was held in Cairo (Egypt). It was organized by No Peace without Justice (an Italian NGO) under the auspices of the Egyptian Government through the National Council on Childhood and Motherhood, with technical co-operation between AIDOS, the Centre for Reproductive Rights, and Rainbo. The participants were representatives of NGOs and governments from 28 African and Arab countries as well as representatives of various international and donor organisations. The outcome was a landmark document "The Cairo Declaration for the Elimination of FGM."

In spite of a favorable political and legal climate generated from these efforts, policies have not translated into practice and significant reductions in prevalence are yet to be seen. It will take more than just policies and laws to bring about behavioural and social change at the community level. Some key questions that need to be addressed are:

- 1) What impact does the legal and policy environment have on behavioural and social change?
- 2) What interventions need to happen at community level to bring about behavioural and social change?
- 3) What can be learned from approaches used in the past to develop effective interventions to eradicate FGM/C?
- 4) How can laws and policy at the national or regional level be synchronised to enhance change at family and community level?

## Examples of Community Approaches

The majority of projects have focused on one-way delivery of information about health complications of FGC. These have not been successful in changing knowledge or practice. Lack of substantial progress in ending FGC was noted by FGM program managers at UNICEF, USAID, WHO, UNFPA, and the World Bank. In 1999, they approached Rainbo to help answer the following questions:

- What are the combined elements which could help stop FGM/C ?
- Is there any evidence of change?
- Is it possible to identify which actions are most likely to bring about change?

- How can current knowledge be utilised to design more effective actions?
- What would be effective and practical means to monitor and evaluate progress in the future?

To answer these questions, it was necessary to analyse approaches and assumptions to identify the more successful elements. Consequently, Rainbo was commissioned to conduct the Female Genital Mutilation Review Evaluation and Monitoring (FGM-REM) project (2001–2002). The project’s mandate was to research, document and evaluate past and existing FGM/C programs throughout Africa and summarise their effectiveness.

The review focused on examining the effectiveness of various approaches for ending the practice of FGC among families and by communities. Secondary reports and evaluation studies were analyzed in collaboration with a technical committee. The review drew on the proceedings of a technical consultation of international experts in this field.

There was limited availability of descriptive and analytical reports or evaluation studies in FGM/C. As a result, it was difficult to make definitive conclusions and develop recommendations. A total of six approaches were reviewed:

- 1) The Health Risk approach (often called Harmful Traditional Practices),
- 2) Targeting Practitioners approach,
- 3) The Alternative Rites of Passage approach,
- 4) The Integrated approach,
- 5) The Social Marketing approach, and
- 6) The Positive Deviance approach.

In depth analysis was possible for only the first four approaches due to lack of reliable descriptive or analytical reports on the other two. All approaches had some degree of “success” in changing certain elements of the practice. This indicates that communities are open to changing practice and at times, are even eager and ready to accept change.

A lack of appropriate understanding of the motives of those who protect and promote the practice has prevented program managers and donors from achieving intended results.

### *Health Risk Approach*

The Health Risk approach or Harmful Traditional Practices (HTP) has been the oldest and most widely used for the past twenty-five years. The approach consists mainly of lecturing communities on health risks of the practice. It focuses on the potential health complication, leaving the principle of the cutting itself unchallenged. This has encouraged families to seek safer circumcision providers often at a higher cost to avoid potential complications. The practitioners changed from traditional healers and circumcisers to health professionals including trained midwives, nurses and doctors. This has been referred to as the medicalisation of FGM/C. For example, in Egypt, a national survey carried out in 2000 found that 97 percent of ever-married women were cut (indicating negligible impact on ending the practice); and that among most recently circumcised daughters 72 percent of operations in urban areas and 55 percent in rural areas were performed by a medical professionals (indicating extensive medicalisation).

There is no documented evidence that the fear of health risks has caused a shift in behaviour towards abandoning the practice. However, the widespread application of the health risk messages has made discussing the practice less taboo. This has provided the basis for formu-

lating new interventions. Overall the Health Risk approach has succeeded in making some preliminary impact but has not been successful in achieving its stated goal of eliminating FGM/C within a specific time frame.

### *Targeting Practitioners Approach*

This approach had the potential for producing tangible results but was largely confined to targeting the circumcisers. It is based on the assumption that if circumcisers are persuaded to stop providing the service, it will put an end to the practice. The approach has been applied in different ways over the years, from providing direct cash substitutes as income to practitioners, training them for alternative jobs, and providing loans for starting businesses. The approach has been known to have dramatic effects, for example, in the midst of public festivities traditional circumcisers hand in or break their knives and swear never to practice again.

Evaluations of this approach have shown that it led to a significant proportion of circumcisers stopping the practice, however, the demand for services in neighbouring villages encouraged new providers to emerge and ultimately some of the converted circumcisers reverted to their original practice (see example of evaluations in Box 3).

#### **Box 3. Examples of Evaluation Studies from Mali and Ethiopia**

In Mali interviews were performed with the heads of three NGOs who had implemented the approach, plus 10 field staff and 41 practitioners, and 45 focus group discussions were conducted with 380 community members. Both the community and field staff reported that practitioners were continuing to practice despite denials to the contrary and that the only ones who had genuinely stopped were those who become too old or who were promised income from alternative activities.

In Ethiopia: a project involved 25–30 practitioners who pledged to “lay down the blade” if they were able to participate in an alternative employment program. However, on evaluation it was revealed that many of these women said they had never actually performed any operations. Leading to confusion on whether they were denying earlier activities or were non-practitioners taking advantage of the program.

A major failure of this approach was its focus on the supply side of the practice. It was found that this is not as effective in driving the force of change and as long as there is a demand for services, the practice will continue. It can be concluded that focusing on traditional practitioners alone will not eradicate FGM and can only have very limited effectiveness in changing behaviour.

### *Alternative Rites of Passage*

This approach was popularized mainly in Kenya where FGM/C is performed on young teenage girls as a rite-of-passage into womanhood. The approach focuses on girls at risk but often also engages parents and village leaders to for additional support. It was pioneered by a local organisation Maendeleo Ya

Wanawake (MYWO) with technical assistance from the Programme for Appropriate Technology in Health (PATH) in several districts of Kenya. It has also been extensively duplicated by other NGOs in ways that had limited inputs and questionable outcomes.

The MYWO model involves targeting girls, parents and others with IEC activities. Training is provided to the girls in the traditional seclusion phase and this is followed by a public celebration of the rites of passage. No cutting is carried out during these rituals. A

**Figure 1. A Group of Alternative Rites of Passage Graduates in a Graduation Ceremony**



detailed evaluation of this program was conducted by The Population Council (2003).

Participation in an alternative rite constitutes a public declaration by a family not to circumcise the girl. This approach can motivate practicing families to abandon FGM/C and generate solidarity and support among non-circumcising families. It also creates for a conducive environment for maintaining and sustaining new behaviours.

The alternative rites approach, however, can only be implemented when cutting is performed during a rite of passage ceremony. Evaluations have shown evidence of success of this approach. Among a significant proportion of young women, there was a clearly declared intent or commitment to abandon FGM/C. However there have been instances when interventions were targeted only at restricting the practice during the ceremony without mobilizing support among the girls at risk, their parents and other community members. In these cases, the impact was found to be limited as the girls were “cut” after the ceremony.

### *The Integrated Approach*

The Integrated approach addresses the issue within a broader health, literacy and economic context. Two examples are the TOSTAN project among the Malicounda Bambara of Senegal and the CEOSS projects in the villages of Dir El Barsha and Bani Ghani in Upper Egypt. Both have shown success in changing the behaviours among significant numbers of people. Both projects have shown that long term commitment to the issue by NGO's in building trust is essential for bringing about change.

### *TOSTAN*

The TOSTAN project was a part of a popular literacy and empowerment programme in Senegal. A module on women's health was added to the program under TOSTAN. This led to a discussion of women's human rights. A group of women who participated in the process decided to work for the abandonment of FGM in their village. In July 1997 this village made a collective statement to abandon FGM/C and two other villages considered doing the same. Ten more villages subsequently decided to abandon the practice. In a different part of Senegal 14 more villages involved in the TOSTAN programme resolved to abandon the practice and enlisted four other communities with whom they intermarried to collectively abandon FGM.

The success of the program led to the development of the Village Empowerment Programme (VEP), which is a scaled down version of the original TOSTAN literacy programme but focused specifically on FGM abandonment. Since 1997, 1,271 communities in Senegal



have abandoned FGC through 16 Public Declarations. This represents 25 percent of the 5,000 communities that practiced FGC in 1997. While there is evidence that villages can be motivated to make public declarations about abandoning the practice, no evaluation has been done to show that this actually translates into practice.

**Figure 2. An Example of a Public Declaration Made by a Community in Senegal**



The Tostan project was successful in building trust by providing services that were needed by the communities; an aspect that is essential for bringing about social change. Public declarations were essential to support individual decisions of community members. The declarations signalled a new social order that no longer accepted the practice.

### *Social Marketing Approach*

This approach utilizes principles used in marketing to sell ideas and change attitudes and behaviours in a specific target audience. It has been borrowed by family planning and other health promotion programs.

In 1996 UNFPA initiated the Reproductive, Education and Community Health (REACH) programme in the Kapchorwa district of Uganda where FGM/C is practiced. The initiative was built on the premise that the practice could be discarded without necessarily destroying the cultural values associated with it. The target group were the key elders and community leaders. Program strategies included rallying community support through key agents. One of the main activities involved social mobilization of the community through a cultural day dedicated for finding symbolic alternatives to FGM/C.

Findings from a baseline report in 1998 indicated that a positive change in knowledge, attitudes and practices related to FGM/C was evidenced by the declining prevalence in FGM/C. However, further evaluations showed that most young women at risk were cut in subsequent years. The young women who were cut in preparation for marriage were not involved in the project and no effort was made to change their beliefs or empower them to reject the practice.

The social marketing approach in the REACH program was not successful in putting an end to the practice of FGM/C. The main weakness of this approach was that it targeted elders

and clan leaders and did not involve the women and girls themselves. The women and girls also perceived FGM/C to be associated with their sense of identity and to enhance their eligibility to marriage, therefore not addressing their beliefs proved detrimental to the program.

### *Positive Deviants<sup>3</sup> Approach*

This approach was adapted to FGM/C and pioneered in Egypt by the Centre for Development and Population Activities (CEDPA) in 1998. As the name suggests, the approach focuses on identifying individuals who have already decided to stop practicing FGM/C and use them as positive role models in the community.

The approach is implemented in three phases:

- *Phase one “Breaking the Silence”*: Involves training local NGOs and community leaders in identifying Positive Deviants in addition to identifying Positive Deviants in the community and empowering them with their decision.
- *Phase two “Mobilization phase”*: The program works to mobilize the community preparing them to hear/discuss the issue of FGM publicly. This takes about 6 months, and involves, activities, and the local NGOs choose their own activity.
- *Phase three “Girls at risk phase”*: The program’s focus shifts to the girls families’. The local NGOs, with the Positive Deviants, define the meaning of ‘at risk.’ They

decide the at risk age, working on the specific community, mapping, tracing and documenting all the families that have girls, then with the local NGO’s they define and decide what the “at-risk” age in the given community is. The phase also involves training the Positive Deviants on selected community monitoring techniques. Every positive deviant chooses families, which they will be responsible for, for close monitoring.

Monitoring and evaluation of the phases is built within them. The program is still in its third phase but unfortunately evaluation studies on assessing the effectiveness of the approach have still not been undertaken (source: CEDPA). See Box 4 for an example of a project using the Positive Deviants approach.

#### **Box 4. An Example of Positive Deviants in Egypt**

*“The Positive Deviants—in our days—are seeds if you do not water them they will die.”*

—Warda



Amal Asis Tawfeek (also known as Warda) is 24 years old. Warda became a Positive Deviant in 1997, when she joined a training undertaken by The Coptic Organization for Services and Training (COST). Warda is currently married and has a daughter aged 3 years old. Warda is one of the first generation of

Positive Deviants, who have managed to stay uncircumcised in the community.

3. Positive Deviants are individuals who have “deviated” from socially accepted behavioural norms, resulting in a positive outcome.

# The Role of Legislation in Ending FGM/C

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For many years, activists seeking ways to stop the practice of female genital cutting (FGC), or female genital mutilation (FGM), have wondered about the possible role of law in combating this deep rooted problem. On the one hand, there was a strong belief that passing legislation on its own cannot possibly dissuade people from practicing FGC. On the other hand, there was the desire create a new national consensus by using legislation to protect girls from being violated. Some of the questions that have been raised over the years are:

1. Should there be lobbying for new legislation to criminalize FGM/C or will such legislation only manage to drive the practice underground?
2. Is passing new legislation necessary in countries where there are child protection and prohibition of grievous bodily injury laws already in existence?
3. Is passing a law against FGM/C desirable in countries where citizens (both men and women) have few rights and law enforcement system is poorly resourced, not sensitive to women's rights and easily corruptible?
4. Is it appropriate to speak of individual (girls) rights under the law in kinship-based economies the same as in modern free market economies?
5. Should a situation be created where members of a family or a community are encouraged to report a criminal act perpetrated by their own people, risking the fracturing of important social and economic units and alienating the dissenting members?
6. Have we learnt any lessons on the role and usefulness of anti-FGM legislation passed in the West and those passed in Africa?
7. When is passing a law a legal measure, an advocacy tool or a political act?

8. Is passing prohibitive legislation desirable in all countries at any time or should there be strategic thinking around the timing of the legislation and activities around their introduction?

While many of these questions remain to be answered, legislating against FGM is no longer a theoretical debate but a reality that must be addressed as a matter of urgency. Laws are being passed in an increasing number of African countries and in most Western countries where Africans have immigrated. Yet the motivation behind passing these laws and their possible consequences on the targeted communities, and particularly women, has barely been considered.

While facilitating the passage of such legislation serves the purpose of demonstrating political will on the part of governments, a certain amount of time and effort must be invested in deliberation and consultation regarding the timeliness, content and use of these laws. Good governance and the democratic and just principles of protecting the vulnerable need not occur against their own will or while ignoring or repressing their other rights. In the case of women and the practice of FGM/C a host of other legal and non-legal measures must be considered as an essential accompaniment to passing specific anti-FGM laws. Failure to do so runs the risk of making a mockery of the law or creating a situation where girls and women are faced with the double jeopardy of suffering FGM/C to appease an old social order and then get penalized by the modern legal system. This need not be the case if women's and girls interests are truly at the heart of efforts to stop FGM and therefore central to considerations for any new legislation.

# FGM/C and the Work of the World Bank

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## Current Efforts and Approaches

The first document of the World Bank to mention FGM was the *1993 World Development Report: Investing in Health*. The report mentioned education of girls and women as a cost effective way to improving health. A more broad based approach to ending FGM was developed, and this included public education, involvement of professional organizations and women's groups, as well as interaction with communities and major national and international organizations to end this practice.

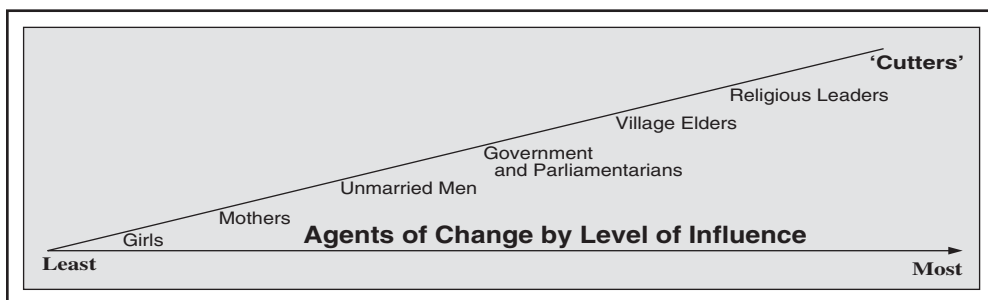
As a way to mainstream Female Genital Cutting into health, nutrition and population operations, the Bank tested a community approach and private sector development in a pilot experience in Kouroussa, Guinea. This community directed initiative supported by the Bank through its Population and Reproductive Health project was awarded a US\$150,000 award at the Development Marketplace in 2000.

The main goals of the project were to provide: (i) education about the harmful effect of FGC; (ii) training of former "cutters" in grassroots management; (iii) assistance in developing small businesses as an alternative to "cutters" current harmful profession. The "cutters," who are usually the keepers of traditions would still use the influence of their status to improve the life of the community. A collective decision, using the "cutters" training as a forum for self-reflection by the entire community, has the double advantage of being sustainable while not disrupting the social fabric.

The initiative focused on the following three phases, involving a classic Bank operation, the World Bank Institute and the IFC.

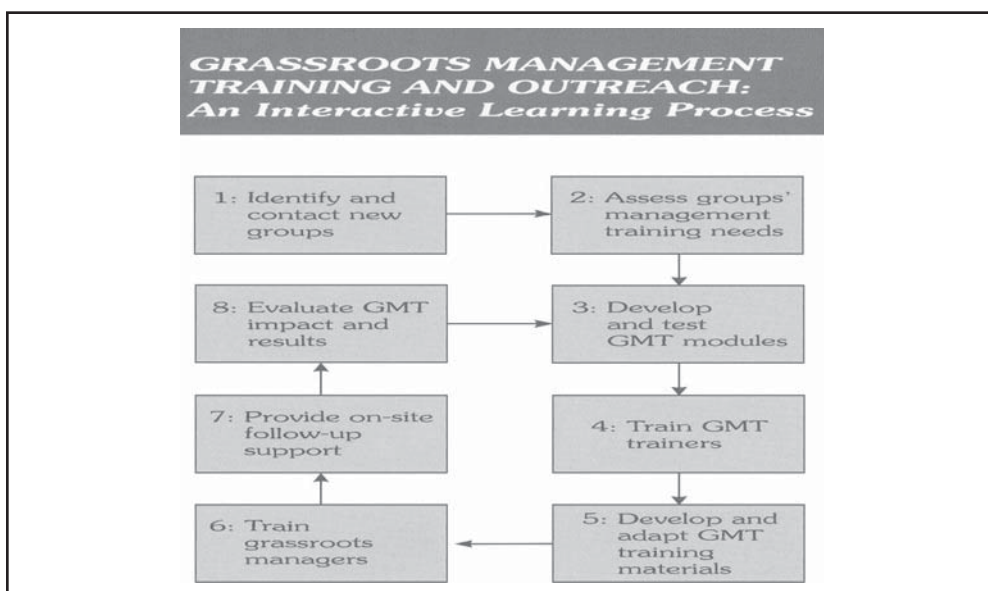
### Phase I: Public Awareness Campaigns

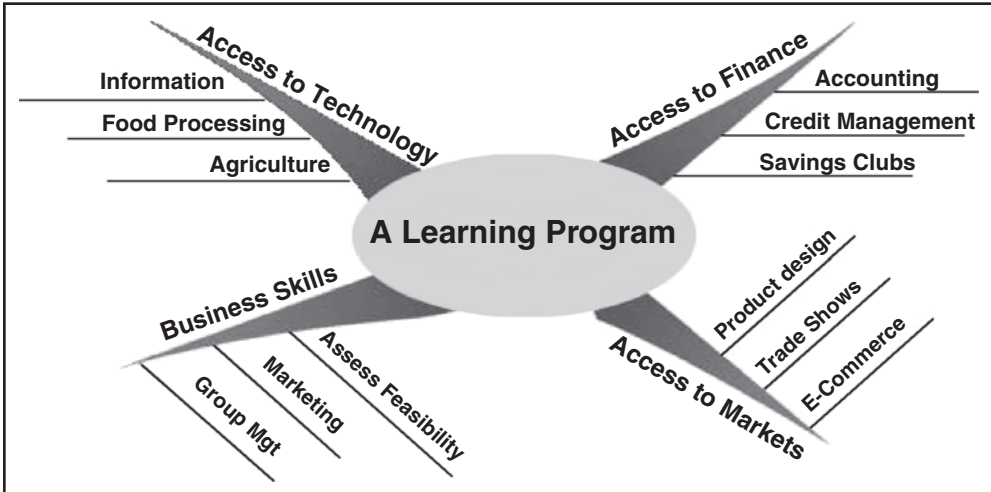
Because FGC is a delicate subject and often considered taboo in the traditional African society, developing public awareness campaign materials for schools (all levels), community groups and community leaders adapted to the cultural context is crucial to obtain the desired impact of eradicating the practice. The public awareness campaigns materials we developed in close consultations with communities who identified according to what they perceived as the level of influence in the community for abandoning the practice.



### Phase II: Grassroots Management Training

Developed by WBI, this concept has been tested in both Africa and Asia has been used successfully in providing women with the necessary tools to manage their own small businesses.





### *Phase III: Financial Support*

Providing access to micro financing and market support which would include assessment of institutional capacity of "clearinghouse" for financing of activities.

### *Lessons Learned from the Guinea Initiative*

The initiative was successful in Kouroussa but necessitated a thorough follow up by communities. The recipient NGO needed further "community coaching" to ensure that the concept was well understood from women in the community. Overall the initiative was a success and as a result of the example of Kouroussa, several provinces in Guinea also replicated the initiative. It is too soon to assess the degree to which the practice has been abandoned, however the program was effective in establishing community ownership including among former circumcisors.

## **Opportunities Not to be Missed: Reaching the MDGs and Preventing HIV/AIDS**

As one of the most influential voices in development, the Bank has been advising governments to increase activities to eliminate FGM/C. It is in the interest of the Bank that activities which support the elimination of FGM/C be in the form of grants. Only few countries have passed laws against FGC. Even when governments have supported the policy and legal aspects for addressing FGC, it has been insufficient in bringing about social change necessary for eradicating this practice.

Governments can seek partnerships with civil society to efficiently address FGC. Through most of its HINP, Social Protection, Education and Rural Development projects, the Bank has an opportunity to have a more effective impact on ending FGM/C in sub Saharan Africa.

Another approach is to include FGM/C prevention interventions and care into the civil society's response to HIV/AIDS in the context of the MAP projects. Because civil society is traditionally very active in addressing community issues, using the channel of HIV/AIDS to tackle FGM/C is a great opportunity of the Bank. Through the various lending and grants instruments such as the Japanese Social Development Grant mechanism, the Gender and Law grant program and of course the DGF-Adolescent Reproductive Health program, the Bank has the comparative advantage unavailable to WHO, UNICEF, UNFPA, UNICEFRM and local NGOs to have a positive impact on preventing new FGM/Cs. However, the challenge is to be able to accurately assess not only the extent to which the practice persists, but also the range and extent of its negative impact on individuals and societies.

Scarce resources are available for FGC activities because of inadequate commitment to the issue from the international community. The lack of accurate scientific data on FGM/C presents additional challenges. Support available from governments for eliminating harmful traditional practices in general is limited. To combat FGM/C effectively, there is a need to generate funding and build capacity at all levels of the social structure.

The following are extracts from various World Bank Documents on its efforts to tackling FGM/C:

- The Bank has no specific policies for FGM/C, but FGM/C is mentioned in two of its sectors, 1) gender and Development (within the Poverty Reduction and Economic Management Network) and 2) The Health Nutrition and Population Sector.
- The World Bank recognizes that FGM/C is both a health and human rights issue.
- The Banks work in combating FGM has been through adopting a more broad based approach including public education and involvement of professional organizations and women's groups as well as interaction with communities to address the cultural reasons for its perpetuation.
- The World Bank has been financing reproductive health activities for almost 30 years; overall about one third of the Banks total lending has been through health nutrition and population operations.
- For FGM the Bank has financed governments and NGOs through World Bank grant funds, such as in Guinea, Burkina Faso and Chad, Djibouti including IEC activities as well as training.
- Since 1996 the World Bank's Development Grant Facility Population and Reproductive Health Capacity Building Program, a special fund of Health, Nutrition and Population provided grants for the Small Grants Program of Rainbo and for the Inter African Committee.
- In 200 the World Bank's Development Market place program awarded \$150,000 to test an approach of retraining village traditional practitioners who perform FGM in Guinea.

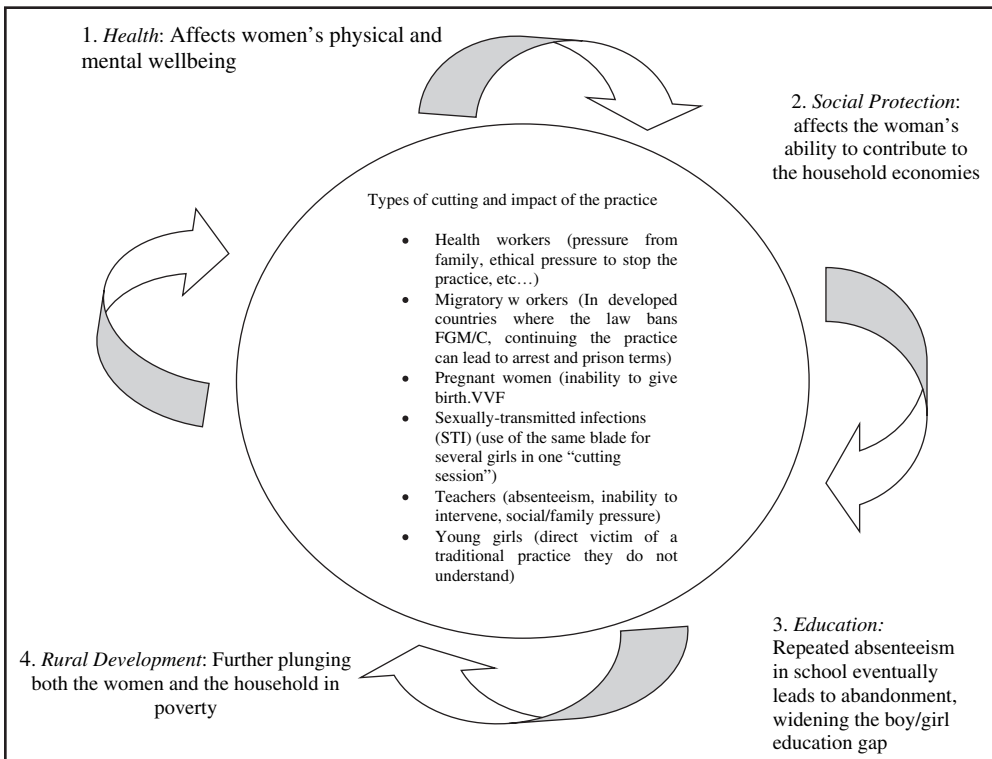
## **Recommendation for Future Role of the World Bank**

While discussion and full analyses of the objectives, philosophy and operational modalities of the World Bank are beyond the scope of this paper, a certain degree of understanding of



Bank current programs and financing mechanisms is necessary for recommending appropriate and practical steps for WB involvement in the global efforts to end FGM/C.

The following model taken from the paper "Integrating Gender Issues into HIV/AIDS programs: An operational Guide" can be applied to four aspects of development which are directly impacted by FGM/C.



### *Government Policy Articulation and Implementation*

The World's Bank's is an intergovernmental institution concerned primarily with economic development. Its comparative advantage is its capacity for policy dialogue and resource mobilization. During the past few years the Bank has focussed intensively in improving its effectiveness in the social sectors. Therefore, the Bank is well positioned to facilitate synergistic policies that link investments in different sectors to achieve optimum impacts bringing together the planning and budgeting authority of the Ministry of Finance, with the needs and implementation capacities of the Ministries of Health, Education, Rural Development and Social Welfare.

The convening power of the Bank as persuasive partner in promoting government policy (including the possibility of appropriate and timely legislative change) to address FGM/C through allocation of targeted resources within Bank grants and encouraging government collaboration with reputable and active NGO's.

### *Integration Within Existing Bank Operations*

A crucial question frequently asked of those promoting efforts to end FGM/C and reiterated by Bank staff is whether it is advisable to integrate horizontally with larger programs or to support stand-alone vertical projects. The answer is both. Integration has the potential for better financial and administrative support and ensures a higher profile and commitment from the institution for an issue that can easily be marginalized. It can also create a wider impact.

A risk of integration is that the lack of specialised skills among program staff will result in neglect or mishandling of the issue. Integration without skills enhancement and specialised training on new topics has a high rate of failure. The second risk is the inability of broader programs to experiment with new ideas and approaches for improving efficiency in the new area.

Support of pilot and specialised projects should go hand in hand with integration efforts. Skill enhancement training should be provided by specialists in the area to program staff. Discussion with Bank staff and review of programs documents lead us to make the following recommendations for integration with existing World Bank operations. This is a first step towards developing policy and program plans to end FGM/C with World Bank support. A further, articulation of activities within each sector can be developed by World Bank operation staff who are more familiar with their sectors' operations.

### *Reproductive Health and HIV/AIDS*

In 1997 a Health Nutrition and Population sector strategy paper described reform initiatives for improving effectiveness through better definition of public and private sectors in financing and delivering health services, better organization and management of health systems and greater community involvement in designing and monitoring services. The *2004 World Development Report* focuses on "Making Services Work for Poor." Linking efforts to end FGM/C with service delivery institutions in health and education is an effective means for mobilising resources and adding value through integration.

Currently the Bank's largest health related effort in Africa is the multi-country MAP program. The link between FGM/C and HIV transmission at the time of cutting and from traumatic sexual intercourse is recognised but not fully researched. Another relevant link between FGM/C and the MAP program is found in Early Childhood Development (ECD) project theme.

During early childhood, patterns of behaviour, competency, and learning are initiated and established; socio-environmental factors begin to modify genetic inheritance and brain cells grow in abundance.

Early childhood is the most rapid period of development in human life. For better or worse, the period 0–8 has an enormous effect on the future health, cognitive development, cultural attitudes, and productivity of an individual.

—From *Turning Bureaucrats into Warriors*, World Bank, 2004, pp. 157.

The severe trauma and complications of FGM/C occur mostly in those formative years. Enlisting the cooperation with ACTAfrica (AIDS Campaign Team for Africa) to integrate efforts for ending FGM/C into policy and funding mechanisms of the MAP program is another option available to the World Bank.

## *Education*

The Bank is the world's largest financier of education. Education is empowerment for people and in particular girls and women. Integrating FGM/C into education projects will help reach many children, their parents, their teacher and ultimately the rest of the community. An emphasis on bridging the gender gap in education can be form the basis for empowering girls who will become mothers in the future and can play a role in preventing FGM/C.

In addition to formal education the World Bank has recently looked into indigenous knowledge (IK) in the Africa Region as important resource for influencing social development. The Bank publication "Indigenous Knowledge: Local Pathways to Global development" (World Bank 2004) demonstrates strong links between IK and social change through examples. "Women's Indigenous Knowledge: Building Bridges Between the Tradition and the Modern" by Dr. Mamphela Ramphele of South Africa and (at the time) Managing Director of the Bank is particularly relevant to FGM/C. The example of the achievements of the Malicounda Bambara of Senegal to end the practice of FGM/C in their village is sited in her article and described fully in IK Notes (page 78). The continuing efforts to use IK could integrate elements specific to empowering women and promoting a culture of protection for children's rights by the community.

## *Social Development Sector*

The Environmental Sustainable Social Development department of the of the World Bank defines the term rural as a geographic and social space rather than activities linked only to rural development. Including gender issues in development has been an increasing concern in this department. FGM/C is an important gender issue that can be integrated into the overall social development sector strategy and into ensuing operations.

## *Support for Technical Training of National NGO's*

Review of different country projects have shown that many NGOs and CBOs are already engaged in or willing to work towards ending FGM/C. In almost all countries, there is a lack of technical knowledge on effective project design and appropriate methodology to yield desired outcomes. Clear project objectives and outcomes need to be linked to monitoring and evaluation indicators that will eventually result in reduction and total eradication of the practice. Training on effective design, monitoring and evaluation is therefore urgently needed.

A World Bank supported training and capacity building effort can increase the number of qualified individuals who can provide training and technical assistance at the national level and in indigenous languages. With the assistance of international NGOs such as Rainbo, the Inter African Committee Against Harmful Traditional Practices, AIDOS and other in country NGOs, the World Bank through its World Bank Institute has the expertise to provide its existing technical and training tools for further development and distribution.

The Bank has the financial capacity to support the strengthening of successful interventions and expanding their effects through modelling, training and replication.

Funding for NGO training and support may provided through special Trust provided by governments and external donors with the aim of creating ownership and sustainability by communities.



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*Female Genital Cutting, Women's Health, and Development* is part of the World Bank Working Paper series. These papers are published to communicate the results of the Bank's ongoing research and to stimulate public discussion.

This strategy paper provides a comprehensive understanding of the issue of female genital mutilation/cutting—scope, challenges, opportunities, best practices, and how communities, development agencies, and national governments can work together to eliminate the practices on the ground. The World Bank is committed to assisting governments in ending the practice of female genital cutting, as the practice has a direct, negative impact on the health and well-being of women around the world. The recommendations set forth in this paper take advantage of the World Bank's comparative advantage in dealing with governments. Continued silence perpetuates the practice, thereby undermining women's productivity.

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