Global Health eLearning Center

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Female Genital Mutilation/Cutting (FGM/C)

What Is FGM/C?

In this session, we discuss the terminology used to describe and define female genital mutilation/cutting (FGM/C). In addition, you will learn about who is generally affected, and some reasons why FGM/C is practiced.

Definition

According to the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and the United Nations Population Fund (UNFPA), female genital mutilation/cutting (FGM/C) comprises

". . . all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons."

According to UNICEF, It is estimated that at least 200 million girls and women have undergone some form of genital mutilation/cutting, and if the practice continues at recent levels, 68 million girls will be cut between 2015 and 2030 in the 31 countries where FGM is routinely practiced.

In 2016, the United Nations General Assembly adopted The Girl Child Resolution (A/RES/70/138) recognizing FGM as a form of "discrimination against the girl child and the violation of the rights of the girl child. In addition, the Sustainable Development Goal (SDG) 5.3 target on FGM/C is to eliminate all harmful practices, such as CEFM and FGM/C. In 2008, UNICEF, in partnership with UNFPA developed a joint-program

that works to tackle female genital mutilation through interventions in 17 countries: Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Nigeria, Senegal, Sudan, Somalia, Uganda and Yemen.

This course will highlight the lessons learned from the unified, global stance towards the elimination of FGM/C, in addition to outlining promising practices and case studies.

Sources: UNICEF 2022a, UNFPA 2012a, SDSN 2012, UNFPA 2021

Did you know?

Due to COVID, there could be as many as 2 million additional cases of FGM by 2030?

Economic hardship has attributed to an increase in girls' risk of undergoing FGM, with parents agreeing to it while seeking 'bride prices', cutters who abandoned the practice start cutting again to make money, and in some cases programs focused on mitigating FMG/C were interrupted.

Source: Musa et al., 2021

Terminology

Despite more than 40 years of advocacy work, the terms used to describe the practice (e.g., "mutilation" and "cutting") are still the subject of debate.

Some fear that parents may resent the implication that they are "mutilating" their daughters. The term "cutting" is less judgmental and corresponds better to terms used in many local languages.

However, many women's health and human rights organizations and activists use "mutilation" not only to describe the practice but also to underscore the basic violation of women's human rights.

Previously, some referred to the practice as "circumcision" to equate FGM/C to male circumcision. However, this term obscures the serious physical and psychological effects of cutting women's genitals and fails to distinguish between the various types of cutting.

Due to this continual debate, USAID uses "female genital mutilation/cutting." Note that this term does not directly translate into many indigenous languages. Those who practice FGM/C may have very different conceptions about the practice, and therefore use different descriptions and terms for it.

Source: UNFPA 2015a

Glossary Term:

Circumcision
Female genital mutilation
Female genital cutting
Infibulation
Prepuce

Highlight

"Efforts to empower women cannot begin with using language that offends them." — Nahid Toubia, (a Sudanese surgeon and women's health rights activist) (Skaine, R. 2005)

Highlight

"Female genital mutilation targets little girls, baby girls—fragile angels who are helpless, who cannot fight back. It's a crime against a child, a crime against humanity. It's abuse. It's absolutely criminal and we have to stop it." — Waris Dirie

Both of these quotes underscore the passionate feelings regarding the terminology used to describe FGM/C.

Types of FGM/C

Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.

In 2008, the WHO/UNICEF/UNFPA Joint Statement classified female genital mutilation into four types:

- Type I
- Type II
- Type III
- Type IV

Although the extent of genital tissue cutting generally increases from Type I to III, there are exceptions. Severity and risk are closely related to the anatomical extent of the cutting, including both the type and amount of tissue that is cut, which may vary between the types.

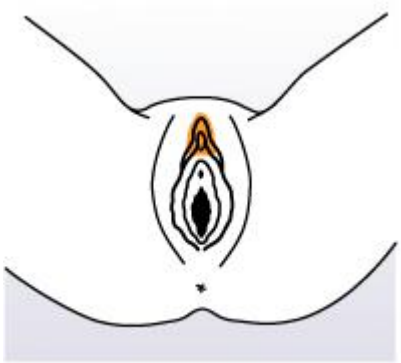
Type IV comprises a large variety of practices that do not remove tissue from the genitals.

Girls and women may not always be certain which procedure was performed on them. Moreover, the extent of the cutting may vary significantly from community to community depending upon the conditions in which the practice is performed, the instrument used, and the practitioner.

The following pages will provide more details about the differences between the four types of FGM/C.

Sources: WHO 1997; WHO 2015a

Type I



Type I: Refers to the partial or total removal of the clitoris and/or the prepuce. The affected area is highlighted in orange.

This practice is also referred to as **clitoridectomy**.

Source: WHO 2008

Glossary Term:

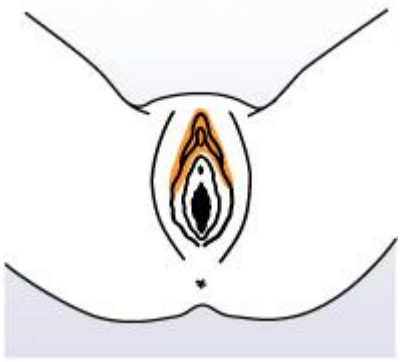
Prepuce

Highlights

Type I is the *most common* among countries that practice FGM/C.

Source: UNICEF 2005; UNFPA 2015a

Type II



Type II: Refers to the partial or total removal of the clitoris and the labia minora, with or without excision (surgical removal or cutting) of the labia majora. The affected area is highlighted in orange.

Source: WHO 2008
Glossary Term:
Excision

Highlight

In a number of countries, such as Burkina Faso, Cameroon, Sierra Leone, Ghana, Guinea-Bissau, Kenya, and Mali, excision of the clitoris (Type II) is most frequently practiced.

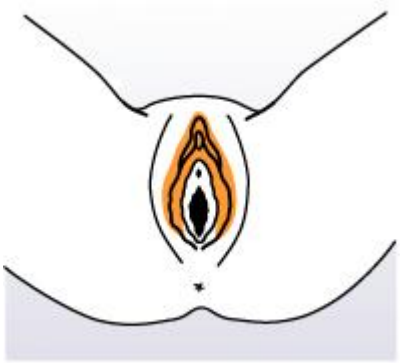
Source: UNICEF 2013a

Did you know?

In French, the term "excision" is often used as a general term covering all types of female genital mutilation/cutting.

Source: WHO 2015b

Type III and Type IV



Type III: Refers to the narrowing of the vaginal orifice, with creation of a covering seal, by cutting and sewing the labia minora and/or the labia majora together—with or without excision of the clitoris. The affected area is highlighted in orange.

This practice is also referred to as **infibulation**.

Type IV: Refers to all other harmful procedures to the female genitalia for non-medical purposes (e.g., pricking, piercing, incising, scraping, and cauterization).

The reasons, context, consequences, and risks of the various practices subsumed under Type IV vary enormously. These practices are generally less well known and studied than Types I, II, and III.

Source: WHO 2008
Glossary Term:
Infibulation

Highlight

In Somalia, Northern Sudan, and Djibouti Type III (infibulation) is experienced by about 10 percent of all affected women.

Source: UNFPA 2022

Geographic Distribution of Affected Population

Female genital mutilation/cutting has been documented in 30 countries located in Africa, as well as in parts of the Middle East (Yemen, Oman, United Arab Emirates, Bahrain, and Northern Iraq) and Asia (India, Malaysia, and Indonesia).

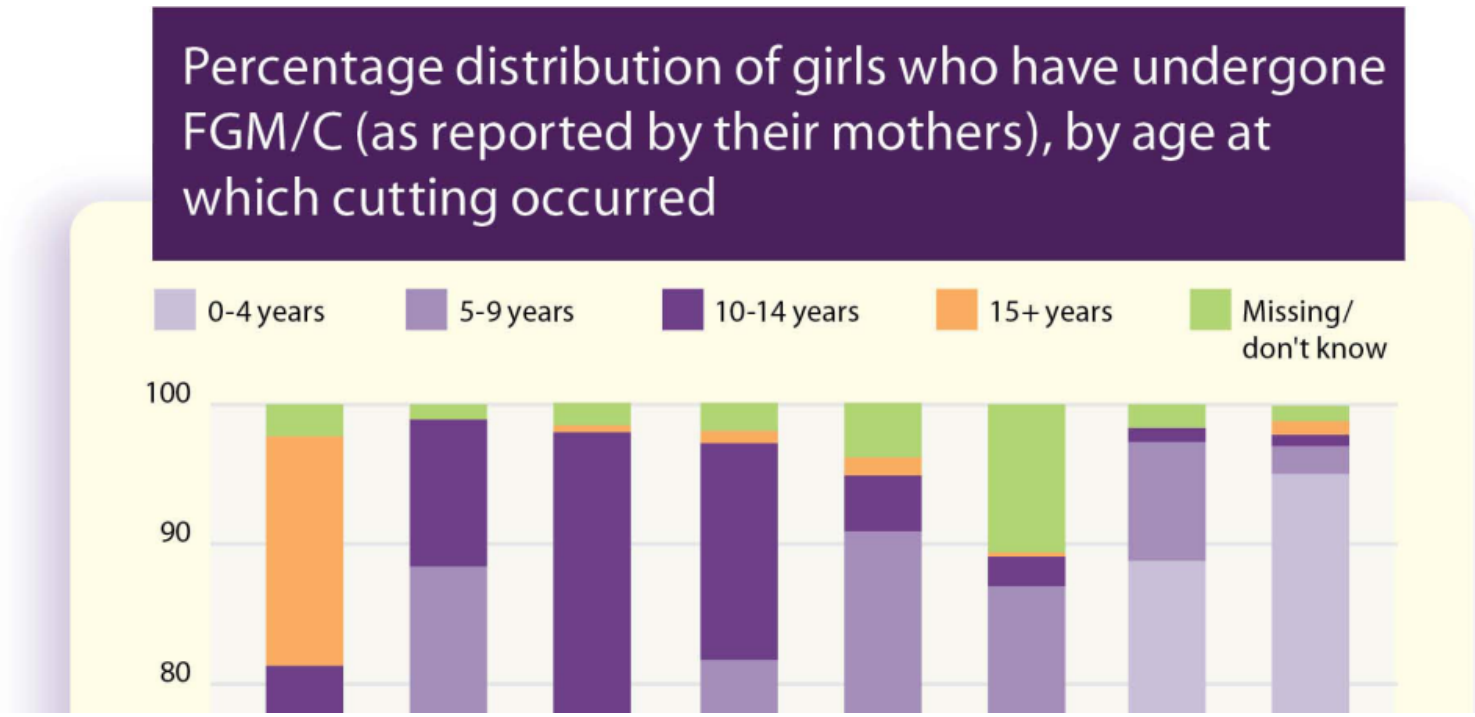
However, the range may be even farther-reaching. No nationally representative data on FGM/C currently exists for Colombia, Jordan, Oman, Saudi Arabia, and parts of Indonesia and Malaysia, even though it has been documented that the practice has long existed there.

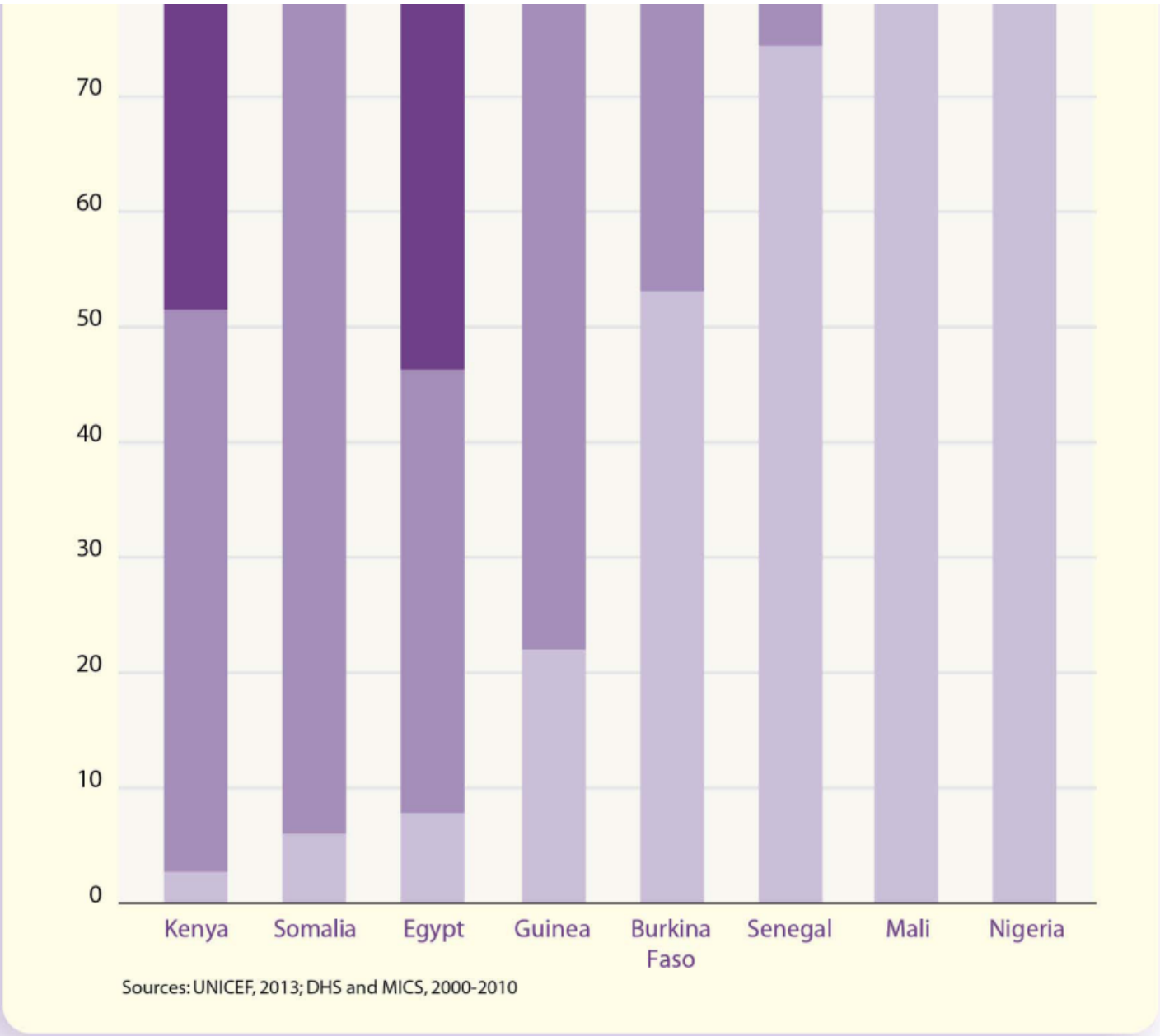
In addition, **growing migration has increased the number of girls and women living outside their countries of origin who have undergone FGM/C or who may be at risk of being subjected to the practice.**

Attention has been focused on the continuation of the practice among immigrant communities throughout Europe, the United States, Australia, and Canada, although data on the practice in these communities have been harder to obtain.

Sources: WHO 2022, PRB 2013, UNICEF 2013a

Age of Affected Population





While earlier data was reported in samples of women age 15 to 49, in 2010, a new data collection plan was implemented to include prevalence rates of girls 0-14 years of age. This information is particularly useful for the evaluation of more recent interventions. However, it is also challenging to collect; see the last page in the next session for more details on the challenges to measuring FGM/C prevalence.

In half of the countries with available data, the majority of girls were cut before age 5. For example, in Nigeria, over 90% of girls were cut before age 5. In Yemen, 85% of girls experience this practice within their first week of life.

Important differences in age at cutting are also found among ethnic groups living in the same country. For example, data in Kenya show that the mean age at cutting among females ages 15 to 49 ranges from 9 years among the Somali to 16 years among the Kamba and Kalenjin ethnic groups. Another study shows that the prevalence of cutting was high throughout Kisii and Somali women and almost zero among younger women (15–19 years) of the Kalenjin, Kamba, Kikuyu and Taita/Taveta ethnic groups.

Source: Kandala et al, 2019

Glossary Term:
Ethnic group

Reasons for FGM/C

The justifications offered for the practice of FGM/C are numerous and, in their specific contexts, compelling.

The motivation for the practice is often linked to the perception of specific benefits. FGM/C assigns status and value both to the girl or woman herself and to her family.

Some common reasons given for FGM/C include that it ensures the following:

- A girl's or woman's status
- Marriageability
- Chastity, morality, and fidelity
- Preservation of virginity
- Health and fertility
- Beauty
- Hygiene/cleanliness
- Family honor/social acceptance
- Religiosity
- Male sexual pleasure
- Religious necessity/approval

According to Demographic and Health Survey (DHS) data, **the majority of women cite gaining social acceptance as a benefit of FGM/C**.

Sources: DHS 2013, UNICEF Innocenti Research Centre 2005; UNICEF 2005; UNICEF 2013a

Global Prevalence Rates

In this session, we highlight some country-specific prevalence rates as well as in-country variations and discuss the challenges to measuring FGM/C prevalence.

FGM/C Prevalence

DHS and MICS data: Country of origin, source- and year of publication, overall prevalence (%) and the prevalence of Type III and other types of FGM/C (%); Statistics Netherlands dataset on first- and second-generation female migrants.

Country of origin	**DHS and MICS data**					**Statistics Netherlands**		
	Source	Year of publication	Overall FGM/C prevalence (%)	Type of FGM/C (%)	First-generation	Second-generation	Total	
				Type III	Other types or unknown			
Benin	MICS	2014	9.2	10.1	89.9	102	83	185
Burkina Faso	DHS	2010	75.8	1.2	98.8	135	145	280
Cameroon	DHS	2004	1.5	5.0	95.0	924	697	1621
Central African Republic	MICS	2010	24.3	7.0	93.0	30	10	40
Chad	DHS	2014–15	38.4	9.4	90.6	27	39	66
Côte d'Ivoire	DHS	2011–12	38.2	8.7	91.3	530	351	881
Djibouti	MICS	2006	93.2	67.2	32.8	79	63	142
Egypt	DHS	2015	87.2	0.7	99.3	4716	5214	9930
Eritrea	PHS	2010	83.0	38.6	61.4	6271	784	7055
Ethiopia	DHS	2016	65.2	6.5	93.5	7266	2920	10186
Gambia	DHS	2013	74.9	0.0	100.0	347	286	633
Ghana	MICS	2011	3.8	7.9	92.1	7255	4864	12119
Guinea	DHS	2012	96.9	7.5	92.5	1118	979	2097
Guinea-Bissau	MICS	2014	44.9	6.0	94.0	106	78	184
Iraq	MICS	2011	8.1	0.0	100.0	7004	3038	10042
Kenya	DHS	2014	21.0	9.3	90.7	1546	944	2490
Liberia	DHS	2013	49.8	0.0	99.9	593	692	1285

Country of origin	DHS and MICS data					Statistics Netherlands		
Mali	DHS	2012–13	91.4	10.6	89.4	82	95	177
Mauritania	MICS	2015	66.6	4.5	95.5	32	62	94
Niger	DHS	2012	2.0	6.3	93.7	54	74	128
Nigeria	DHS	2013	24.8	5.3	94.7	3038	3025	6063
Senegal	DHS	2016	22.7	7.1	92.9	385	419	804
Sierra Leone	DHS	2013	89.6	9.0	91.0	1349	973	2322
Somalia	MICS	2006	97.9	79.3	20.7	12924	6824	19748
Sudan	MICS	2014	86.6	77.0	23.0	1909	1101	3010
United Republic of Tanzania	DHS	2015–16	10.0	6.6	93.4	565	606	1171
Togo	DHS	2013–14	4.7	15.4	84.6	446	377	823
Uganda	DHS	2016	0.3	0.0	100.0	1104	411	1515
Yemen	DHS	2013	18.5	0.0	100.0	360	137	497
Total						**60297**	**35291**	**95588**

The most reliable and extensive data on the prevalence and nature of FGM/C are provided by Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS).

The table provides recent data from DHS and MICS, indicating that **FGM/C prevalence varies significantly from country to country,** from as low as 0.3% in Uganda to as high as 98% in Somalia, 97% in Guinea, and 93% in Djibouti.

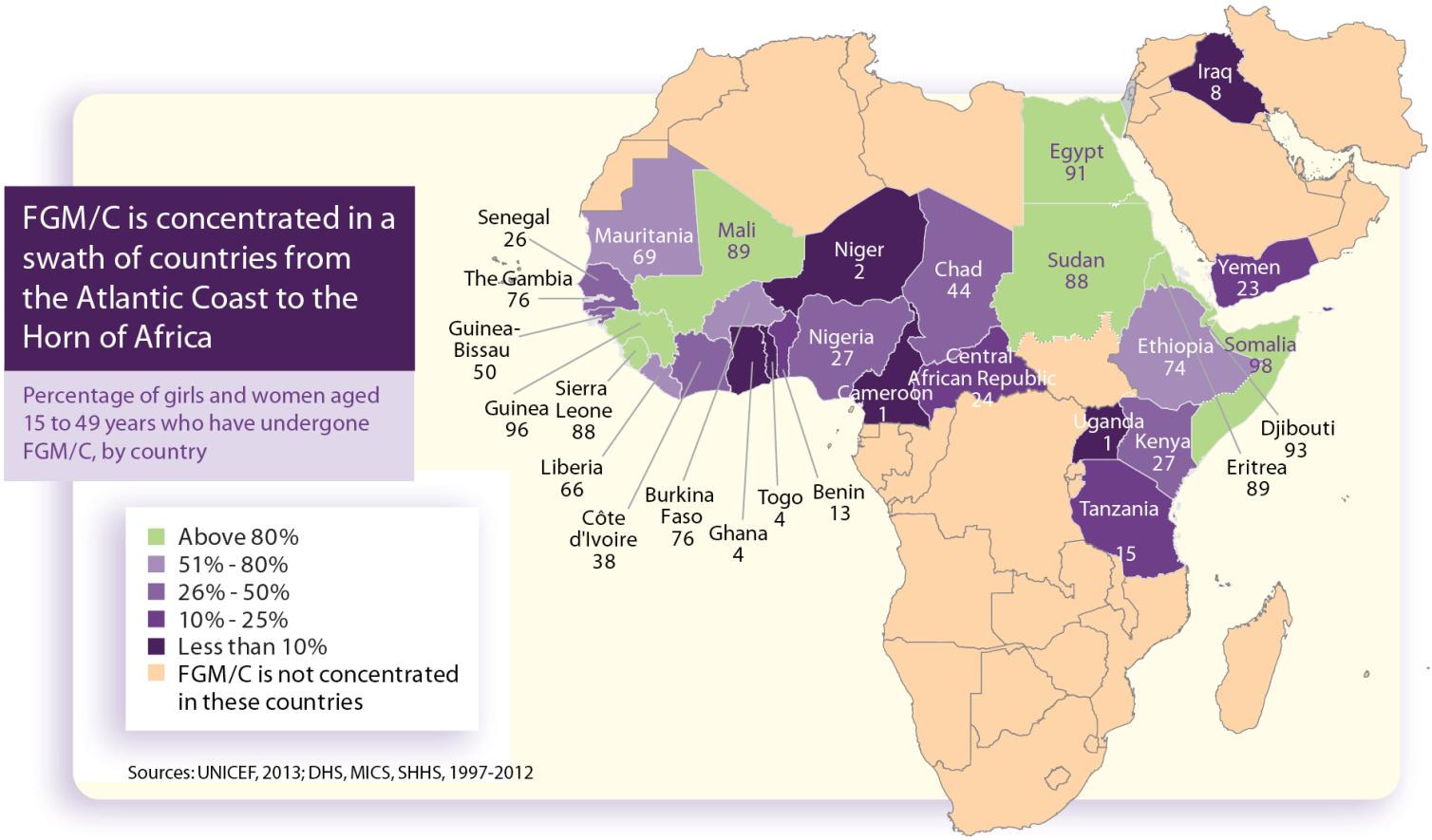
Source: Kawous R, et al, 2020

Glossary Term:

FGM/C prevalence
Demographic and Health Surveys (DHS) Female Genital Cutting Module
Multiple Indicator Cluster Survey (MICS)

FGM/C Prevalence in Africa

The majority of girls at risk of undergoing FGM/C live in Africa and the Middle East. In Africa, these countries form a broad band from Senegal in the west to Somalia in the east. In some of the countries such as Somalia and Guinea, 98% of women and girls, aged 15-49, have undergone some form of FGM. UNFPA's FGM dashboard contains more information on FGM prevalence and practice in various countries.



Source: UNFPA 2022

Country Groupings by Prevalence Rates

Often countries are discussed and examined based on their prevalence rates. As a result, **five general groupings** have been established:

Prevalence Rates for Women who have Undergone FGM/C

Groups	Level of Prevalence	Country Percentages
Group 1	Very High (more than 80%)	Somalia: 98% Guinea: 96% Djibouti: 93% Egypt: 91% Eritrea: 89% Mali: 89% Sierra Leone: 88% Sudan: 88%
Group 2	Moderately High (between 51%-80%)	The Gambia: 76% Burkina Faso: 76% Ethiopia: 74% Mauritania: 69% Liberia: 66%

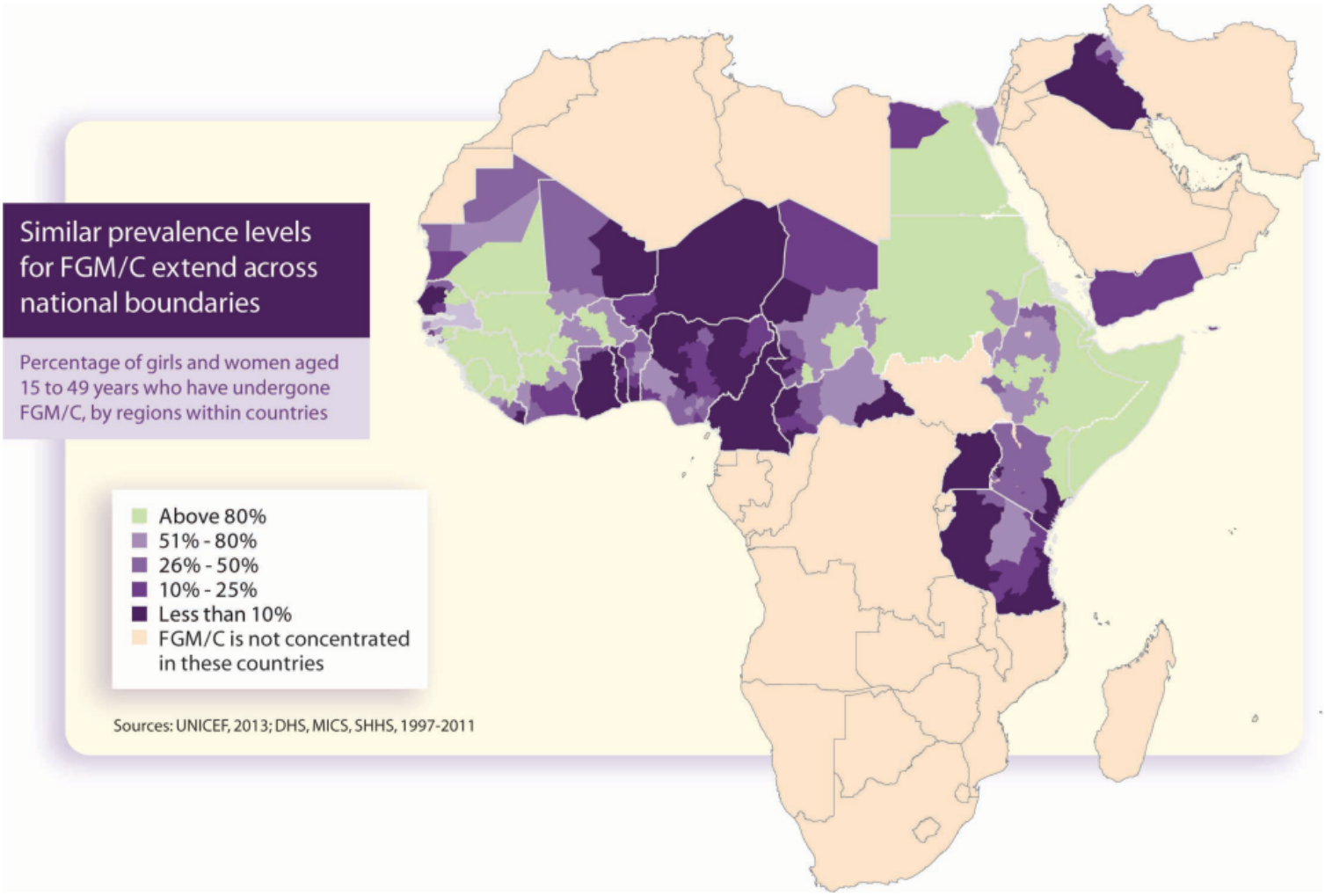
Groups	Level of Prevalence	Country Percentages
Group 3	Moderately Low (26-50%)	Guinea-Bissau: 50% Chad: 44% Côte D'Ivoire: 38% Kenya: 27% Nigeria: 27% Senegal: 26%
Group 4	Low (between 10-25%)	Central African Republic: 24% Yemen: 23% Tanzania: 15% Benin: 13%
Group 5	Very Low (less than 10%)	Iraq: 8% Ghana: 4% Togo: 4% Niger: 2% Cameroon:1% Uganda: 1%

Source: UNICEF 2013a

What Disaggregated Data Reveals

Although the five groupings are useful in providing a broad sense of the practice in each country for which national-level data are available, DHS and MICS also permit national-level data to be disaggregated by age group, urban-rural residence, household wealth, women's education, and region or province.

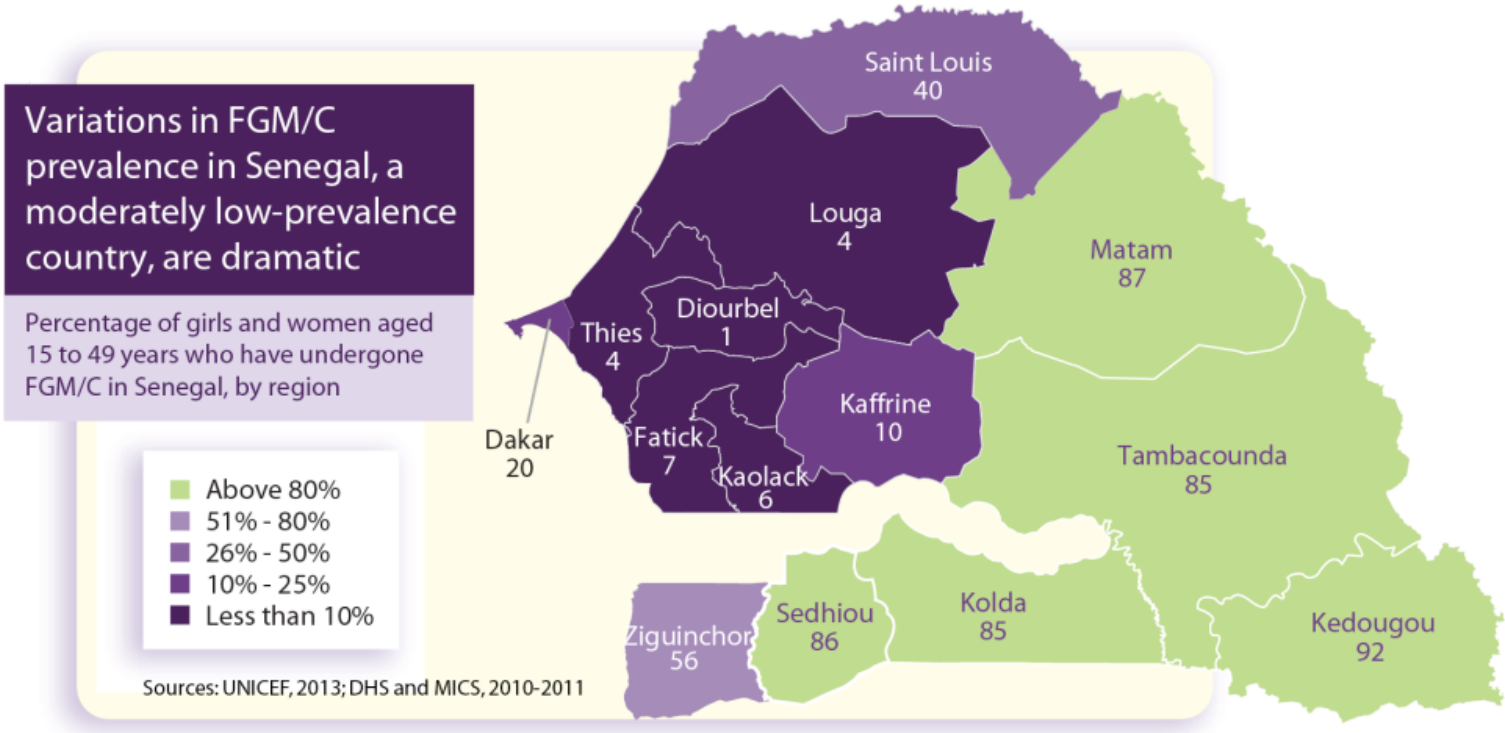
The possibility of **analyzing the disaggregated data on prevalence is of crucial importance because national averages can disguise significant in-country variation**, as illustrated below.



Source: UNICEF 2013a

Example of FGM/C Prevalence within Senegal

Senegal provides an excellent example of in-country variation.



Senegal is a moderately low-prevalence country, with a national prevalence rate between 26% and 50%. DHS 2011 data report that the prevalence rate for girls and women aged 15 to 49 who have undergone FGM/C is 26%.

At the regional level, FGM/C prevalence ranges from 1% in Diourbel to 92% in Kedougou. This illustrates the dramatic geographic variation between regions and communities. This variation is largely explained by the presence of diverse ethnic groups with differing attitudes and practices regarding FGM/C.

Source: UNICEF 2013a

FGM/C Prevalence in the United States

The Population Reference Bureau (2015) reports that more than 500,000 women and girls in the United States are estimated to be affected by or at risk of FGM/C. This number has more than doubled since 2000. The main reasons for the increasing prevalence include population growth and increased international immigration, especially from African countries.

There are generally three types of cases that affect women in the US:

- **Immigrants:** The most common cases involve immigrant women who move to the US, but had already undergone FGM/C in their birthplaces.
- **Vacation cutting:** This often involves children of immigrants, who are sent abroad (often being told they are going on “vacation”) to have the procedure done. In 2013, a federal law made it illegal for parents/guardians to knowingly send their girls abroad to undergo FGM/C.
- **Underground:** Even though performing FGM/C has been illegal in the US since 1996, in some communities, medical professionals will perform FGM/C at the request of parents. Other times, parents will have someone come to the home to perform the procedure.

To learn more about the FGM/C practice in America, see ABC News’ Underground in America: FGM.

ABC NEWS ABC NEWS

Video Underground in America: FGM Survivor and Activist Speaks Out

Jaha Dukureh underwent female genital mutilation as a baby in the Gambia, and is actively campaigning to end the practice around the world.

Read this on abcnews.go.com >

Sources: Equality Now 2015; PRB 2015

Did you know?

Three countries—Egypt, Ethiopia, and Somalia—account for over half of all US women and girls at risk. Not only do these countries have high FGM/C prevalence rates, but they also have a relatively large number of immigrants to the US.

Did you know?

According to Equality Now, only 40 states have laws against FGM to date.

Source: Equality Now 2022

Challenges in Measuring FGM/C Prevalence

The best available data on FGM/C prevalence, as well as information on health consequences attributable to FGM/C, comes from large-scale population-based surveys. However, the ability to make inferences from self-reported data is limited due to the following factors:

- **Recall:** It may be impossible for some women to remember any details regarding the experience, especially for those who had undergone the procedure in early childhood or infancy.
- **Fear:** Women and girls may fear reporting that they (or their daughters) have undergone FGM/C, due to legal sensitivities.

Despite these reasons, a number of hospital-based and epidemiological studies have been developed to provide a clearer picture of the national and global picture of FGM prevalence.

Sources: UNICEF 2013a; Morison and Scherf 2001; WHO 2006; Yoder et al 2008

Glossary Term:
Selection bias

Socio-Demographic Factors Correlated with FGM/C

This session highlights the research findings regarding the possible correlations between different socio-demographic factors and FGM/C.

Overview

Research over the last 35 years has examined the possible correlation of different socio-demographic factors with FGM/C. **This research has found that the relationships of these factors to the practice vary dramatically by country and, more importantly, by ethnicity.**

Some of these factors studied include the following:

- Ethnicity
- Place of residence
- Household wealth
- Education
- Religion
- Age and generational trends

This session explores what the research has uncovered and the ways in which these factors do not necessarily tell the whole story.

Ethnicity

According to DHS analysts, data vary far more by ethnicity than by any other social or demographic variable. This means that **ethnic identity and the practice of FGM/C are closely linked**. For example, in Benin, FGM/C prevalence ranges from 0.2% among the Adja and Fon to 74% among the Bariba, Benin's fourth-largest ethnic group.

When analyzing data on ethnicity, multiple issues need to be considered:

- Ethnic groupings rarely correspond to clearly defined national and international administrative divisions.
- Different ethnic groups that practice FGM/C may be present in the same provinces or districts.
- In certain countries, inter-ethnic marriage has become increasingly common. As a result, a sharp and stable boundary may not always exist between practicing and non-practicing ethnic groups.
- Ethnic groups may have subgroups that differ with respect to FGM/C practices.

Sources: UNICEF Innocenti Research Centre 2007; UNICEF 2013a, 28 Too Many, 2019

Glossary Term:

Ethnic group

Place of Residence

Variations in FGM/C prevalence based on residence refers to the fact that residence is determined by factors such as the area's ethnic composition, neighboring countries, dominant religious affiliations, and level of urbanization.

The correlation is not in only one direction. For example, in Nigeria, the FGM/C status of daughters is higher in urban areas. However, the opposite is true in in Kenya, where FGM/C prevalence among rural girls is four times that of urban girls.

Some researchers contend that this is an issue of urban-rural differences and may be somewhat understated due to urban-rural migration. In other words, **the association between place of residence and FGM/C prevalence should NOT be interpreted as a direct influence**, in part due to urban-rural migration flux. It is possible that women migrated after being cut.

Sources: UNICEF 2005; UNICEF 2013a

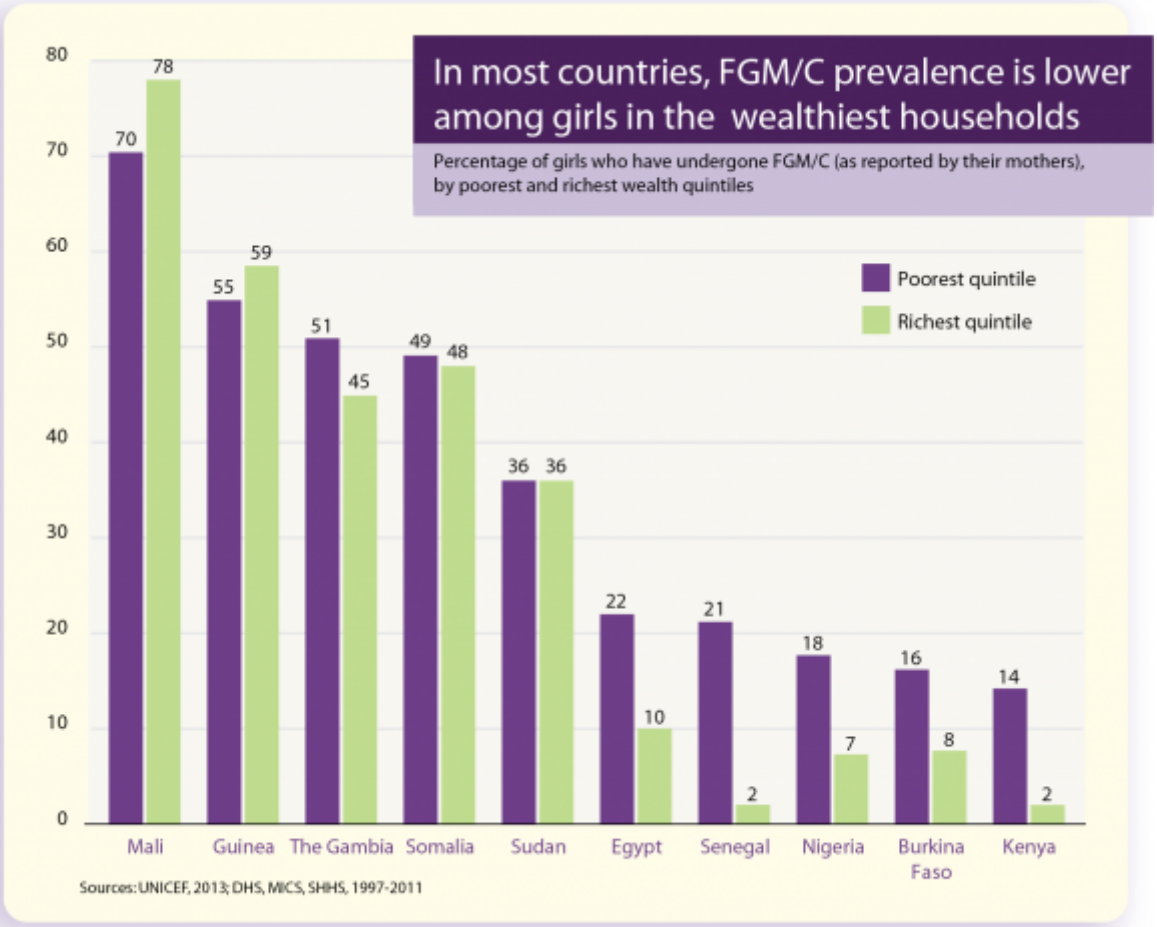
Household Wealth

Because women can be born or marry into wealth, it is important to examine the relationship among daughters' and mothers' household wealth.

The graph on this page indicates that in most countries, the poorest households more frequently report that their eldest daughter has undergone FGM/C than do their counterparts in the richest households. However, in Mali and Guinea, the opposite is observed.

Even though household wealth appears to have some correlation to FGM/C status, **the relationship is not always consistent.**

In most cases, FGM/C prevalence seems to be **lower in wealthier households.**



Sources: UNICEF 2005; UNICEF 2013a

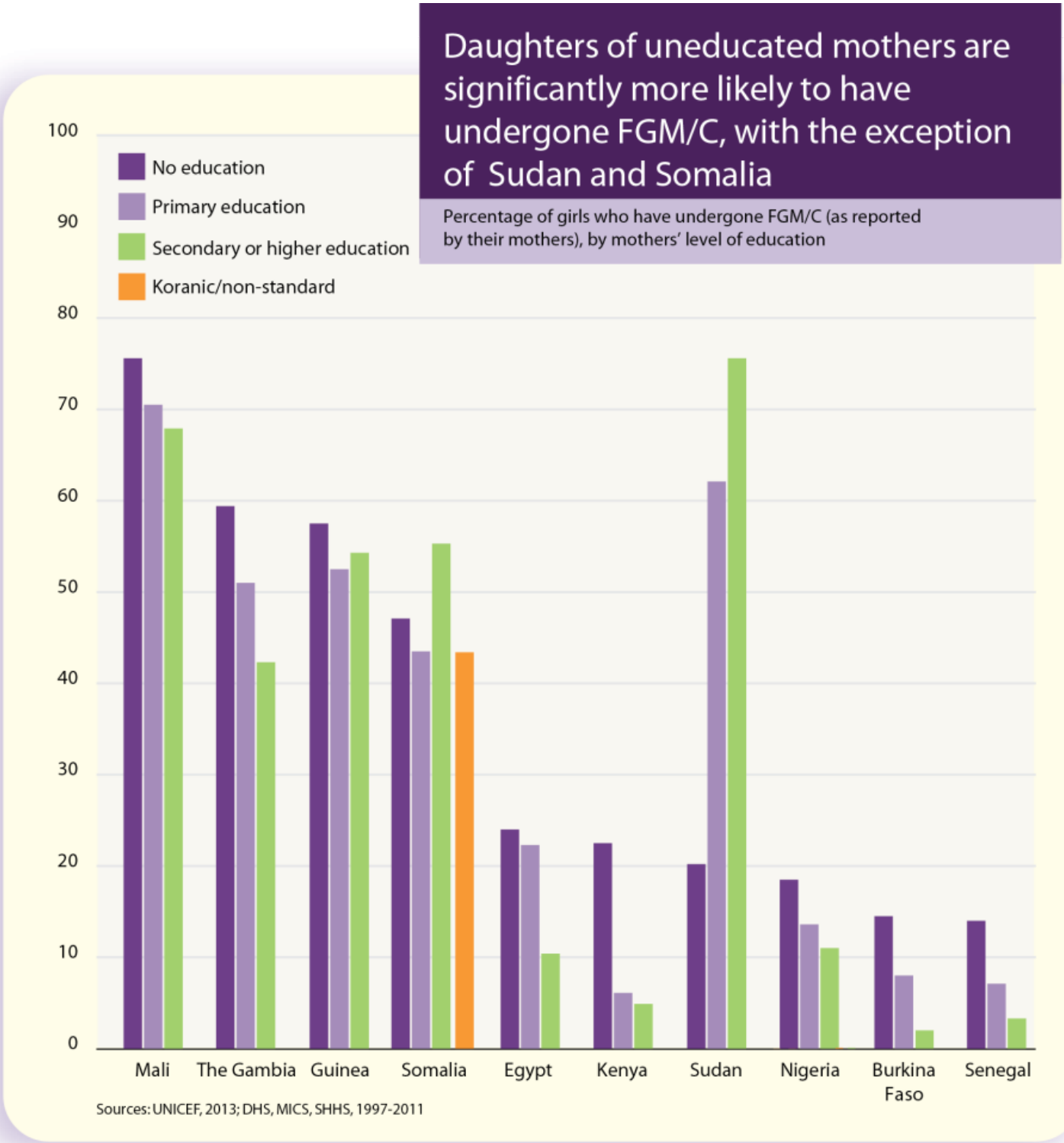
Education

Education, especially of women, can play an important role in safeguarding the human rights of women and their children. However, **education alone is not sufficient to lead to the abandonment of FGM/C.**

Because FGM/C usually takes place before formal education begins or is completed, a mother's level of education has been hypothesized to be a significant determinant of the FGM/C status of her daughters.

Available survey data from 20 countries of both high and low prevalence show that the expected prevalence of FGM/C is generally highest among daughters of women with no education. **FGM/C prevalence tends to decrease substantially as a mother's educational level rises. Daughters of women who have a primary education are 40 percent less likely to be cut than those whose mothers have no education.**

Sudan and Somalia are the only exceptions. In these countries, the prevalence of FGM/C is positively correlated to increased mothers' educational levels.



Sources: UNICEF Innocenti Research Centre 2007; UNICEF 2013a. UNICEF 2021a

Religion

FGM/C is not prescribed by any religion. However, this is not the general perception, especially regarding Islam

No text requires or even condones cutting female genitals. In fact, Islamic Shari'a protects children and safeguards their rights. From a Christian perspective, FGM/C has no religious grounds either.

In fact, **research shows that the relationship between religion and FGM/C distribution is inconsistent at best**. While the majority of girls and women who undergo FGM/C are Muslim, it is also prevalent in other religious groups. For example, in Nigeria, Tanzania, and Niger, the prevalence is greater among Christian groups. **This variation can be attributed to ethnicity and the overall distribution of various religious groups within these countries.**

FGM/C predates Islam and Christianity, and many religious leaders have denounced it. Scholars and activists across religions have concentrated a great deal of effort to demonstrate a lack of scriptural support for the practice.

Despite this, in certain settings, FGM/C is widely held and believed as a religious obligation, even by Islamic imams. For example, in Guinea, Mali, and Mauritania, significant proportions of women and men reported that FGM/C is required by their religion. In Mali, for example, nearly two-thirds of girls and women and 38% of boys and men regard FGM/C as a religious duty.

Sources: UNFPA 2015a; UNICEF 2005; UNICEF 2013a

Glossary Term:

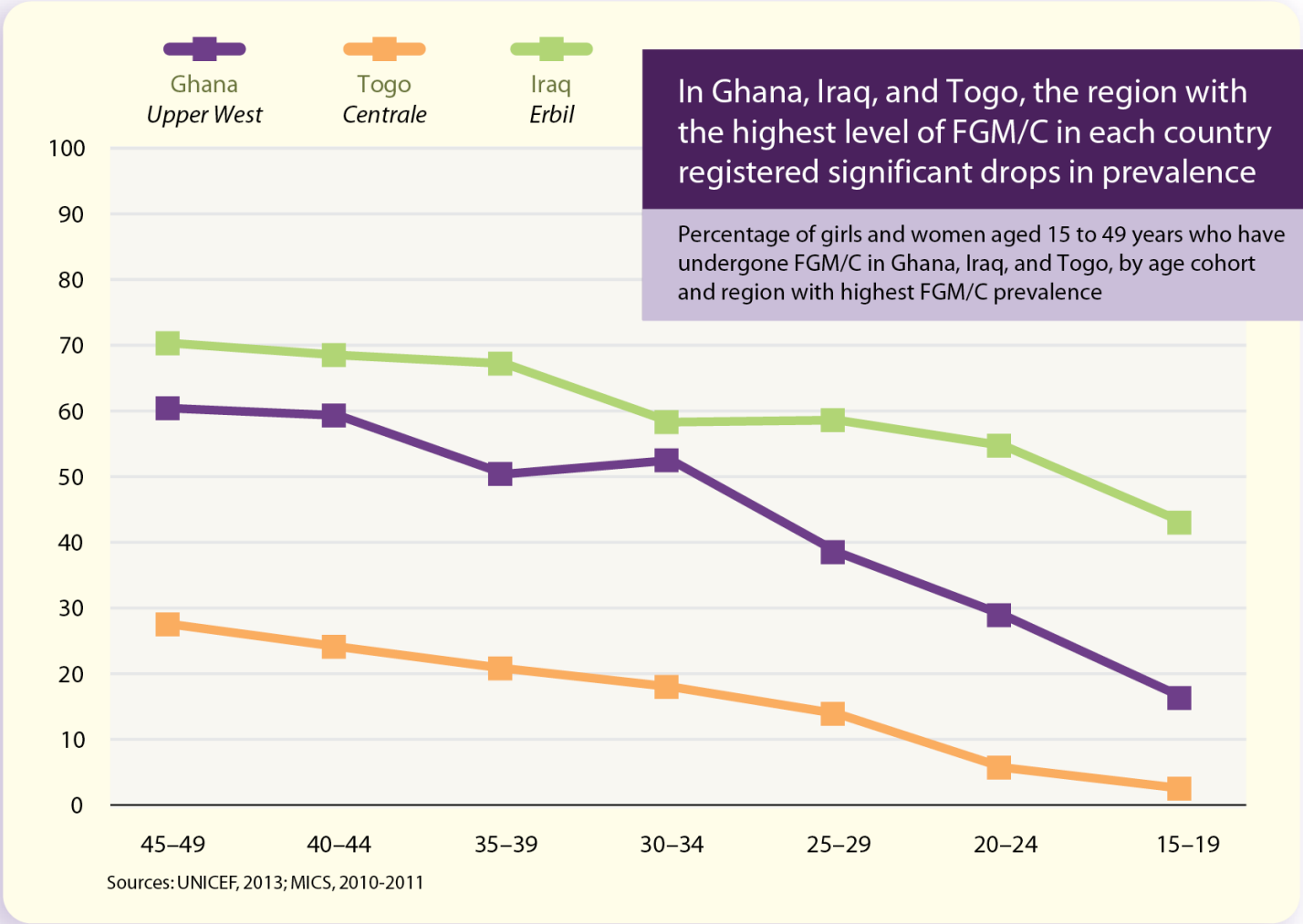
Shari'a

Age and Generational Trends

In most of the 30 countries surveyed, **FGM/C is less common among adolescent girls than middle-aged women**. This could be due to a number of different positive and negative factors:

- Increasing **international pressure** for the abandonment of FGM/C
- Increasing number of **anti-FGM/C national legislation**
- Positive results from FGM/C abandonment **interventions**
- **Underreporting** of FGM/C practice due to legal sensitivities

It is worth noting that in countries with very low national FGM/C prevalence, the practice tends to be concentrated in select areas. In Ghana, Iraq, and Togo, the region with the highest level of FGM/C in each country experienced significant drops in prevalence between women aged 45 to 49 and girls aged 15 to 19. However, clear patterns of change across age groups have not been observed in countries with low national prevalence, such as Cameroon, Niger, and Uganda.



Source: UNICEF 2013a

Health Consequences

In this session, we cover what are currently termed the short- and long-term health consequences of FGM/C. In addition, we discuss the evolving medicalization of FGM/C and its relation to health care training and service provision.

Short-Term Complications

The immediate health consequences of FGM/C for a girl or woman depend on a number of factors:

- The **extent and type of the mutilation/cutting** (see Session 1: What is FGM/C?)
- The **cleanliness** of the tools used and the setting
- The **physical condition** of the girl or woman

In most countries, FGM/C is performed in poor sanitary conditions, mainly by traditional practitioners who may use scissors, razor blades, or knives.

The lack of hygiene leads to severe infections and septicemia; additionally, the pain and trauma can cause severe shock.

Other immediate complications are tetanus or sepsis, urine retention, ulceration of the genital region, and injury to adjacent tissues. Hemorrhage and severe bleeding can result in death.

Sources: WHO 2008; WHO 1997;

Glossary Term:

Septicemia
Tetanus
Sepsis
Hemorrhage

Long-Term Complications

In the longer term, many women experience sexual, psychological, and obstetric problems.

A number of serious health outcomes have been identified in medical reports:

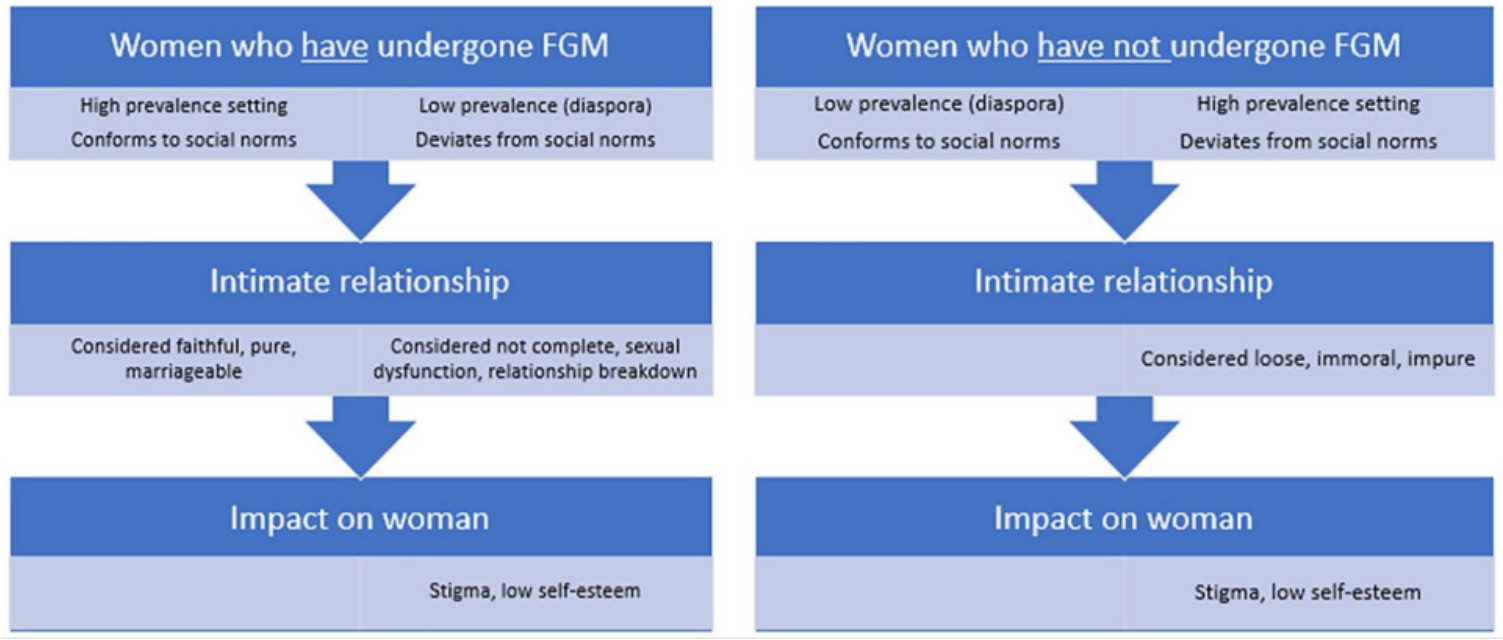
- Gynecological problems
- Psychosexual difficulties
- Obstetric complications
- Infertility

If women and girls do not receive appropriate health care as well as psychological and emotional care, these health impacts are further complicated. Many women might not be aware that the health problems they experience later in life are related to FGM/C; therefore, these problems go unreported.

The WHO Study Group conducted the first large-scale, international study to break through the silence and confusion around FGM/C. Based on the direct observation of more than 28,000 women in six African countries, the prospective **study shows clearly that FGM/C (Types I, II, and III) is associated with an increased risk of obstetric complications, including cesarean section, postpartum hemorrhage, episiotomy, extended hospital stays, the need for infant resuscitation, and in-patient death**. The risk and severity of complication varies according to the type of FGM/C, with Types II and III leading to worse outcomes.

In 2021, another research study provides qualitative evidence of the psycho-social impact of FGM and provides a framework for understanding ways FGM affects the sense of identity, self-esteem, participation in society and the overall well-being of the lives of women who have experienced it.

For figure below shows how a woman's FGM status can effect her intimate relationships and how that in turn may affect her body image, her identity and overall well-being.



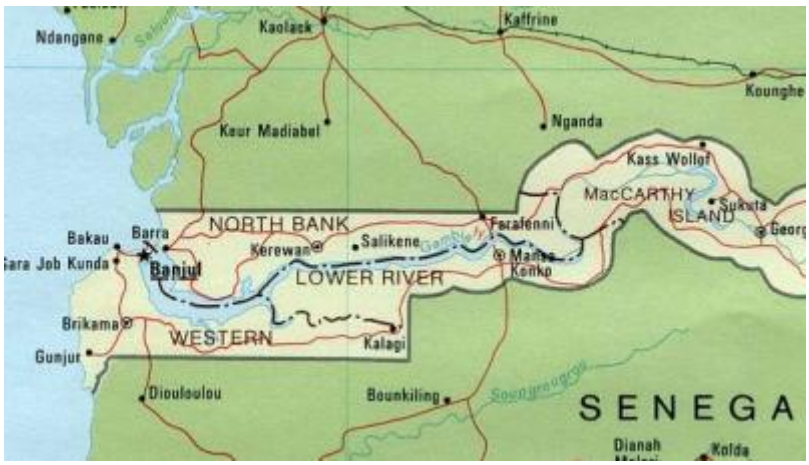
Source: WHO 2006, O'Neill et al, 2021.

Glossary Term:

Gynecological problems
Psychosexual difficulties
Obstetric complications
Infertility
Cesarean section
Postpartum hemorrhage
Episiotomy
Perinatal

Example from the Field: The Gambia

The Gambia is a moderately high FGM/C prevalence country of 75%, where three in four girls and women have undergone FGM/C. FGM/C is carried out in girls aged from seven days up to preadolescence, and usually before their first menstruation. In 2015, FGM was officially banned in The Gambia under president Adama Barrow.



A study conducted in The Gambia, in which survey and clinical data were collected from 588 female patients, found that **women with FGM/C are four times more likely to suffer complications during delivery, and their newborns are four times more likely to have health complications**.

Women with Type I and II FGM/C had a significantly higher prevalence of long-term health problems (such as dysmenorrhea and vulvar or vaginal pain), problems related to abnormal healing, and sexual dysfunction.

Women with FGM/C were also much more likely to suffer complications during delivery (perineal tear, obstructed labor, stillbirth) and complications associated with anomalous healing after FGM/C. Similarly, newborns were found to be more likely to suffer complications such as fetal distress and caput of the fetal head.

Sources: Kaplan 2013; UNICEF 2013b, Reuters 2018

Glossary Term:

Dysmenorrhea

The Medicalization of FGM/C

Although FGM/C is usually performed by traditional practitioners, **incidences of FGM/C medicalization have been increasing for some time. According to UNICEF, 1 in 4 survivors of female genital mutilation were cut by a health provider as of 2020.**

While medicalization most often refers to the shift from traditional practitioners to health care providers, it sometimes also refers to the use of medical instruments, antibiotics, and/or anesthetics.

In a 1997 joint statement, WHO, UNICEF, and UNFPA adopted the term and clearly stated that **health-care providers who perform such procedures are violating women's human rights and the fundamental medical ethic of "first, do no harm."**

Despite this, **evidence from DHS and MICS indicate a growing trend towards the medicalization of FGM/C. This trend may reflect the impact of campaigns that emphasize the health risks associated with the practice, but fail to address the underlying motivations for its perpetuation.**

In Egypt, mothers report that three out of four cases of FGM/C procedures performed on their daughters were provided by a trained medical professional. In Egypt, about 1.5 million girls and women have been cut by health care providers and 1.2 million of which were cut by doctors.

However, Egypt banned the practice in 2008 and increased the penalty for the practice as recently as 2016.

Sources: UNICEF 2005; UNICEF 2020a; UNFPA and UNICEF Joint Programme 2014, UNFPA 2018

Glossary Term:

Fistula

Perineal tear

The Response to Medicalization

In countries such as Egypt, Kenya, Guinea, Somalia, and Sudan, **the medicalization of FGM/C has constituted one of the greatest threats to abandonment**.

“Doctor-sanctioned mutilation is still mutilation. Trained health-care professionals who perform FGM violate girls’ fundamental rights, physical integrity and health,” - UNICEF Executive Director Henrietta Fore.

In collaboration with ministries of health and other relevant stakeholders, the UNFPA-UNICEF Joint Programme has employed a number of strategies to address the medicalization of FGM/C:

- Prohibiting medicalization through **decrees and development of adequate health policies**
- Training of doctors, midwives, and nurses on **integrating prevention and counseling** around the abandonment of FGM/C into services
- Integrating FGM/C **prevention activities into school curriculums**
- Conducting **evidence-based advocacy work**

From 2008 to 2013, close to 5,600 health facilities in 15 African countries integrated FGM/C into their antenatal and postnatal care routines. Over 100,000 doctors, midwives, and nurses were trained on integrating FGM/C prevention into services. This has contributed to the strengthening of capacities for FGM/C-related prevention, response, and tracking in the health sector.

Sources: UNICEF 2005; UNICEF 2020a; UNFPA-UNICEF Joint Programme 2014

Highlights

As of 2013, Kenya has integrated FGM/C prevention into prenatal, neonatal, and immunization services in 55 county and provincial hospitals.

Source: UNFPA-UNICEF Joint Programme 2014

Highlights

In Senegal, prevention activities have been integrated into elementary and junior high school curricula, in a model that seeks to empower young people.

Source: UNFPA-UNICEF Joint Programme 2014

Care for Mothers with FGM/C

Studies conducted in Africa have shown that FGM/C is associated with increased risks of cesarean section, postpartum hemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant, low birth weight, and inpatient perinatal death.

However, studies performed in high-resource settings suggest that a high standard of obstetric care (such as defibulation and follow-up of the pregnancy) can minimize these risks.

There exist significant limitations in the current literature. The aforementioned studies are limited by being of observational design and small sample size. The FGM/C types of the women included are often only self-reported, instead of being documented with a vulvar exam.

Sources: WHO 2015a; Abdulcadir 2014

Glossary Term:
Defibulation

Training of Providers in FGM/C Prevention and Management

Health care provider training is an important component of improving clinical outcomes for women with FGM/C. However, **FGM/C is not included in the curriculum of most medical, nurse, midwifery, and public health training programs.**

Studies have described a lack of provider awareness of the prevalence, diagnosis, and management of FGM/C. In Egypt, poor knowledge of FGM/C was reported among medical students. In Sudan, a country with a high prevalence of FGM/C, a study among midwives found that while 80% of the respondents practice FGM/C, only 7% were able to correctly identify the four types.

Appropriately trained medical personnel could lead to improved communication, diagnosis, and documentation, and therefore to better health care and FGM/C prevention for future generations. **It is important that training also include cultural, psychosexual, and legal information, along with medical and surgical care and obstetric management.**

Source: Abdulcadir 2014

Guidance for Providers

In 2016, WHO released guidelines for health-care professionals involved in the care of those who have been subjected to FGM/C.

Interventions: Lessons Learned

Over the last 30 years, a variety of interventions aimed at eliminating FGM/C for the next generation have been implemented, with varying degrees of success. This session will highlight a number of these interventions and some of the key lessons learned.

How Can We End FGM/C?

USAID's Collective Action to Reduce Gender-based Violence (CARE-GBV) is centered on strengthening USAID's collective prevention and response, or "collective action" in GBV development programming. This also includes guidelines, strategic plan, training and professional networking support.

The implementation plan was developed to provide a road map on how to contribute to the vision of ending FGM/C and child, early and forced marriegae and unions (CEFMU) by 2030. Below are a few components of the implementation plan to consider:

Integrate FGM/C prevention and response across sectors: Evidence indicates that context-specific programs and combinations of programs such as girls' and women's empowerment; access to quality education; provision of comprehensive sexuality education and gender-sensitive and FGM/C-specific sexual, reproductive, and maternal health services; laws and policies; access to justice; immigration and asylum; and communication and media are effective to prevent FGM/C and respond to the needs of girls and women who have experienced FGM/C.

Invest in Gender-transformative programming across the continuum of FGM/C prevention and response: In addition to integrating FGM/C within and across sectors and programs, new programs that are specifically designed to prevent FGM/C and respond to the needs of survivors are needed to accelerate progress. Also,

discussions about FGM/C at all levels of society, should engage men and boys. It is also important to support gender-transformative health services in preventing and responding to FGM/C.

Expand collaboration and partnerships with funders and other stakeholders to be more inclusive and survivor-centered: Collaborate and strengthen relationships with international programs, and the private sector and civil society, including survivor-, girl-, youth-, and women-led organizations, networks, and coalitions at the local and regional levels.

Support Governments to adopt policies to eliminate FGM/C and meet the needs of survivors: Commit to supporting policies and strategies at the local, country, regional, and global levels in ways that create enabling and empowering environments to end FGM/C and advance the rights of all girls and women, including survivors.

Document progress and challenges, integrate lessons learned and promote best practices: Thoughtfully designed and well-implemented monitoring and evaluation to track progress toward the goals of this implementation plan will help in holding the individuals and institutions accountable to its commitments and will contribute to expanded global learning about FGM/C. In addition, generate, utilize and disseminate locally driven, context-specific data and evidence. FGM/C occurs in more than 90 countries, although national data are collected in only 31 countries. The collection of more reliable and accurate disaggregated data is urgently needed.

Advancing gender-equal social norms: Social norms are diverse and complex and do not lend themselves to simple interventions. Support for youth-led engagement and grassroots survivor activists to contribute to community dialogue, including with traditional and community leaders and faith-based actors, and use of media and communication campaigns to stop the silence around FGM/C, can help shift social norms so that FGM/C is no longer considered necessary or desirable, and therefore, no longer carried out.

Supporting enabling legal and policy environments for rights-based approaches to end FGM/C: A rights-based legal framework that clearly defines FGM/C, prohibits its practice, and provides criminal sanctions against it is an effective way to fulfill a state's obligations to end the practice. Such a framework would also send a strong message that FGM/C is an unacceptable, harmful practice and would contribute to a positive environment for ending the discriminatory gender and social norms that underpin the practice.

Advancing girls' and women's rights, decision-making, and leadership skills, especially for the most marginalized: Advancing the rights, decision-making, and leadership skills and capacity of women and girls, especially the most marginalized, can be the first step in creating a more equitable distribution of power and control between parents and girls and between men and women. In addition to providing empowerment opportunities for individual girls and women and building their decision-making and leadership skills, programs can create a more enabling environment for gender equality by engaging family and community leaders in programming; in other words, programs must work across multiple levels of the socioecological framework.

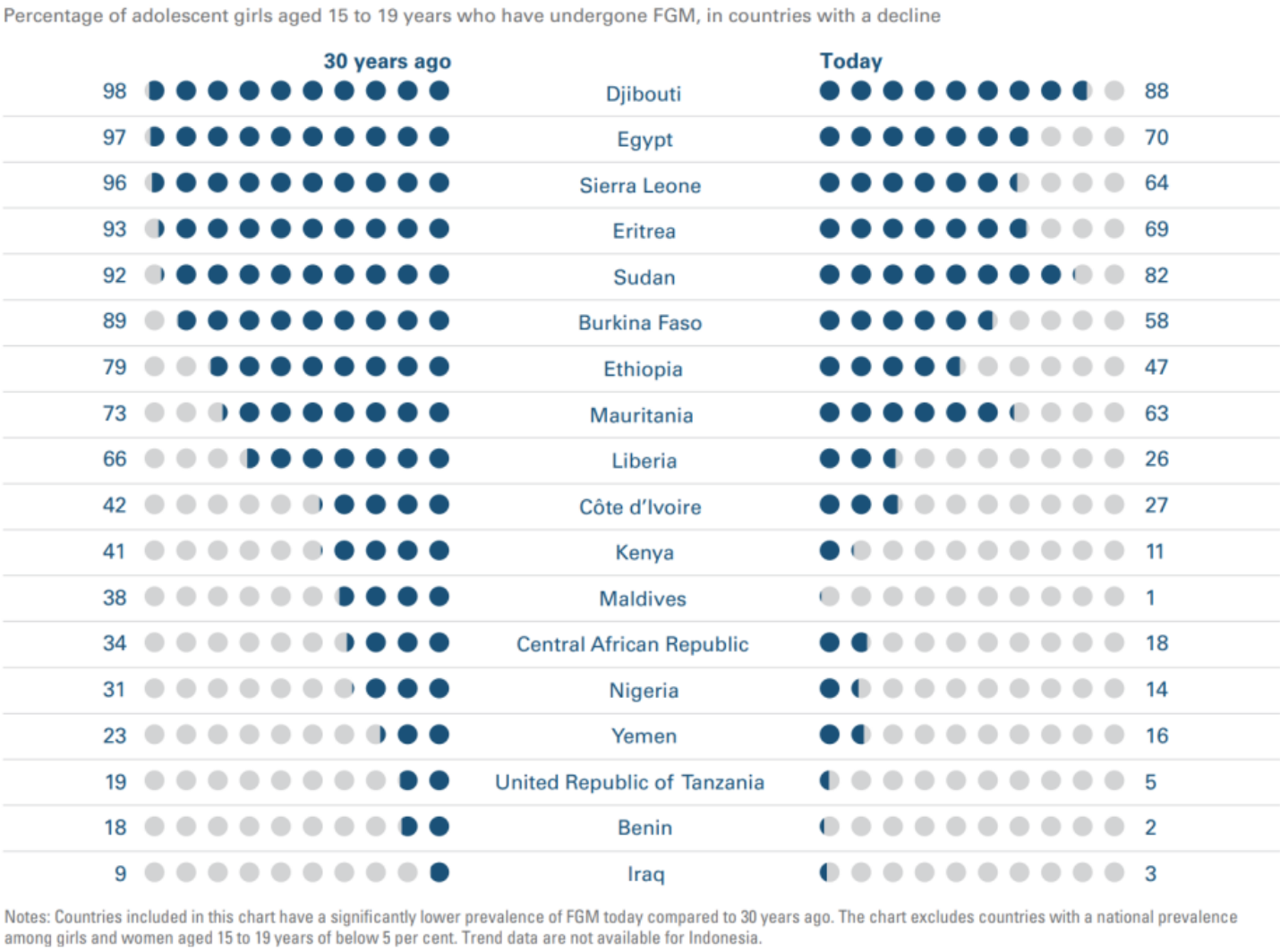
Specific interventions will be discussed in greater detail throughout the remainder of this session.

Source: UNICEF 2013a

International Commitments to Eliminate FGM/C

Over the past 50 years, most governments in countries where FGM/C is practiced have ratified international conventions and declarations that make provisions for the promotion and protection of the health of women and girls.

FIGURE 1: Female genital mutilation (FGM) is becoming less common in countries where it was once universal, and in countries where it only occurred in a few communities



Local Laws to Eliminate FGM/C

To be as effective as possible, national and local laws need to be supported by community educational outreach campaigns and activities, so that people are aware of the law and informed of their rights. In addition, the laws must be enforced. Otherwise, FGM/C practitioners and community members will not adhere to them.

To date, Columbia, Philippines, Liberia, Malawi and Somalia still do not have any laws or decrees that criminalize the practice of FGM/C.

Sources: Center for Reproductive Rights 2008; UNFPA 2015a; UNICEF 2013a, Wikipedia 2022

Examples from the Field: Kenya, Nigeria, and Sudan

Kenya

In Kenya, a 2011 law passed stating that anyone subjecting a girl to FGM/C will be sentenced to jail for seven years or fined 500,000 shillings, and anyone who causes death in the process could be liable to life imprisonment. In addition, anyone convicted of assisting in the performance of FGM/C could face a prison sentence of three to seven years and a fine of 100,000 to 500,000 shillings. The bill replaced the Children's Act of 2001, which outlawed the practice of FGM/C on girls.

Nigeria

In May 2015, the outgoing president signed groundbreaking legislation outlawing the practice of FGM/C. In Nigeria alone, an estimated 20 million women have undergone the practice. As Nigeria is the most populous country in Africa, this legislation sends "a powerful signal not only within Nigeria but across Africa."

Caption: Copyright: Muhammad Daffa Rambe. Image Source. License CC BY-SA 3.0

Sudan

In 2020, the Sudan government outlawed the practice of FGM/C and put in place a new law that criminalizes FGM/C. In Sudan, anyone who performs FGM/C faces up to possibly three years in prison and a fine.

Sources: PRB 2013; Holloway 2015; New York Times 2020

Overview of Promising Practices

A number of promising interventions have been implemented to address the elimination of FGM/C. These interventions are based on various theories regarding the social drivers of FGM/C. Some interventions work well in some countries and among some ethnic groups—but not others.

The most successful interventions have been participatory. These interventions generally guide communities to define the problems and solutions themselves.

An example is USAID's Collective Action to Reduce Gender-Based Violence (CARE-GBV) is centered on strengthening USAID's collective prevention and response, or "collective action" in GBV development programming across USAID. CARE-GBV is working to accomplish five key objectives:

- Develop and disseminate foundational elements for integrated and standalone GBV programming in development contexts.
- Strengthen prevention and response programming on harmful GBV practices, including female genital mutilation/cutting (FGM/C) and child, early, and forced marriage (CEFM), across different sectors through convening workshops, implementation plans, and learning agenda development.
- Create knowledge products to strengthen GBV programming.
- Strengthen the USAID GBV community of practice and donor coordination in GBV programming.
- Award small grants to new, local, and under-utilized partners to promote capacity building and learning focused on GBV staff and organizational wellness and resiliency.

The remainder of this session will highlight promising interventions (noting ones that would be more successful if implemented as part of a multi-faceted approach). These interventions include the following:

- Targeting practitioners
- Partnership with religious and traditional leaders
- Communication and mass media
- Intergenerational dialogues
- Safe houses
- Alternative rites of passage
- Integrated approaches

Targeting Practitioners

Targeting practitioners is based on the assumption that if FGM/C practitioners are persuaded to stop providing the service, it will put an end to the practice.

This approach has been applied in different ways over the years—providing direct cash substitutes as income to practitioners, training them for alternative jobs, and providing loans for starting businesses.

Although this approach has been effective in persuading some practitioners to stop providing FGM/C services, it has not addressed the continued demand for FGM/C. Continued demand has led to the emergence of new providers, and has also caused some converted providers to revert to their original trade.

A major failure of this approach is its sole focus on the supply side of the practice. **To eliminate the practice, the demand for services needs to be addressed.**

The international community continues to call on all health workers to mobilize against FGM/C as part of its broader joint statement issued by UNFPA, UNICEF, the International Confederation of Midwives, and the International Federation of Gynecology and Obstetrics on International Day of Zero Tolerance for Female Genital Mutilation (February 6, 2015).

Source: Rogo, Subayi, and Toubia 2007; UNFPA 2015b

Partnering with Religious and Traditional Leaders

In communities where FGM/C is prevalent, religious obligation is often used to justify the practice, particularly in Islam. Therefore, **the involvement of traditional and religious figures is critical in addressing this perception and in creating an enabling environment for change.**

From 2008 to 2013, approximately 21,000 religious and traditional leaders from 15 African countries (in the UNFPA-UNICEF Joint Programme) made public declarations stating that FGM/C is not a religious requirement. Additionally, about 2,900 proclamations were issued in support of the abandonment of the practice.

Starting in 2005, the Population Council developed a religious-oriented approach to engage Somali communities in the Wajir region of Kenya, where FGM/C is practiced by 97% of the Somali population. The approach aimed to generate discussion regarding the position of Islam on FGM/C and to build consensus among religious scholars to abandon the practice. **Partnering with religious and traditional leaders must still be coupled with whole community engagement, mainstreaming FGM/C in other development programs, and targeting youth education.**

Sources: UNFPA and UNICEF Joint Programme 2014; Abdi 2008

Glossary Term:
Infibulation
Imam

Communication and Mass Media

In 2011 alone, millions of people across 15 African countries were reached by radio and TV programs denouncing FGM/C. These included more than 2.8 million in Somalia, 2.5 million in Guinea, 350,000 in Burkina Faso, 300,000 in Djibouti, and 271,000 in Mali. In fact, more than 26,147 newspaper articles and TV and radio programs discussed the benefits of ending the practice. Facebook, Twitter, and other social media platforms have provided rich opportunities for public dialogue surrounding FGM/C, especially among young people and adolescents.

Raising community awareness of the harmful effects of FGM/C is critical to addressing the demand for it. With the potential to reach a global audience, the media can play an important role in efforts to end FGM/C. Awareness can be raised through traditional media such as newsprint, television programming, or radio, or through more recent innovations such as social media platforms.

Source: UNFPA-UNICEF Joint Programme 2014

Example from the Field: Burkina Faso

This example from the field illustrates the importance of a multi-faceted approach that combines a number of approaches, such as political commitment, targeting multiple stakeholders (including religious leaders and medical practitioners), and reaching the community through mass media campaigns.

In the 1990s, **the government of Burkina Faso established the National Committee for the Campaign against Excision (CNLPE) to lead the anti-FGM/C effort.** Besides actively coordinating with law enforcement, political and religious leaders, medical personnel, and community youth and women's associations, they also developed mass media campaigns and committed resources to establish support services for families that wished to abstain from FGM/C.

Following the 20-year government campaign, a 2010 DHS analysis for Burkina Faso found that 90% of women think the practice should stop. Nonetheless, the national prevalence still remains high at 76%.

Source: UNFPA-UNICEF Joint Programme 2014

Intergenerational Dialogues

Because FGM/C is often embedded in traditions passed from generation to generation, **fostering discussions between older and younger generations is crucial to changing these harmful practices**. Older community members, men, and boys should all be engaged, as they are often the carriers of tradition and key influencers in the family.

Promoted by GIZ (Deutsche Gesellschaft fur Internationale Zusammenarbeit), **Intergenerational Dialogue is a participatory approach that engages members of the community across genders and generations.** It consists of six stages that allow communities to share viewpoints at public meetings, engage in the process of identifying legal and health improvements, and demonstrate their commitment to implementing them:

1. **Community consultations**
2. **Intergenerational dialogue workshops**
3. **Public meeting – Presenting pledges and requests**
4. **Follow-up period**
5. **Public meeting – Assessing changes**
6. **Community consultation and results assessment**

Results from a 2009 evaluation in Mali showed improvements in knowledge, attitude, and behavior among the participating groups. Of the participants surveyed, 74% said they had taken steps to end FGM/C in the community and 94% said they would not subject their daughters to FGM/C.

Source: PRB 2013; GIZ 2011

Example from the Field: The Grandmother Project in Senegal

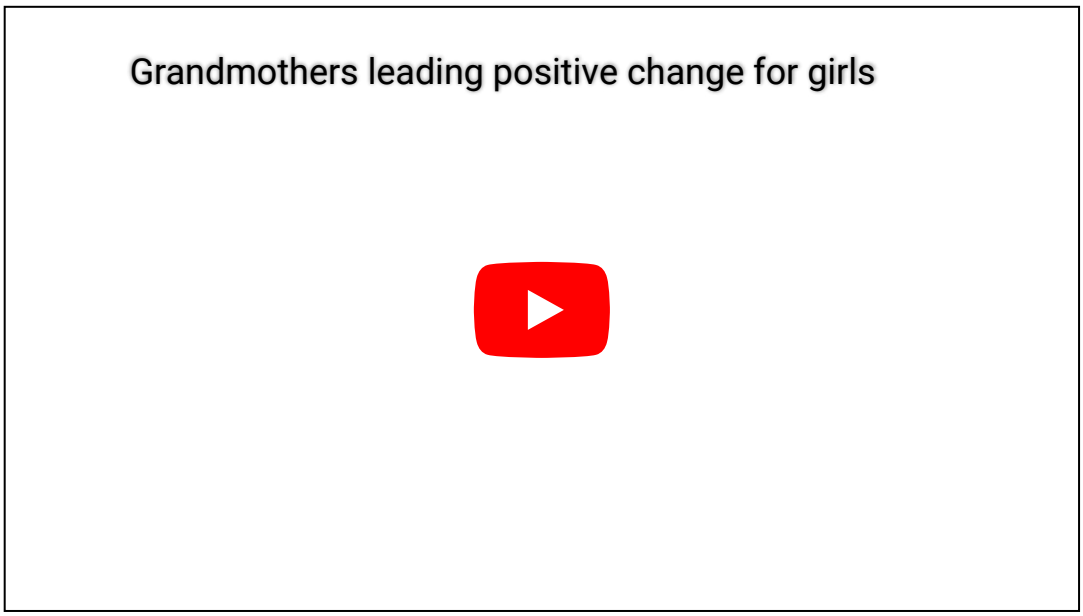
In collaboration with World Vision, the **Grandmother Project (GMP) established a three-year initiative in southern Senegal** aimed at strengthening positive cultural values and practices and promoting the adoption of positive community attitudes, including the abandonment of FGM/C.

The Project involved intergenerational dialogue that depended on the active participation of elders, especially grandmothers. Because grandmothers are often viewed as respected members of the community, they become an invaluable resource and potential agents of change.

Results of the project (collected through a rapid assessment, surveys, and qualitative reviews) found that the program led to strengthened social cohesion and changes in social norms and practices related to girls' well-being. For example, in the baseline survey conducted in 2008, nearly half of mothers (45%) and grandmothers (47%) said they would be ashamed to have a daughter or granddaughter who is not cut. Two years later, in the endline survey, only 3% of mothers and grandmothers expressed the same sentiment. Similarly, while the 2008 baseline revealed that the majority of mothers (88%) and grandmothers (86%) believed FGM/C to be a cultural obligation, the endline survey showed that only 9% of mothers and 5% of grandmothers still held the same belief, signaling a major attitude shift.

The "grandmother approach" has also been implemented in the Amudat region of Uganda, where 50 grandmothers were trained to develop and deliver messages on abandoning FGM/C. In 2013, the grandmothers held 10 dialogues encouraging the abandonment of FGM/C, reaching 114 girls.

Sources: The Grandmother Project 2012; UNFPA-UNICEF Joint Programme 2014



Voices from the Field

> "Our ancestors taught us that girls should be cut so that they will be more faithful to their husbands, but we no longer believe that. We now know that nowhere in Islam is FGM recommended. There are at least 30 little girls in the community who were born in the last two years who have not been cut."

—Dinde, elderly grandmother from Saré Faremba

Voices from the Field

> "Everything we know today about sexuality, teenage pregnancy, and life in general, we owe to our grandmothers. We now know the value of a grandmother. We share with them our most unbelievable problems and they always have a solution for us."

—Marlama, young girl from Saré Boulel

Safe Houses

Safe houses are another approach to FGM/C abandonment for girls and women who want to escape being cut.

While this strategy can temporarily remove the girl or woman from the situation, **it can also be problematic when it fails to address the social norms and pressures driving the practice**. Therefore, long-term implications of removing women and girls from their families and communities must be examined.

In Kenya, in particular, girls who face FGM/C ceremonies are given a safe place to live and go to school. The Tasaru Ntomonok Initiative (TNI), established by Kenyan Agnes Pareyio and supported by Equality Now, includes a residential community-based rescue center that offers holistic services for girls escaping FGM/C and early marriage.

In addition to providing a safe house, TNI also engages community members, religious leaders, and law enforcement in discussions and trainings about FGM/C. An important aspect of the program is that TNI facilitates reunions between girls who have been saved from cutting and early marriage and their families.

Source: PRB 2013

Alternative Rites of Passage

This approach focuses on young teenage girls who go through FGM/C as a rite of passage into womanhood. Although it targets girls at risk, the success of this approach depends on the engagement of parents, village leaders, and the community at large for additional support.

In cases where FGM/C is performed as a rite of passage*, alternative ceremonies that are not harmful need to be put in place to replace FGM/C.

FGM/C is **not always performed as a rite of passage.*

Example from the Field: Alternative Rites of Passage in Kenya

In Kenya, the alternative rite of passage approach was pioneered by a local organization, Maendeleo Ya Wanawake (MYWO), with technical assistance from the Program for Appropriate Technology in Health (PATH) in several districts.

The MYWO model involves targeting girls, parents, and other community members with information, education, and communication (IEC) activities. The rite of passage ceremony with its various teachings remains intact. The FGM/C piece is simply eliminated from the ceremony.

In 2012, about 400 adolescent girls from three communities in Kenya went through an alternative rite of passage. The community provided food and resources for the girls during the weeklong program where they learned life skills, the importance of education, and the negative consequences of FGM/C and child marriage. In a final celebration with their families, the girls were blessed and awarded certificates of recognition for committing to stay uncut.

The Population Council performed a detailed evaluation of this program in 2001. It found that **this approach can motivate participating families to abandon FGM/C and generate solidarity and support among non-FGM/C-practicing families in some regions.**

Sources: Rogo, Subayi, and Toubia 2007; Chege, Askew, and Liku 2001; PATH 2005; UNFPA 2014

Integrated Approach: Tostan

Tostan's Community Empowerment Program (CEP) is a 30-month participatory, non-formal education program with a human rights foundation.

It embodies the key elements necessary to change a social convention at the community level, including collective action and public declaration of abandonment of FGM/C.

Established in 1991, Tostan started its program in Senegal and has since expanded to six other African countries. Tostan's mission is "to empower African communities to bring about positive sustainable development through a comprehensive non-formal education program in local languages."

A 2008 evaluation examined villages that participated in the CEP during the late 1990s and had made public pledges to abandon FGM/C. The study found that nearly 10 years later, the prevalence of FGM/C had fallen by more than half in participating villages: 30% of girls had been cut compared to 69% in comparison villages.

Tostan's CEP approach has been gaining momentum since it was first implemented in 1997, when only two villages participated in the first public declaration of FGM/C and child marriage abandonment. **By 2011, 5,315 communities in Djibouti, The Gambia, Guinea, Guinea-Bissau, Mali, Mauritania, and Somalia had participated in 56 public declarations.**

Sources: Rogo, Subayi, and Toubia 2007; Feldman-Jacobs and Ryniak 2006; Diop et al. 2004; UNICEF 2013c

Bringing about Change

This session highlights the key lessons learned from implementing interventions to eliminate FGM/C over the last 30 years, key elements for success, promising results, and the direction for future research.

Ten Lessons Learned

Clarify Goals and Tailor Approaches

1. Define goal and indicators.
2. Decide if the goal is to abandon the practice or make is safer.
3. Interventions and goals should match a community's readiness for social change.

Use a Multi-faceted Approach

1. The most effective approaches for the abandonment of FGM/C are multi-faceted, intervening at many strategic points and promoting a different norm publicly.
2. Focus on reducing social support for the practice rather than abandonment by practitioners.
3. Implementing laws against FGM/C is an effective component of change.
4. Approaches that use alternative rites can only work where FGM/C is an integral component of a social rite of passage and must be preceded or accompanied by community sensitization

Engage Key Partners

1. Use the media.
2. Medical providers can be effective change agents within their community.
3. In areas where the practtice of FGM/C is entrenched though a belief that it is a religious requiremenr , a community-based intervention working with religious leaders and scholars on the religious aspects of FGM/C paramount.

Source: Population Council 2007

Highlights

In 2007, the Donors Working Group on FGM/C published Toward a Common Framework for the Abandonment of FGM/C, which highlights a number of lessons learned.

Importance of Community Engagement

Within the spectrum of initiatives to end FGM/C,the most successful approaches engage and empower communities to lead in the abandonment of the practice. This engagement is evidenced through public acknowledgments and declarations that aim at leveraging action for the collective abandonment of FGM/C.

To be successful in adapting community-based approaches that have demonstrated positive outcomes, it is important to consider communities' shared characteristics (geographical proximity, ethnic groups, similar associations with the practice, etc.). It is also important to seek the opinions of local leaders, who can serve as change agents, regarding the applicability of the initiative within their unique social and cultural environments.

Source: UNICEF Innocenti Research Centre 2007

Six Elements for Success

1. A non-coercive and non-judgemental approach whose primary focus is the fulfillment of human rights and the empowerment of girls and women.
2. An awareness on the part of a community of the harm caused by the practice.
3. The decision to abandon the practice as a collective choice of a group that intramarries or is closely connected in other ways.
4. An explicit, public affirmation on the part of communities of their collective commitment to abandon FGM/C.
5. A process of organized diffusion to ensure that the decision to abandon FGM/C spreads rapidly from one community to another and is sustained.
6. An environment that enables and supports change

Source: UNICEF Innocenti Research Centre 2005

Engaging Survivors

Engaging survivors in the effort to end FGM/C is critical. Survivors played an integral role in the development of the 2020 report "Female Genital Mutilation/Cutting: A Call For A Global Response." The report is a call from survivors of FGM/C across cultures, communities, and countries to governments, the international community, and donors to recognize FGM/C as a global issue, requiring urgent global attention. Each of these women was cut. Now they are breaking the cycle of tradition.

Example: In Asia, Voices to End FGM/C is mobilizing a critical mass of storytellers and activists from across the globe by bringing people together to share and heal from their experiences of female genital mutilation/cutting (FGM/C), connect and grow as leaders in their own communities, and create short videos calling for an end to this harmful practice.

Quote: " How can you ask a survivor to speak out against FGM and then face all the consequences – criticism and online defamation, her family and her tribe may disown her, maybe her husband will divorce her – without proper support. I don't expect these women to speak out and face society. We have to give them the help and support they need"

A survivor-centered approach is the hallmark of quality gender-based violence (GBV) programming. This approach focuses on the empowerment of survivors by creating a supportive environment for healing. It is reflected through organizational policies and structures, as well as staff knowledge, skills, attitudes, and practices.

The infographic below displays the key aspects of a survivor-centered approach including four guiding principles and six strategies to reach survivor agency, dignity, and empowerment.

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Guiding Principles

- **Safety**: Promote the safety of survivors, including preventing and mitigating further violence
- **Confidentiality**: Protect the confidentiality of survivors, including their right for information about them to be shared only with their informed consent and their right to choose whether and to whom to tell their experiences.
- **Respect**: Demonstrate respect for survivors' rights, needs, and wishes, including those that service providers may disagree with.
- **Nondiscrimination**: Practice nondiscrimination, ensuring that survivors, in all their diversity, are able to access and receive appropriate services and meaningful support.

Strategies

- Engage locally-led women's rights organizations and other groups working on GBV and human rights.
- Assume program participants and organizational staff include survivors of GBV, whether or not they have self-identified as survivors.
- Develop and implement standard operating procedures, safeguarding policies, and ways of working.
- Map GBV programming and survivor resources and develop referral networks.
- Train and work with all staff to build their knowledge and ability to promote survivor-centered attitudes and practices.
- Strengthen multisectoral approaches to GBV.

Source: Equality Now, 2020, End FGM European Network 2020, SAHIYO 2018

Promising Results: Decreases in FGM/C Prevalence

Although ending FGM/C remains a global challenge, promising progress has been made in many countries.

In Egypt, DHS survey data revealed a decrease in FGM/C prevalence in women ages 15 to 49, from 96% in 2005 to 87% in 2020. In addition, only 45% of mothers of 0- to 3-year-olds intended to cut their daughters, suggesting a significant decline in the number of girls who will be cut over the next 15 years.

Women's attitudes toward the practice have also changed drastically, as support for FGM/C fell from 82% in 1995 to 54% in 2020.

The situation in Egypt is not unique. FGM/C prevalence is also declining in other countries, such as Kenya and Sierra Leone.

In Kenya, the overall prevalence of FGM/C has been steadily declining—from 38% of women in 1998 to 21% in 2020. The 2008-9 DHS survey also revealed that 80% of women surveyed do not see any benefits of FGM/C, while 82% believe it should be stopped.

Source: PRB 2014; UNICEF 2016; UNICEF 2020b;

Promising Results: Changes in Views and Attitudes

In areas where FGM/C practices are intimately ingrained in cultural values, **real change will only come when individuals begin to collectively view FGM/C practices as harmful and decide to combat them.**

Launched in 2003, the FGM-Free Village Model is Egypt's national program to eradicate FGM/C. By mobilizing the media, policy makers, and religious and medical communities, the model aims to create an environment conducive to dialogue on the factors that lead to FGM/C, with a focus on the practice's harmful effects and its violation of human rights.

A 2011 midterm evaluation found that the program helped change views and attitudes toward FGM/C. Compared to control groups, women in intervention groups were six times less likely to cut their daughters. In addition, 27% of women in the intervention group believed that FGM/C should continue compared to 77% of women in the control groups.

The evaluation recommends that future efforts adopt multi-sectoral approaches in order to sustain advocacy and maintain impact for future generations.

Source: PRB 2014

Future Research Directions

Although much progress has been made in raising the awareness of the harmful effects of FGM/C, more work is needed to eliminate the practice entirely.

In order to ensure that we are implementing proven approaches, more research needs to be done, particularly in the following areas:

- **Health consequences of FGM/C**, specifically around whether or not FGM/C leads to an increased risk of fistula, HIV/AIDS, and/or infertility
- **Approaches that address the medicalization of FGM/C** and the effectiveness of these approaches
- **FGM/C prevention and management** training for health care providers
- **Treatment of persons with FGM/C**, such as care procedures for mothers with FGM/C
- **Girls' experiences of the practice**, including psychological consequences
- **Dynamics of social and cultural change** that lead to the abandonment of the practice
- **Impact of legal measures** to prevent the practice

Sources: WHO 2015a; Abdulcadir 2014