Female Genital Mutilation

Preventive work in Africa's Horn

Socialstyrelsen

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Förord

In 2003 the National Board of Health and Welfare was tasked by the government, amongst other things, to follow international efforts to counter FGM. The Government stressed the importance of disseminate such information to different organisations and target groups in Sweden.

In order to expedite this directive, a field visit to Ethiopia, Kenya and Eritrea was conducted in 2004. The purpose of the trip was to collect good examples and experiences of work taking place to prevent and end FGM from countries where migrant communities living in Sweden originate. The Board met with 28 international, national and local organisations.

This report contains trends and activities that were observed.

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Acronyms

ADRA	The Adventist Development Relief Agency
AIDOS	The Italian Association for Women in Development
AMWIK	The Association of Media Women in Kenya
CEDAW	The Committee on the Elimination of All Forms of Discrimination Against Women
CRC	The Convention on the Rights of the Child
DHS	Demographic and Health Surveys
FEMNET	The African Women's Development and Communication Network
FGM	Female Genital Mutilation
GTZ	Deutsche Gesellschaft für Technische Zuzammenarbeit
HIV	Human Immunodeficiency Virus
HTP	Harmful Traditional Practices
IAC	The Inter-African Committee
IEC	Information, Education, and Communication
MOE	The Ministry of Education
MOH	The Ministry of Health
NCA	Norwegian Church Aid
NPA	Norwegian People's Aid
NCTPE	The National Committee on Traditional Practices in Ethiopia
NGO	Non-Governmental Organisation
NUEYS	The National Union of Eritrean Youth and Students

NUEW	The National Union of Eritrean Women
TBA	Traditional Birth Attendant
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	The United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	The World Health Organization

Summary

Following the recommendation of the Swedish national plan of action to prevent female genital mutilation (FGM) and in line with its implementation, a field visit to Ethiopia, Kenya, and Eritrea was organised and conducted in November 2004 by the National Board of Health and Welfare.

The purpose of the trip was two-fold:

- to collect good examples and experiences of work taking place to prevent and end female genital mutilation;
- to gather relevant information on efforts to end the practice from countries where migrant communities living in Sweden originate for dissemination in Sweden.

Choice of region

Ethiopia, Somalia, and Eritrea were selected, as these countries represent the largest migrant communities living in Sweden that are considered likely to continue the practice. However, due to political instability, it was not possible to visit Somalia, Puntland, or Somaliland. A visit was made to Kenya instead, to meet with Somalian and international organisations, based in Nairobi, working for the eradication of FGM.

Overall picture and trends to end the practice

Ethiopia

The overall trend to eradicate FGM in Ethiopia is characterised by sustained education against the practice with consistent reinforcement by powerful women's associations; the integration of FGM into policies concerning other areas, such as development and HIV/AIDS; and changes in legislation. This has resulted in measurable results from many groups working together to end FGM. Activists reported that work was still needed to address fear and prevailing myths about FGM. However, there was confidence that if the practice continues to decrease at the present pace, one can foresee the prevalence rate of FGM dropping from 72 percent at present to between 25–30 percent within the next 10–15 years.

In 2004, the parliament passed a new law making FGM a criminal act in Ethiopia. The jail sentence for circumcising a girl has been increased from three months to ten years. The provisions of the law are that the circumciser, the consenting adult, and anybody else who supports the practice are liable to prosecution.

Parliamentarians are now obliged to monitor the new revised Penal Code and follow up its implementation in their constituencies.

Kenya

The most recent trend show a drop in the FGM prevalence rate, although concern was expressed that this might be due to the practice going underground and becoming less noticeable. Nevertheless, there are positive changes. People are now talking more openly about FGM, and they are adapting positive alternative practices. For example, there is a large Christian evangelical community in Kenya and when Kenyans are "*born again*" they abandon FGM. There is also more networking and some integrated approaches to the problem. A few concerns were voiced that the practice is also being medicalised.

Although there is evidence of political commitment to end FGM, it would seem that this commitment has not translated into political will or action.

Somalia

It was very difficult to discern a difference in the prevalence rate of FGM in Somalia. Most people were of the opinion that there has been no discernible drop in the rate of the practice. Efforts to stop the practice seemed to have changed the nature of the practice, from Type III cutting to Type I. However, medical and health professionals who work with Somali women reported that the physical appearance between Type III and Type I cutting was very subjective. Women were equally damaged and scarred in both types of cutting. Concerns were also expressed that current interventions are not systematic, and it is therefore difficult to foresee a downward trend in the practice of FGM in the near future.

Eritrea

The main focus of work to stop FGM in Eritrea has been to raise awareness, especially at the community level, and to provide training for a range of target groups, notably, women and girls in the community, religious leaders, police, and local justice systems. These activities have made it easier to talk about FGM, and more people are aware of its complications. There were few reports that the practice is moving from Type III to Type I. Much work still remains to be done towards total eradication, as some activists felt that messages through raising awareness and advocacy campaigns have yet to be internalised. The hope was that FGM could stop in Eritrea in about 10 years' time.

The government has decided to use the Convention on the Rights of the Child (CRC) and the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW) as the basis for protecting women, girls, and children, rather than a specific law against the practice of FGM. The government invites people to change their behaviour through awareness-raising and sensitisation campaigns.

Gender relations

Ethiopia

The general response was that it is easier to talk about sex, sexuality and FGM with mixed groups of youth in urban areas than mixed groups of youth in rural areas. For best results, it was recommended that older people be separated from younger people when discussions are held, as there are difficulties talking on the subject across generations.

Kenya

Whilst it is possible to speak on sexuality and FGM with mixed educated groups, better responses seem to be achieved when men are separated from women. Parents do not speak with their children about sex or sexuality, and there seems to be a need to integrate the subject with other topics, for example gender and early marriage.

Somalia

It was reported that Somalis living in Kenya do find it hard to speak about sexuality and FGM, whilst from another experience of Somalis in Somalia, sexuality and FGM did not appear to be a sensitive topic. Most respondents agreed that it is best to have same-sex groups, not mixed groups, for fruitful discussions. It was also noted that men, even in same-sex groups, do find it harder to talk about sexuality, especially about women's body parts. In the case of educated Somalis living in Kenya, it might be possible to speak in mixed groups about sexuality and FGM.

Eritrea

It was considered not only best to separate the sexes, but also to separate age groups in Eritrea when discussing sexuality and FGM.

Are uncircumcised girls ostracised within their communities?

In Ethiopia, it was reported that uncircumcised girls do face ostracism in tight-knit communities, particularly in rural areas.

In Kenya, the girls themselves ask to be circumcised due to feelings of inferiority and pressure from society. One respondent suggested that there should be a new focus on the education of boys, as girls feel they must be circumcised in order to be considered suitable for marriage.

Whilst girls in Somalia do face pressure and request circumcision, recent studies seem to suggest that boys are saying that they do not want girls to be cut.

In Eritrea, it was reported that girls would be considered unacceptable marriage partners if they were not circumcised.

Information about the Diaspora

Message to those who wish to continue the practice

Ethiopian women emphasised that FGM is no longer part of an Ethiopian woman's identity and that real efforts are now being made to eradicate the practice totally. *Kenyans* agreed that FGM is not only a negative traditional practice, but is also meaningless. It is child abuse and a violation. *Somalis* in the Diaspora were invited to find ways to build trust with their girls, noting that FGM has no links with religion and there is therefore no excuse for the practice. FGM is against the rights of *Eritrean* women, and is an unacceptable and harmful traditional practice.

Do people in the homelands know about laws against FGM in European countries and the Diaspora?

The general feeling in all countries visited was that people working to eradicate FGM might be aware of laws in Europe and other countries in the Diaspora to end the practice, but this is not information that people would generally know. It was reported that Somalis living in Somalia and Somaliland might be aware, as girls are sent back home for circumcision. One organisation working in Eritrea reported that they always mention the existence of laws against FGM in other countries.

Movement of girls from the Diaspora back to their homelands for circumcision

One respondent pointed out that not only are girls from the Diaspora returning to *Kenya* to be cut, but also that girls from the cities are taken to the countryside to be cut. There was total agreement by all respondents who work in and have knowledge of *Somalia* that this practice does take place. In *Eritrea*, only one respondent reported that girls are taken back home for circumcision. Others reported that either it did not happen or that they were not aware of this practice.

Role of the Diaspora in ending FGM

People living in the Diaspora are often unaware of activities taking place in the homelands to stop the practice, and of the results of those activities. A number of suggestions were made on how those living outside their homelands could take part in activities to end the practice in their homelands. Kenyans cited the need for refuge centres for girls fleeing circumcision, and partnerships with anti-FGM groups in the Diaspora, in order to nurture a constant flow of information through regular contacts and visits in both directions. However, concerns were expressed that people in the homelands might take offence and not be prepared to listen to those in the Diaspora as they might be viewed as '*outsiders*'.

Activities by organisations

Schools

In *Ethiopia*, information about harmful traditional practices, including FGM, has been included in the curricula of schools and higher-training institutions since 2002.

Anti-FGM groups in schools and universities in *Eritrea* provide training in junior and high schools. These clubs are run by students and teachers, and form part of the schools' extra-curricula activities.

Religious leaders

Work with religious leaders has been and remains a very sensitive area in regards to FGM. At best, the results, where documented, are patchy.

In Somalia, and elsewhere, it has been difficult to get a clear statement from religious leaders. There are different interpretations of the haddiths. Imams, who may agree privately that FGM is not a requirement of Islam, fail (seem unable) to speak out against the practice, and some Imams preach that whilst Type III is not acceptable, Type I is. On one occasion in Eritrea, a workshop with the Orthodox Church produced a decision that the priests would take an anti-FGM message to their followers. A number of respondents thought that religious leaders (particularly Muslim religious leaders) were concerned that if they stated publicly that FGM were not a religious obligation, their followers would challenge them. Why had they not made this declaration before and saved the women who had been cut from such suffering?

Introduction

Background

The National Board of Health and Welfare was tasked by the government of Sweden to implement a National plan of action for the prevention of female genital mutilation (FGM) in Sweden (November 2003).

The National Board of Health and Welfare was requested to follow international efforts to counter FGM, ensuring that information on such work is promulgated and disseminated in Sweden to the different activities, organisations, and target groups, in particular, decision-makers at municipal and county levels; relevant population groups; non-governmental organisations and associations; and the professional groups concerned.

In particular, the board was to follow efforts to stop FGM in countries where migrant communities (in Sweden) come from, and to ensure that migrant communities living in Sweden are informed of developments and the results of activities to prevent and end FGM in their homelands.

In order to expedite this directive, a field visit to Ethiopia, Kenya, and Eritrea was organised and conducted in 10–23 November 2004 by the National Board of Health and Welfare. The purpose of the trip was to collect good examples and experiences of work taking place to prevent and end FGM for a databank; and to gather relevant information on efforts to end the practice from countries where migrant communities living in Sweden originate.

The information collated would also contribute to the knowledge bank to be created, primarily for use by key statutory groups specifically identified in the National Action Plan.

Choice of region

Ethiopia, Somalia, and Eritrea were chosen, as these countries represent the largest migrant communities living in Sweden that are likely to continue the practice. However, due to political instability, it was not possible to visit Somalia, Puntland, or Somaliland. A visit was made to Kenya instead, to meet with Somali and international organisations based in Nairobi working to eradicate FGM among Kenyans, and especially among Somali immigrants.

Models of good practice – collation exercise

The development of a knowledge bank of good examples and experience from preventive work is one of the activities of the Action Plan. The collation of models of good practice in FGM was a desk exercise, and a trip to the region of Africa indicated above provided an opportunity to expedite the compilation of the models of good practice by conducting a rapid appraisal of a range of FGM projects and completing the good practice exercise.

Following FGM activities in [key] international arenas

The visit also enabled the collation of broad and relevant information from the international arena in order to better share knowledge with the relevant groups in Sweden. The visit also provided an opportunity for the creation and continuation of contacts and dialogue with others working with the issue.

All information gathered is for dissemination to the relevant groups and individuals in Sweden, and especially migrant communities living in Sweden.

Structure of the report

This report contains:

A summary of the trends of the practice, the work of governments, gender relations, the fate of uncircumcised girls, and specific activities by some organisations in the countries visited.

A detailed report by country is presented from conversations with specific contacts in the next section. The questions asked can be found in Appendix 2.

Some conclusive remarks concerning, amongst other things, information that would be relevant to migrant communities living in Sweden that come from the lands visited..

FGM in Ethiopia

Overall picture and trends to end the practice

Ms Bogalech Alemu**,** Chairperson of the National Committee on Traditional Practices in Ethiopia (NCTPE), noted that although traditional societal attitudes and values are very difficult to change in Ethiopia, there have been measurable results that include circumcisers "throwing down their knives". It was not possible to talk openly about FGM in Ethiopia some 12 years ago. Now, many groups and organisations are working against, and advocating the end of, the practice at different levels. The government, primarily through the Women's Affairs Office, non-governmental organisations (NGOs), women's groups, youth groups, and community, religious and tribal leaders all condemn the practice as a serious community and social problem. FGM has been integrated into policies on health, education, the media, and governance from the highest to the lowest levels.

Ms Alemu reported that the practice of FGM is reversing and the prevalence rate is falling. She added that this is more obvious in urban areas, where girls face no stigmatisation for not being circumcised, than in rural areas. Studies show that there has been a reduction in the practice. Impact assessment studies have been carried out in the areas where the NCTPE has worked. In the Kembatta region in November 2004, 25,000 girls publicly declared that they had not been circumcised and were not going to be. The NCTPE normally conducts a pre- and post-intervention assessment. Indicators used are the number of mothers refusing to circumcise their daughters, the number of daughters refusing to be circumcised, and the number of girls taking part in public declarations.

In June 2004, the government enacted a criminal code to penalise anyone who continues the practice of FGM.

Sister Kennedy, at Addis Ababa Fistula Hospital, reported that there is a lot of fear – psychological fear – on the part of girls regarding circumcision. As parents believe FGM is good for initiation into adulthood, girls are under pressure from their parents and their peers to be circumcised. Girls are often mocked in the playground with taunts of "*Miriam with the long clitoris*". This is particularly true of the Somali communities in Ethiopia.

Even though FGM is in the domain of the "*old woman*", Snr Kennedy believes that men must be targeted in order to bring about the eradication of the practice. She usually talks to men and asks them if they want to have a really intelligent son. She adds that if they are looking for a wife who will produce an intelligent son, then it has to be a lady who has not been circumcised. A lady who has been circumcised risks having delivery delays in the second stage of delivery. If there is a delay in the second stage, the baby is likely to suffer hypoxia – lack of oxygen. A child who has suffered hypoxia cannot manage at school, no matter the amount of punishment. The child

cannot keep up. If it is an older man, she uses the same argument regarding a grandson: *Don't you want to have an intelligent grandchild*?

Snr Kennedy also reported that she uses another strategy when talking to women about the practice concerning one of the myths: that FGM stops the clitoris from growing into a penis. She uses the fact that a circumcised girl can get a clitoral cyst – which can form as a result of circumcision – which can become just as big as, if not bigger than, a man's penis. She shows pictures and gets the women to realise that this is possible. She uses shock tactics, pointing out that although the women think they avoid the creation of a penis by circumcision, what they can create through circumcision is bigger than a male penis.

Pressure to conform

In Ethiopia, a girl from the Oromiya region met a young man who was from a Muslim community from the East. He married her and took her home. She had had clitoridectomy (Type I). She became pregnant, and was down at the well talking to the other women. They asked her what kind of circumcision she had had – she explained. They understood that she was not completely closed. They told her that if she was not completely closed at delivery, and her mother-in-law saw this, the mother-in-law would force her son to divorce the girl. At five months' pregnant, the girl had circumcision to be closed so she would be accepted by her mother-in-law.

Snr Kennedy's opinion is that FGM is a tradition, which continues because everyone does it. Snr Kennedy believes that the practice is dying out amongst Ethiopians living in Europe. It is not being practised by the educated or city dwellers. FGM is not practised everywhere in Ethiopia, for example, within the Gambella region. She reported that continued, sustained education against the practice, which has been reinforced by powerful women's associations over the past 20 years in some areas of Ethiopia, has significantly reduced the prevalence of the practice. These women's associations also monitor activities in local communities.

The Ethiopian Media Women's Association reported that the practice is much reduced, and this became noticeable about three years ago in rural areas. For example, in the Amhara region, it was discovered that people had been made aware of the problems of the practice of FGM through the implementation of a food security project. There is a new strategy being used by development projects to integrate harmful traditional practices (HTPs), including FGM, into their activities. In Eastern Ethiopia, some three or four years ago, work was done in the Oromiya region with religious leaders and other elders, who all participated in a sensitisation programme on FGM. In Western Ethiopia, health and development and education projects all address FGM as a harmful traditional practice.

By integrating FGM into these other programmes, communities tend to accept what is said. They share experiences, debate, and often decide to end the practice. With integration, it is also best to establish a link with commu-

nity members by using one of their own people. Usually, communities do not accept information easily from someone outside their community that they do not know. Using the method that integrates FGM into every kind of development activity by someone who is from the same community seems to support acceptance of the message and a trend towards a decline in the prevalence of FGM.

The Ethiopian Media Women's Association reported that in their opinion, the message that FGM is harmful is getting through. Now even older women, traditionally the gatekeepers of the practice, are discussing FGM. It is no longer assumed, even by women of the older generation, that a girl will be circumcised.

When will FGM end completely in Ethiopia?

Ms Alemu (NCTPE) is confident that if reversal in the practice continues at the present pace, then one can foresee the prevalence of FGM changing from 72 percent at its present rate to 25–30 percent within the next 10–15 years.

One Ethiopian Media Women's Association member said that within the next five years, if there is continued collaborative effort and alternative income for circumcisers, the practice could be eradicated in Ethiopia. She felt that people need to internalise what they have understood in order to completely end the practice.

Another Ethiopian Media Women's Association member said that within 10 years, FGM would be eradicated in Ethiopia. She was concerned that the message had not yet reached most of the country and that the older women – grandmothers who normally support the practice – have yet to be convinced in large numbers. The key, she believed, is to bring about behaviour change although this is very difficult. There are problems reaching rural areas because of weak or non-existent infrastructure. There are also limitations to financial resources.

Work with the government of Ethiopia

Parliament receives training and a law against FGM is passed

The NCTPE reported that it conducted a workshop for members of the parliament from the House of People's Representatives on harmful traditional practices in July 2003. The aim was to raise awareness by presenting basic information and to advocate the support of the parliament in formulating laws against HTPs. The committee is the only non-governmental organisation to make such a presentation to the parliament. A short video film on FGM in Ethiopia was shown, and NCTPE regional council members and co-ordinators were invited to make short presentations on the status of FGM by describing ongoing work and the problems to date. As a result of this workshop and presentation, the parliament agreed to raise the issue, review efforts at local and regional levels, and conduct a survey on the impact of interventions to stop harmful traditional practices.

In June 2004, the parliament enacted a Criminal Code which makes FGM a criminal act in Ethiopia. The jail sentence for circumcising a girl was in-

creased from three months to 10 years. The provisions of the law are that the circumciser, the consenting adult, and anybody else supporting the practice will be prosecuted.

Another provision of the law is that parliamentarians are now obliged to monitor the new revised Penal Code and follow up the implementation of activities in their own constituency. They should check to what extent government machinery supports the execution of the Code and provide feedback to the parliamentary legal standing committee, the women's standing committee, and the social standing committee within the parliament.

The NCTPE reported that HTPs have become very topical, including FGM. Every parliamentarian recognised this and talked of their commitment to help and support the eradication of these practices within their constituency. The NCTPE and others continue to monitor the activities of parliamentarians, not only within the parliament, but also within their constituencies.

Gender relations

The NCTPE reported that in urban areas, it is easier and possible to talk about sexuality and FGM openly in mixed groups with boys and girls, as well as with mixed youth. There are HIV/AIDS clubs, literature clubs, and reproductive health clubs where these discussions are held.

In rural areas, youth groups and others organise coffee ceremonies. They visit community members in their homes to discuss issues that include HIV/AIDS and FGM. Then a meeting is held where they discuss and debate the issue. No consensus or community decision is formed. People are left to make their own decisions. One result of this kind of intervention is that there is a rise in the number of victims of FGM going to the courts for redress. In rural areas, the NCTPE has also found that the divide is not so much between sexes when talking about sexuality and FGM, but between generations. The older generation will not sit with the younger generation to discuss these issues. It is more comfortable for each generation if they can discuss sexuality and FGM separately, with members of their own generation.

The Ethiopian Media Women's Association reported that in the city, it is still not possible to talk about FGM. It is often incorporated as part of some other topic. Increasingly, FGM is being integrated into HIV/AIDS projects as circumcisers use a single razor to cut many girls and there are concerns about infection. FGM is also integrated into gender and early marriage projects. The disadvantages of FGM and its health consequences, including fistula, are explained.

Snr Kennedy (Addis Ababa Fistula Hospital) believes it is more beneficial to talk to men and women separately about sexuality and FGM. She has also found that people will listen to the subject comfortably from health professionals, religious leaders, community leaders, or anyone they know. It is much harder for someone outside the community to discuss this topic.

Are uncircumcised girls ostracised within their communities?

Snr Kennedy reported that girls who have not been circumcised do face stigmatisation. She explained that the girls often live in a tight-knit, sheltered community. It is a herd instinct to circumcise, as every girl practises it. She believes that providing information for education will do an enormous amount to rule out the practice.

Information about the Diaspora

Message to those who wish to continue the practice

Ms Alemu (NCTPE) found it hard to imagine that any Ethiopian who has lived abroad, adopted Western views, and received an education would want their daughter to undergo the practice. She is aware of one ethnic group that travels to Ethiopia in order to have their daughters circumcised. She was very clear that now that a law has been enacted, people from the Diaspora could be told categorically that FGM is a forbidden and illegal practice in Ethiopia. She admitted training and education is still needed to inform everyone about the legislation in order to completely end the practice.

Ms Alemu added that there is a national movement to stop the practice. She invited Ethiopians in the Diaspora to be part of this movement. Her message was that Ethiopians in the Diaspora should no longer live in the past, but in the present, where Ethiopians are ending the circumcision of girls. She said that circumcision is no longer part of the identity of Ethiopian women and urged those living in the Diaspora to abandon the practice as thousands in Ethiopia are abandoning it. They were encouraged not to continue living isolated from activities taking place in Ethiopia to end FGM.

Snr Kennedy of Addis Ababa Fistula Hospital explained her understanding of the situation in the Somali migrant community, adding that she was more knowledgeable about the U.K. situation. Africans who practise circumcision and live outside Ethiopia (or Somalia, etc.) tend to be concerned about the lack of morality in the societies where they live. They monitor the children – especially their daughters - extremely closely. The girls have older brothers who protect or '*look out for*' them. Parents tend to be fearful of the negative influences of the West. The parents allow the children access to anything that is within the confines of school, after which the children return home.

An idea might be to have lunchtime clubs – different group clubs – where someone from the same ethnic group gives a talk on topical issues, including FGM. Due to the communal nature of most African traditions, Snr Kennedy believed it is important that these are group discussions, not one-to-one talks. It is then possible that the girls and young women could go home and share and discuss the issues raised with their parents.

With respect to those Africans in the Diaspora who feel they must take their daughters back to their homelands for circumcision, Snr Kennedy suggested that mothers of uncircumcised girls could allow their daughters to travel back to the home country with a non-African (Swedish) friend. This

might take the pressure off having the girl circumcised. Another suggestion is to take back a group worker (from the school class/club for example), who is from the same country or ethnic group as the family, to the home country. The Ethiopian Media Women's Association's message to Ethiopians who feel they must take their daughters back to the home country for circumcision is: "*We are ending the practice here. You are lagging behind. In rural areas, we are stopping it, in urban areas also*".

> "Your sisters in Ethiopia are having their eyes opened, and are stopping the practice across the board. Unlearned girls who have never had an education are doing this. FGM has nothing to with Ethiopian culture - it has everything to do with ignorance. In order for you - living abroad - to reflect your level of understanding and knowledge, you cannot, must not circumcise your girls."
>
> Snr Kennedy, Addis Ababa Fistula Hospital

Activities by organisations

Higher-training institutions integrate debate on harmful traditional practices into curricula

The NCTPE reported that information about HTPs has been included in the curricula of schools and higher-training institutions since 2002. In collaboration with the European Union, the committee conducted sensitisation seminars for curriculum developers at federal and regional levels; teachers in classrooms; and policy-makers in regional educational authorities. Everybody in the education sector received the same basic information about FGM: facts, figures, and the reasons for FGM, its effects, its links with HIV/AIDS, its impact on health, its violation of bodily integrity, and the fact that continuing the practice was an obstacle to development.

The training provided for curriculum developers enabled them to include FGM in the school syllabus. The material created by curriculum developers was then used by teachers to raise awareness of and update knowledge of FGM so that they could in turn sensitively include FGM in their lessons and programmes at the classroom level. The work with the policy-makers was to raise political will concerning the issue and to encourage them to integrate FGM issues into policies formulated and any laws formed.

Another development that has taken place by student initiative is the creation of "harmful traditional practice clubs". These clubs meet after school and are run solely by the pupils themselves on their own initiative. A number of different clubs was formed, such as the HIV/AIDS club, the reproductive health club, etc. The students decided to merge the clubs into one. This club then became an association, which eventually sought permission from the local municipality to become an NGO.

Work with religious leaders

A series of meetings was organised by the NCTPE to involve religious leaders. Religious leaders are often regarded as gatekeepers for communities and are therefore important stakeholders to include in work on FGM. The aim was that key representatives from the Christian and Muslim faiths would attend the meetings, which would also be used to lobby Christian and Muslim leaders to publicly condemn the practice of FGM. At a National Forum for Religious Leaders, sponsored by Intrahealth, a Muslim lady had downloaded and distributed online materials in Arabic, which stated that FGM is not recommended. Every religious leader at the meeting was upset, disappointed and angry: "*Who are you to give us this document*?" The religious leaders were very resistant, and said that they cannot be told what to do, and that it is not possible to produce materials for them. They just needed to be given the information, and they would know what they should do with it.

There were more problems connected with the meetings: The meetings had been partly organised and led by a woman, and the person who had produced the information, although in Arabic, was also a woman. The Muslim religious leaders also found it difficult, if not wrong, to take instructions from a woman. Furthermore, the religious leaders lost confidence in the organisers; they became suspicious that an NGO from the United States of America (U.S.A.) had co-sponsored the event, and began to question their motives for doing so.

The NCTPE was also of the impression that the religious leaders (particularly the Muslim religious leaders) were concerned that if they stated publicly that FGM was not a religious obligation, their followers would challenge them. Why had they not made this declaration before, and saved the women who had been cut from suffering?

Mr Abebe (NCTPE) made a number of suggestions for working with religious leaders:

- Lobby a few religious leaders so that they can act as change agents to run the meetings for other religious leaders;
- Support religious leaders as they work to convince others to speak out against the practice;
- If you can, get a statement or a ruling by a notable, respected religious leader against the practice;
- Realise that you may be challenged, so be prepared beforehand on how to deal with this;
- Segment your audience: Let men contact men for participation at the meeting;
- Help religious leaders to identify an honourable exit, if they are likely to be challenged by their communities and followers about why they have waited this long to condemn FGM, or any harmful traditional practice.

Work with circumcisers

The Gender and Law Project worked from 2000 to December 2004 to end harmful traditional practices by focussing on FGM. The work against FGM

involved selecting well-known circumcisers and convincing them to end the practice. To date, 60 circumcisers have been re-trained in this project. Circumcisers completed a questionnaire on the practice and a follow-up interview was conducted with 30 circumcisers from five woredas (wards within districts) in the East-Wollega zone in July 2002.

Question	Answer
Why is circumcision performed?	Because of tradition[1]
How did you start circumcising girls and how did you learn?	Inherited or learned from family
What is your age?	70% aged 40–59[2]
What do you use to cut the girls?	A razor blade
How do you sterilise your instrument?	A new razor blade is boiled (23 of 29 used one blade for one person)
When (season or time) do you cut the girls?	September–November
What is the age of the girls you cut?	Aged 7–12 years[3]
What is involved in the celebration of the cutting of the girl?	Feast, with presents for the girl
What is the attitude of the girl towards the cutting?	It is purely the demand of the family
How are you paid for performing the circumcision?	Money only

Other findings from interviews with circumcisers

- Religion did not determine whether a girl was circumcised or not: There seemed to be little difference in the practice between Muslim or Christian families.
- Circumcision is done at the residence of the girl. The circumciser is informed a week or two beforehand and she goes to the girl's home.
- If a family has two or more girls, they are circumcised at the same time.

The training of circumcisers covers the religious, health, and social reasons usually given for continuing the practice. For religious reasons, they discuss the writings of the Bible and the Koran. For health reasons, they teach about health complications resulting from FGM, especially during childbirth. For social reasons, they discuss the economic costs of the feast and the loss of income. The objective is to approach FGM from all the usual reasons as to why the practice must continue, but leave no loophole for it to do so. Ms Woldeyohanis (Gender and Law Project) reported that they found the circumcisers open to information, and during discussions the women have ul-

[1] Whilst the highest response was that it was a traditional requirement, the next-highest response from the circumcisers was that it was a means of income. Other reasons given were: for purification; it is shameful or insulting not to be cut; cutting generates income; a girl will be an adulteress and unsuccessfully married; it is a religious requirement; a girl will face problems during delivery; a girl will be disobedient and unruly; a girl will be extravagant.
[2] 60% started the practice on their own daughters, 16% learned by trial.
[3] The richer a family, the earlier it has its daughters circumcised.

timately been convinced not to continue the practice. They have also persuaded other circumcisers who have not attended the training to end the practice. After the training, the circumcisers not only stopped the practice but also joined the movement to end it.

Alternative practice for circumcisers by Snr Kennedy

In Chad, ex-circumcisers became traditional birth attendants (TBAs). They were given height sticks measuring 1m 45cm. These women were required to go around in their communities and target every pregnant woman they saw. They planted the height stick against the woman and if her height was under 1m 45cm, she was ordered to go to the nearest antenatal clinic or health facility. These new TBAs were given training in basic women's health and issues concerning FGM. They were given the stick and recognized as a TBA in the community at a public ceremony. The chief and village elders, as well as a government official at the village level, attended this ceremony. A lot of respect, dignity, and status were awarded to the position. These TBAs reported regularly to health centres and health posts; they had cards which had to be dated, signed, and stamped at the health facility, as most of these women were illiterate.

If an ex-circumciser who had become a TBA went back and circumcised anyone, her stick was broken in public. The fact that she had carried out a circumcision was publicly declared and her card was not stamped. There was a period of "*punishment*", which lasted anything from six weeks to six months. This period was deemed just long enough to chastise and make the point that FGM was reprehensible, but not too long as to cause serious lack of face for the TBA or lack of income, which might cause the circumciser to return to circumcision as a way of earning an income.

Media Policy of the Ethiopian Media Women's Association

The Ethiopian Media Women's Association reported that the Constitution of Ethiopia and recent changes in the Penal Code provide some protection to victims of harmful traditional practices (HTPs). It is from these documents that media policies are formed, especially editorial policies, for different media outlets. It is a code of ethics that the print media use – for example, they do not mention the name of the person, and they do not show the face of the person.

Activities by the National Committee for the Prevention of Harmful Traditional Practices (Mr Abebe Kebede, Executive Director)

Mr Kebede itemised the five harmful traditional practices in Ethiopia that the committee works on: FGM, early marriage, abducted marriage, vulva cutting, and milk teeth extraction.

He explained that the goal of the committee is to eradicate HTPs, especially FGM, and to promote beneficial traditional practices. Prior to 1998, the committee disseminated information on FGM without an assessment of those areas in the country that were free of FGM, and those areas of the country where FGM was practised. For example, in the western part of the

country, Gambella, FGM is not practised at all. A survey was conducted to assess which areas of the country practised FGM, to determine what the strategies and desired impact of such interventions should be. The survey covered 10 regions; 65 ethnic groups and 44,000 people participated. One of the outcomes of this baseline survey on HTPs, the results of which were published in September 1998, was that the prevalence rate for FGM had fallen from 90 percent to 72 percent. The reasons for this decline in prevalence rate were attributed to:

- Interventions by the committee and others, mainly through sensitisation, information, education, and communication activities about the harmful effects of FGM. Specific activities included training, seminars, workshops, and work with the media;
- The whole country was covered, and in the southern region of the country, nearly 50 percent of the population does not practise FGM. This would serve to decrease the national weighted average;
- The age at which circumcision is carried out varies widely. For example, within the Somali ethnic group, the age is seven years, within other groups (such as the Jebelawi, Oromo and Amara), circumcision is at birth.

Activities by Pathfinder International (Ms Bogalech Alemu)

Pathfinder International provides financial support. It has built a 28-partner group to work on integrating HTPs, including FGM, into their ongoing programmes. They are involved in activities such as the Violence Against Women Day (25th November) and high-level advocacy to stop HTPs in Ethiopia. They receive financial support from USAID and the Packard Foundation, and they also follow up activities.

Activities by the Ethiopian Media Women's Association (Ms Abebech Wolde, President)

The association has been advocating women's rights, including the eradication of FGM, since 1999. The aims of the association are to upgrade media women practitioners' skill – for members of the association as well as non-members. The association is unique because it serves women in the government as well as those in the private media. It has some 150 members. The association began working on FGM two years ago in association with AIDOS in Italy.

The present FGM project is called "*Challenging Harmful Traditional Practices in Ethiopia*". This project has received sponsorship of $10,000 from the Global Fund for Women. The activity will start with an assessment of awareness of FGM at the community level. The plan is to conduct workshops and disseminate information about FGM. The work will take place at the community level in the Kebele region. Work will begin with an assessment of the current situation, followed by focus group discussions after awareness-raising through posters, audio/video materials, and listening centres.

Activities by the Ethiopian Women Lawyers' Association (Ms Yetnayet Andarge)

The Ethiopian Women Lawyers' Association promotes the economic, political, and social rights of women, helping them to secure full protection of their rights under the Ethiopian Constitution and other human rights conventions. Amongst other activities, the association provides free legal services to women victims of injustice. It lobbies for the creation of specific laws to end specific harmful traditional practices. Specifically for FGM, it has a public education programme, as well as a law reform and advocacy programme. Within the public education programme, it works with:

- schools – providing assertiveness training for women, reproductive health, and women's rights training
- teachers' associations (especially female teachers) – providing training
- women employees in different institutions
- paralegals – mainly women and a few men – providing training
- police – package for women police investigating cases of HTP
- other law enforcement groups – providing training.

FGM in Kenya and Somalia

Overall picture and trends to end the practice

Kenya

Ms Mburia (AMWIK) reported that the national weighted prevalence rate is 38 percent; the practice of FGM can vary from 13 percent to 100 percent among ethnic groups. She expressed concern that although the rate is dropping, the practice might be going underground. She was also concerned about the present resurgence of the practice among a small radical group in the Kikuyu tribe, who say there is a need to go back to old traditions and that circumcision is necessary in order to be African. She added that Christianity and education are changing the nature of the practice. She added that although Christianity and education are helping to prevent the practice, there is also evidence of medicalisation – children are taken to hospital and cutting is carried out in collusion with nurse attendants. The Children's Act (2001), which prohibits the cutting of girls below the age of 18, is thus neither upheld nor enforced.

Ms Mburia said that one clear trend is that people can talk more openly now about FGM than before. The silence is broken and FGM is no longer a taboo issue. This is true in the cities as well as in rural areas. However, in a few areas, it is not possible to talk openly. Where there has been work, in particular an advocacy activity, it is possible to talk openly about FGM. The overall decline of the practice, however, is very slow. There is a need to maintain the pressure on ways to stop the practice.

Ms Wandia (FEMNET) reported that the prevalence of FGM is not being reduced in Kenya, instead it is being made less noticeable. Girls who have not been circumcised are looked down upon; they are made to feel they are not adults. These girls then request circumcision as a way of showing they have attained womanhood. Ms Wandia believed sensitisation and awareness-raising is very important. There is little or no awareness-raising in rural communities. There is a need to target and work on FGM in the same way that early marriage is being targeted. Communities are now aware that FGM is not a religious requirement. She added that men still support the practice – *they are going to look for a girl who has not been circumcised and go and have her circumcised* – the lyrics for a recently popular Kenyan song relate. She noted that the target for the practice within the Somali communities is children.

Ms Wandia said that due to the health consequence message, the practice is being moved from the home to hospital, and communities likely to continue the practice tend to do so in hospital. She explained that in the Somali community, FGM is seen as a sign of purity before marriage. Even if an unmarried girl becomes pregnant, the baby is aborted and the girl is stitched up again so that she is able to marry. Ms Wandia was of the opinion that

there is a need to de-link perceptions of the practice from marriage and the belief that men want circumcised women.

Ms Kamau (GTZ) reported that prevalence amongst tribes in Kenya is declining. Ms Kamau was of the opinion that there are now more groups working together through networking, in a spirit of transparency, from advocacy at the community level to the policy level on FGM. FGM is now being tied to developmental issues, and this is attracting more funding. There is an increasingly integrated approach. In schools, FGM has been inserted in schools' extra-curricular material. In churches, leaders are taking a stand against it. People are adopting alternative practices – for example, people become Christians and adopt new values that speak against the practice of FGM. However, within the Somali communities in Kenya, FGM is universal. There is no discernible difference in this very close-knit community.

There are reports from the Population Council in Kenya that the risk of legislation driving FGM underground is a serious concern. They have been able to obtain evidence from the Kisii area of Kenya that this has already happened.

A report on medicalisation among the AbaGusii by the Population Council shows that the practice has not only gone underground, but it has become medicalised also, so that nurses are now doing it secretly in the villages.

The Population Council believes that these activities in Kenya (the practice going underground and its medicalisation) is a result of sustained anti-FGM activities in these communities for over a decade, which focussed primarily on the health aspects. The communities' reaction was to medicalise the practice, and then when legislation came in, the medicalised practice went underground.

Report from the Population Council: Medicalization of Female Genital Cutting among the Abagusii in Nyanza Province, Kenya, by Carolyne Njue, Ian Askew by Frontiers in Reproductive Health Program, Population Council, December 2004

Somalia

Dr Jaldesa (Population Council) explained that the physical borders between countries are artificial, given that Somali people have the same religion, the same language, and the same culture. The tradition is uniform. He added that the biggest change he has noticed is the reduction in the severity of the practice. There is now clear evidence that the nature of the practice is changing from Type III to Type I, but they have not been able to identify anyone who has abandoned the practice. From the 2002 DHS survey of Kenya, FGM prevalence in the northeast province, which is predominantly Somali, was 98 percent.

Ms Mohamed (Equality Now) reported that although there are no changes reported in prevalence (in Kenya the official percentage is 38, while in Somalia/Somaliland there has been no nationwide assessments and the old statistics, 98 percent, are still used), there is an increasing willingness to talk about FGM. There are a number of cases of young girls refusing to be cut in Kenya, while some parents in Somalia/Somaliland are silently rejecting the practice and sparing their daughters the suffering of FGM. Despite the fact that there are good connections between urban and rural populations, there is no systematic way of reaching people in rural areas. People living in the city are more ready to change than those living in rural areas. Therefore, most organisations and groups tend to start FGM activities where it is easier to effect change and they believe that in the long run it will be easier to influence rural areas. Ms Mohamed reported that in Somalia, there is a shift from pharonic to sunna, and about 1 percent of families is not cutting their daughters. However, families with uncut girls do not report that their girls are uncut for fear of stigmatisation by their communities.

Dr Abdullai reported that Norwegian People's Aid (NPA) works in Puntland, Las Anod (LA), Galkayo, and Bossasso, but not in the south of Somalia, and also networks with partners in Hargeisa. NPA has developed a project with local partners to integrate FGM into the education of young girls.

NPA does not yet see any change in the practice and does not forsee any change in the near future. Dr Abdullai added that although people talk very openly about FGM, the rate of prevalence has not changed. She felt that it would take a very long time for the complete eradication of FGM in Somalia, for there are a lot of challenges. She cannot foresee FGM being eradicated in Somalia within the next 20 years.

Work by the government of Kenya

A conference on FGM in September 2004 held in joint collaboration with the government of Kenya was, in AMWIK's view, an indication of the government's political will to address the issue of FGM in Kenya. However, implementation of the law against FGM has yet to happen. Policy-makers, parliamentarians, and counsellors do not talk about FGM. Very few politicians will talk openly about FGM, apart from the current Minister of Education and the Minister of State. The latter is seen as a role model – she comes from an ethnic group where there is a 99 percent prevalence of circumcision.

AMWIK was of the opinion that the government is not dedicated to this issue. Funding is difficult, and as it is not seen as an issue on the developmental agenda, money is not allocated for it. There is little or no political will from the senior positions in the government; nor is the government working directly on the issue.

Gender relations

Kenya

Ms Mburia (AMWIK) explained that being able to speak freely about sexuality and FGM depends on the setting. For educated people, it is possible to speak openly in mixed groups. However, girls may not speak, and find it intimidating. It is possible to speak openly, and in mixed groups, in the cities. With youth, in both the cities and rural areas, it is possible to speak openly with mixed groups, except within the Masai tribe.

Ms Wandia (FEMNET) explained that, traditionally, talking about sex between parents and children is a taboo subject. Amongst the elite of society, she reckoned that it was likely parents would talk to their children about sex, but within the larger part of the population, youth speak amongst themselves only. She suggested that as the youth population has access to information on the Internet and exposure to television, this might be used as a channel for anti-FGM messages for young people. This would provide a neutral environment for addressing issues of gender, sexuality, and FGM. Ms Wandia added that the situation is different for youth in rural areas, especially girls. They do not have access to information and can be more easily exploited because of this.

Somalia

In the opinion of Dr Jaldesa (Population Council), people do find it hard to talk about FGM. He recommends same-sex groups if there is to be free discussion on the subject.

FGM is performed to control the virginity of the girl within the Somalian community. It is the women who do all the arranging, and deal with the details of who is cut, and when and how this is carried out.

If there is extra-marital sex and a girl becomes pregnant, this is perceived as the mother's fault. This situation is exacerbated if the girl has not been cut, as cutting is considered to prevent extra-marital sex.

Dr Jaldesa felt that men think FGM is the business of women, and do not have much to do with it, although consent for cutting is necessary from the husband/father. If he is silent about FGM, it is assumed that he approves of the practice. Dr Jaldesa believes that women would not be able to go ahead and circumcise their daughters without the tacit consent of their husbands.

From his experience in Somalia, Mr Hopkins (UNICEF, Somalia) has found that FGM is not a very sensitive topic; it can be talked about in open forum.

From NPA's experience, Dr Abdullai has found that sex and sexuality are very sensitive topics, especially for men. They do not ask about women's body parts. Even in seminars, men will often ask the leader to skip the details about female anatomy and talk about FGM as an issue instead. Although young people feel comfortable talking about sex in mixed groups, NPA has found that it works best if men and women talk about sexuality and FGM separately.

Dr Abdullai added that whenever there are workshops or seminars on FGM, women listen well and patiently. They often even agree with every-

thing that is said. Then they say two things: "*Whilst we are convinced that FGM is not a religious requirement, we need to hear this for ourselves from religious leaders. It needs to be sanctioned by them*"; and "*Men need to tell us also that they do not need us to circumcise our daughters and that they will marry our uncircumcised daughters*".

Ms Mohamed (Equality Now) said that sexuality is not talked about within Somali society. Most discussion takes place within women's groups only. Men do not talk about FGM – she doubted if they talked about it much in their circles. They would rather discuss politics than social issues. She thought that perhaps a group of educated Somalis would discuss FGM in a mixed group, if a woman initiated the discussion. In a meeting with a mixed group of Somalis, they interact and discuss FGM, but not at the community level. In the cities, she is aware that people get a sense of the problems that FGM creates, but in rural areas, people still do not make the connection between women's health problems and FGM.

Virginity and religion

Ms Mohamed (Equality Now) reported that Somalis in the Diaspora are asked why they insist on circumcising their girls, since Muslims in Saudi Arabia do not do it. The response is that girls in Saudi stay in their homes and are not allowed out. In the Diaspora, parents admit they are concerned that their daughters will be taken advantage of and will have pre-marital sex. Circumcision is seen as one way of protecting the girl. In the Diaspora, parents do not feel they have the same kind of parental control over their girls, and they fear they will lose their children. The communities tend to be very religious; they do not want their daughters to have sex outside marriage, or to marry outside the Muslim religion. Out of that fear, they believe the best way to protect their girls is to continue with the practice. Thus both virginity and religion are important determinants in continuing the practice.

Are uncircumcised girls ostracised within their communities?

Kenya

Ms Mburia (AMWIK) reported that girls who experience peer pressure sometimes ask to be circumcised. In the cities, it is the parents that seem to want the girl to be circumcised; whilst in rural areas, peer pressure from other children seems to be the driving force.

Ms Wandia (FEMNET) reported that girls who have not been circumcised face stigma from within their communities. These girls are often pressurised into circumcision. Ms Wandia said that it has been known for girls to request circumcision in order to save themselves from ridicule, and to be accepted by society. Ms Wandia felt that if they had access to information and were made aware of the problems of FGM, and their rights, they would feel empowered and be less likely to succumb to societal pressure.

Ms Kamau (GTZ) felt that there is a real need to educate the "consumers" – the boys. They influence the decisions of girls to be circumcised, but they do not often express this openly.

> In the Kuria region in Kenya, girls with university educations, who believed that no one had asked for their hand in marriage because they had not been circumcised, went back (to the village) and requested circumcision to increase their chances of marriage.

Somalia

Dr Abdullai (NPA) said there is peer pressure on girls who have not been cut. Often, because of this pressure, the girls themselves request circumcision. She confirmed that girls do experience pressure from classmates if they have not been cut. In a study (October 2004) in Somalia, NPA found that 90 percent of girls aged 16 years and below said that they would circumcise their daughters. This evidence shows that these girls want to be circumcised, *but boys* are saying they do not want girls to be circumcised. Dr Abdullai added that the situation might be different abroad. The study also found that boys now say they do not want girls who have been circumcised. Mothers, on the other hand, say they do want their daughters to be circumcised.

> A man married a girl who was cut (Type I). When he found that she was open, he divorced her the very next day. He was 28 years of age. He said he would not marry a girl who had been used, who was not stitched.

Dissemination of information about FGM – use of the media

Ms Mohamed (Equality Now) reported that Equality Now's organisational policy is to interest the media and use it to raise public awareness about FGM issues. There has to be an interesting news angle for the media to become interested, for example, circumcisers becoming ex-circumcisers.

Information about the Diaspora

Message to those who wish to continue the practice

Kenya

AMWIK: "*You should stop the practice. Even here in Kenya, we are trying to stop. The practice has no purpose, it is meaningless. If you say it is your culture – what is your culture? Hold on instead to those things which are positive, let go of the negative traditions.*"

GTZ: "*I would call it child abuse. If you actually feel that the girl has to go through FGM, and you can't wait until she is of an age to make her own decision, then it is child abuse.*"

ADRA: "*No, No, No! We will have to educate those who wish to continue the practice. When they understand the practice, and what it does, they will stop it themselves. It is a violation against human rights. It is a violation and it is outdated.*"

Somalia

NPA: "*Previously, this was a practice done by people who believed it was part of their culture. It was closely related to religion, and people did not know the facts about FGM. FGM has nothing to do with religion. You should think of the health of your daughter and not do it blindly. Now that you have left Somalia, you should use this opportunity to consider FGM and its problems.*"

Equality Now: "*You have to stop it, people at home are making efforts to stop it. You need to find ways of building trust between yourselves as parents and your daughters. You can direct them and educate them sexually. Cutting them is not a solution that "protects" them from sex. Today, there is no excuse for continuing the practice. You need to understand that the practice is a human-rights violation and what you are doing to the girls is wrong.*"

Do people in the homelands know about laws against FGM in European countries and the Diaspora?

Kenya

Ms Wandia (FEMNET) does not believe that people in the homelands are aware of laws in the Diaspora against the practice. As a result, it was discovered during an IAC debate in February 2003 that it was easier for those in the Diaspora to take their children to Africa to have them cut.

At the activist level, Ms Kamau (GTZ) was of the opinion that people know, but not at the community level.

Somalia

According to Dr Jaldesa (Population Council), people in the homelands tend to know that it is not allowed to circumcise daughters in the Diaspora, and that their children can be taken away from the parents if they are at risk of being cut. The details of the laws, however, are not known.

In the cities, Dr Abdullai (NPA) reported that people are aware of laws abroad. In rural areas, people are not aware. People in the cities are aware that there are prohibitive laws in Europe because people in the Diaspora bring their daughters home for circumcision.

Dr Jaldesa mentioned that because of the awareness of laws in Europe and other parts of the Diaspora that prohibit the practice, those Somalis now seeking asylum in Europe and elsewhere are advised by their relatives in the Diaspora to have their daughters circumcised before they leave Africa, in order to avoid the laws governing the Diaspora.

Movement of girls from the Diaspora back to their homelands for circumcision

Kenya

Ms Mburia (AMWIK) said that going back to their homelands for circumcision is very common among the Somali ethnic group. The association receives letters from U.S. immigration authorities asking it to corroborate the FGM testimony of Kenyan asylum-seekers in the U.S. She reported that it depends on the situation. AMWIK makes it clear to the U.S. authorities that women can seek redress in Kenya, and they do not have to go to the U.S. for asylum on these grounds alone.

Ms Kamau (GTZ) reported that the cutting of girls is also taking place within Kenya, as parents take their daughters from urban to rural areas for circumcision, in spite of the law. It is not only girls coming back from the Diaspora who are being circumcised.

Dr Jaldesa said that a girl was sent back by her mother from the U.S. for circumcision. The mother asked that her daughter be circumcised, but not severely. For those from the Diaspora, it seems that the only determining factor of those who want to have their daughters circumcised and those who do not is the price of the air ticket. Those who can afford to bring or send their daughters back home have it done. In his view, the education of the parents has no influence at all on whether or not they continue the practice.

Somalia

Dr Jaldesa (Population Council) confirmed that girls are brought back for circumcision. It does happen.

He added that FGM is a silent drama in the Somali community. It is not carried out as a rite of passage; there is no celebration or feast. It is private, and therefore cutting can be carried out with little or no fuss or attention drawn to it.

Dr Abdullai (NPA) admitted that whilst it is difficult to gather evidence, the practice does happen; girls do go back or are sent back for circumcision.

Ms Mohamed (Equality Now) reported that, in the summer, girls from European and other countries in the Diaspora are taken to Hargesia, Somaliland, Kenya, and Ethiopia for circumcision. She is not aware that girls are taken to Somalia but pointed out that this does not mean that it does not occur.

A Somali family from Europe went to India and then sent for a circumciser from Somali to join them in India to circumcise their daughters.

Role of the Diaspora in ending FGM

Kenya

Ms Mburia (AMWIK) suggested that the provision of refuge centres for girls fleeing circumcision is an area in which the Diasporan community could get involved.

Somalia

Dr Abdullai (NPA) felt that Somalis overseas are likely to have changed, due to more exposure to information, and they return to their homelands to speak against the practice. On the other hand, she wondered whether people in the homelands might take offence and not be prepared to listen to them because those living in the Diaspora would now be viewed as 'outsiders'.

In June/July 2004, a woman from the Netherlands contacted Ms Mohamed, who was trying to track families who had left and come back for holidays to Kenya. She wanted someone to meet them at the airport and inform them that the practice is illegal in Kenya as well. She also wanted to establish procedures for reporting the circumcision of any girls taken back, and was working to find local people who could help.

Ms Mohamed (Equality Now) suggested that groups in the Diaspora - for example in Sweden - could return to their homelands and work with groups who are working against the practice. There needs to be more networking between those in the Diaspora and those at home. People at home need to be informed about those travelling home to have their daughters circumcised, in order to try and convince them to stop the practice. Sharing materials could be another important step in addressing this issue. Ms Mohamed felt that this would be a good monitoring system, as the group would know the number of people coming out of a particular country and when they leave. They could then alert organisations in the home country of the family's return that would then watch out for them. Parents could then be informed on arrival that circumcision is unacceptable, and that their actions were being monitored by local organisations. Ms Mohamed believed that this type of collaboration between groups in the Diaspora and Somalia would be extremely useful.

Activities by organisations

Possible model of good practice for activities at the community level

Ms Mohamed (Equality Now) was of the opinion that ad-hoc meetings were not capable of leaving lasting impressions on communities that would bring about behaviour change. She described an approach, which is being used in Egypt, that promises more sustainable long-term effects. Activists, who are also women from the community, visit a number of homes regularly. They get to know the female members of the households intimately, working to

establish a relationship with the girls in the households. The activist leader has the responsibility of organising meetings – which invariably involves talking about FGM. She will at appropriate times invite religious leaders or medically qualified persons to talk about particular aspects of FGM, sometimes bringing in the mayor of the town to add more political weight to the anti-FGM message. This method creates a secure atmosphere for the women in the households to tackle FGM and its problems. It also gives the girls in the household access to the activist leader if they want to talk about FGM or any sexual issues, or if they feel pressurised into being circumcised.

African Unity – Maputo Protocol

The Protocol on the Rights of Women in Africa has so far been ratified by Comoros, Libya, Rwanda, Namibia, and Lesotho. Nigeria and Guinea are in the process of ratification. Article 5 of the Protocol calls on member states to criminalise FGM, and other equally harmful traditional practices, and to provide resources for educating communities on the need to end it. It also requires governments to support victims of FGM, among other measures. It is important to raise the ratification of the protocol in order to pave the way for more serious political commitment. A coalition of several organisations is running an Africa-wide campaign for the speedy ratification of the protocol, and has generated a petition addressing the heads of states, appealing to them to honour their commitment to the human rights of women[4].

Kenya

Activities by the Association of Media Women in Kenya (AMWIK)

The association started work on FGM in Kenya in 1991. The AMWIK's work on FGM is part of a global project run by eight organisations in Africa. The association's main work on FGM is online research, the details of which can be found on www.Stopfgm.org

The association co-ordinates and influences media reporting on FGM by making FGM activities visible, and by providing training on FGM. The training covers the ethics of reporting on children, as well as the cultural, medical, and religious perspectives that are taught by experts in these areas. One of the aims of the training is to create a core of "FGM-friendly" journalists working in radio and TV (including producers). The AMWIK also identifies story lines and follows up on the reporting of FGM by the press.

There is also an alternative rite-of-passage programme, which takes place when a girl comes of age. It provides training and education for girls on a number of aspects – family life, positive aspects of childhood, and adulthood. The challenges still remain – some communities are hostile.

[4] For information about the campaign, visit http://www.equalitynow.org/english/campaigns/african-protocol/african-protocol_en.html and www.pambazuka.org

Activities by the Ministry of Health, Kenya, and GTZ

As part of the implementation of the 1999 National Action Plan to end FGM, the Ministry of Health, Kenya, requested support from GTZ to develop best-practice projects regarding FGM, in order to reduce the prevalence rate in Kenya to 45 percent.

Ms Kamau explained that the FGM project has been operational some five years in the Transmara Masai region. They are now moving to other areas: Kuria, which borders Tanzania and Kadgado, and two Masai communities to replicate activities. They also plan to begin work among the Meru – a Bantu people in Thakara.

Activities by the Adventist Development Relief Agency

Mr Nyambaro described the activities of the Adventist Development Relief Agency (ADRA) at the Dadab Refugee Camp for Somali refugees in Kenya. These activities were conducted in collaboration with the Refugee Site Co-ordinator, the Ministry of Health, Kenya, and CARE International. Eight months were spent at the camp, sensitising and targeting mothers in hospital, young people in school, and religious leaders. Although the camp was in Kenya, it was not possible to use the Children's Act 2001 to stop the practice of FGM, as the Somalis did not identify themselves as Kenyans. They did not consider that Kenyan laws applied to them. Mr Nyambaro reported that this FGM intervention could not be described as a success; nevertheless, it was found that some young girls refused to be circumcised after the intervention.

Another activity by the ADRA involved sheikhs and religious leaders – people who are well respected within the Somali community. They examined the Koran and concluded that FGM is not a requirement of Islam. Due to the interaction of religious leaders, women decided not to infibulate, but practised sunna instead. The problem was that this extensive cutting was called sunna, although in practice it was not sunna. Thus, the debate has helped – cutting has now moved from Type III to Type I – but it has not ended the practice.

Mr Nyambaro also explained that the alternative rites approach has been tried by the ADRA, and that although it works, there are questions regarding its sustainability.

Somalia

Work with religious leaders in Somalia

Dr Abdullai (NPA) reported that much work has been done on FGM with religious leaders, but there is still no clear consensus. Various imams interpret the haddiths differently and it is difficult to get a consensus. They also might agree at a workshop or when talking to them on a one-to-one basis that FGM is not a religious requirement, but they will not preach this or talk openly about what they believe in the mosque. The imams are quite powerful people in the community and Dr Abdullai suggested that as they cannot gauge the opinions of their followers on FGM, this might be the reason they choose not to speak openly against FGM. From one-to-one interviews with religious leaders, 97 percent in Puntland is against the practice. In work-

shops to discuss FGM, they do not fully agree with total eradication. Some say Type III is bad, but that Type I is a religious requirement and that girls have to have this done. Others say that Type III has to be carried out.

Galkayo Peace and Education Centre, Somaliland

The Galkayo Education Centre for Peace and Development (GECPD) is a girls' and women's education centre in Galkayo town, Puntland, Somalia. Established in 1999, the GECPD implements education, training, and awareness-raising development initiatives to educate women and girls. The GECPD implements these initiatives in three district towns (Galkayo, Jariiban, and Galdogob) and five villages (Harfo, Ba'ad Weyn, Beyra, Bali Busle, and Bur Sallah) in the Mudug region in Puntland. The projects are for women and girls who are mostly returnees and internally displaced persons in these communities. The awareness-raising programme focuses on various issues affecting women: FGM and HIV/AIDS, where the GECPD takes a human-rights approach to these issues. The GECPD is committed to the total elimination of all forms of FGM and violence against women (VAW). The centre now has partnerships with schools that get support from UNESCO and UNICEF.

Activities by Norwegian Church Aid (NCA, Somalia, based in Kenya)

Mr Rukunga explained that NCA has developed training material about FGM for use by those in the medical profession. NCA has also made a videotape of a workshop with religious leaders and conducted a short evaluation of FGM in Somalia.

Activities by UNICEF, Somalia

UNICEF works for the total eradication of FGM. UNICEF, the Italian UNICEF, and the Italian government are working to end FGM in the Northern Province in Garissa and in Boyali.

There is not yet a comprehensive strategy for addressing FGM in Somalia – there is an urgent need to develop such a consolidated strategy. Mr Hopkins (UNICEF) said that two separate studies are presently being conducted: the first is a knowledge, attitudes, and practice (KAP) study by NOVIB Somalia in collaboration with three Somali Women's Umbrella groups (Cogwo, Nagaad, and WAWA); the second is a World Bank study. It is hoped that the combination of these two reports will lead to the development of a comprehensive strategy for addressing FGM in Somalia.

UNICEF works with child-protection issues using child-protection advocates in Somalia. FGM is always one of the child-protection issues raised. Mr Hopkins, UNICEF, is currently working with the TOSTAN initiative from Senegal and the Entishar project from Sudan to consider possibilities for adapting the TOSTAN approach of community capacity development to the unusual and complex contexts of Somalia and Somaliland.

Activities by Equality Now

Ms Mohamed[5] reported that Equality Now manages the Fund for Grassroots Activism to End FGM that supports anti-FGM campaigns run by local organisations in 13 African countries. Equality Now's work in Somaliland and Puntland has been to support the work of the Galkayo Education Centre for Peace and Development and the Women's Inter-Action Group, which are both engaged in raising community awareness of the practice. The use of the usual means of communicating information about FGM has been difficult due to the reticence of key opinion leaders in communities. No local authority will openly condemn the practice, political groups are silent on the issue, religious groups do not preach at the mosques against the practice: they cannot talk about women's body parts. They say it is for private, not public, consumption.

Inconsistent messages about the practice are disseminated, even by NGOs. Some radio messages say stop pharonic practices, not FGM altogether, which has created confusion. Some NGOs use human-rights arguments, while others use health arguments. According to Ms Mohamed, it would be more helpful to give a comprehensive argument of the negative impact of the practice on the lives of women and girls.

Ms Mohamed explained that it was only about two years ago that nurses in some parts of Somalia began making the connection between the high number of delivery problems for women and girls who had been cut, compared with women and girls who had not been cut.

Ms Mohamed was concerned that even if families were convinced that they should not circumcise their daughters, they would usually express concerns about their daughters' marriageability – "*Why should I be the only one in the community whose daughter is uncircumcised?"* or "*Who is going to marry my daughter?*"

Although men are often cited as the reason the practice continues, Ms Mohamed reported that when asked, men often say they are not informed. They know nothing about the practice and even if they preferred women who had not been circumcised, they say that they would not know where to find them.

[5] Ms Faiza Jama Mohamed is the Africa Regional Director for Equality Now. She is Somalian, and was specifically asked questions on work taking place in Somalia and Somaliland.

FGM in Eritrea

Overall picture and trends to end the practice

Ms Zerai (Norwegian Church Aid) explained that the movement of Eritreans into the Diaspora started in the 1960s and 1970s. The DHS 2002 of Eritrea gives the most recent survey of the status of FGM in Eritrea. The Ministry of Health developed a national strategy for FGM in 1998, but there has been no direct implementation by the ministry. Ms Zeria suggested that FGM was not high on the government's priorities – partly due to the war with Ethiopia and partly due to the lack of finances allocated to the issue. There have been attempts to work with religious leaders – especially by NCA – but no specific material has been developed for religious leaders. The Ministry of Health (MoH) is raising awareness about FGM currently through the National Union of Eritrean Women (NUEW) and the National Union of Eritrean Youth and Students (NUEYS), but as yet, there is no specific document that deals with FGM. There is political will, but this is not given priority. The health approach is the prevalent approach used to address FGM. Ms Zerai explained that within the broader programme of violence against women, NCA and the NUEW have worked with the police, teachers, school officials, and various representatives of ministries.

Ms Zerai felt that it was difficult to describe the trend of FGM in Eritrea. During the war, in the army, there was awareness-raising of the problems resulting from FGM. Some of the ex-combatants came back and stopped the practice. Others came back and continued to have their daughters circumcised. From recent studies, it seems families are stopping, especially parents who are health professionals. There is a slight trend towards the reduction of the practice – probably due to more awareness-raising programmes. Ms Zerai thinks that within five to six years, there will be a move from Type III to Type I, but a lot of work is needed to bring about complete eradication of FGM in Eritrea.

Ms Zerai explained that whilst there has been awareness-raising, many people have not internalised the anti-FGM message and behaviour has not changed.

Mr Osman (NUEYS) reported on the prevalence of FGM in Eritrea. In 1995, the prevalence rate of FGM was 95 percent and in 2001 it was 89 percent. Between these two DHSs, there has been a number of awareness campaigns and training to combat FGM. He explained that the target for the NUEYS has been the younger generation, and they have examined the role of women, and traditions, and have sought behaviour change in this generation. The NUEYS uses teachers, as they already exert a powerful influence on students – they are already those who are trained at getting messages across and disseminating information. The NUEYS Gender Unit has made gender-based violence, early marriage, domestic violence, and FGM key issues in its programme.

Dr Gardiner of the United Nations Population Fund (UNFPA), noted that the UNFPA is often in a position where it is questioning traditional practices that affect the health and well-being of women, when trying to improve reproductive health.

She felt that there were two different aspects to FGM, depending on whether an activity was taking place in a home country or in a country where the practising community was a migrant one. In home country situations, it would appear that community education works. In countries where the practising community is an immigrant one, the fear of loss of identity, coupled with feelings of racial or ethnic inferiority, often causes these communities to continue the practice.

Dr Gardiner wondered whether the way the question on FGM is sometimes posed might make people more defensive: "*Why don't you want to end the practice?*" She added that the UNFPA, in collaboration with UNICEF and the WHO, will develop a joint programme for working on FGM in Eritrea. Presently, the UNFPA is working with NORAD to finance the NUEYS to initiate more work on FGM.

Ms Andehaimam (NUEW) explained that the Ministry of Health has decided that the policy for FGM eradication will be to raise awareness of FGM and its consequent problems at the community level, and to provide training. The government will then monitor the attitudes and behaviour of members of the community as a result of the training. If there is no significant change, then a specific law against the practice will be enforced. A law will not be the first recourse, but the last. She added that the MoH and others feel that the provisions of the Convention on the Rights of the Child (CRC) and the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW) already provide sufficient protection for children and women. Eritrea has already signed and ratified both these international declarations. The focus is now to work with the community to raise awareness and change behaviour in order to halt harmful traditional practices, such as FGM. She said that the prevalence rate for FGM is falling. There is a growing tendency for young girls to want to say that they have not been circumcised. They would like them to break the silence, but many are often afraid of ridicule, and pressure to conform and be circumcised. Young girls are often fearful about what will happen to them if they publicly say they are not cut, for there is much concern about being culturally acceptable to the group.

Ms Mehary (NCA) said that the prevalence rate is 89 percent. She felt it is now acceptable to talk about the practice, and that this is important for its elimination. The problem previously had been a lack of awareness, which made the situation complicated. She said that now, a lot more people in Eritrea are aware of the complications resulting from FGM, especially Type III. Even with fanatic religious groups, the outcome is promising. She imagines that in some 10 years' time, the practice will be eliminated in Eritrea.

Ms Hoefers (UNICEF) reported that in Eritrea, there was a 6 percent decline in FGM prevalence between 1995 and 2002. She added that UNICEF's main activity has been community education. It would seem that people are receptive to discontinuing the practice. In urban areas, the practice is much less common than in rural areas. Ms Hoefers said that the focus

on youth has concentrated on education interventions. The reasoning is that the more educated the mothers are, the less likely it will be that they want to cut their daughters, if they believe that this is going to harm their child. Although there is still a persistent downward trend between the two DHS surveys 1997 (95 percent) and 2002 (89 percent), the practice is less common in the towns and cities than in rural areas.

Ms Hoefers reported that UNICEF plans to re-think its mode of operation concerning FGM in Eritrea and hopes to be part of a joint plan of action with the UNFPA and the WHO. UNICEF hopes to find new ways and approaches, and possibly form a human-based approach to programming. One idea they are presently considering is to work in high FGM prevalence communities by raising awareness of the rights of children as well as the responsibility of protecting children from violence. The focus would be to look for suggestions and solutions from the communities as to what kind of strategies are needed to effectively eradicate FGM.

Work by the government of Eritrea

Mr Osman (NUEYS) reported that in 1995, Eritrea signed the Convention on the Rights of the Child and formed a National FGM Committee that is chaired by the Ministry of Health. However, there is no specific law against FGM. Instead, the government's view is that behaviour change can be brought about as a result of awareness-raising and sensitisation campaigns where people are invited to change their behaviour. In 1996, the government issued a clear policy that stated FGM as a health problem. Every organisation active in anti-FGM work is a member of this committee. The NUEYS, UNICEF, and the UNFPA provide technical support, and church-based organisations such as NCA work on clarifying issues with religious leaders. With regard to information dissemination of anti-FGM messages, the MoH also works in conjunction with the Ministry of Information on TV and radio messages. They support radio discussions inviting religious, social, and health workers. This is a powerful medium, as a very large part of the population listens to the radio.

Ms Andehaimam (NUEW) supported the government's position that there presently should be no law in Eritrea prohibiting the practice. She was of the opinion that the creation of a specific law against FGM should be accompanied by sensitisation, awareness-raising, and education as to why the practice should stop, otherwise the practice could go underground.

Gender relations

Whilst it is possible to talk about sexuality and FGM in mixed groups in urban areas, Ms Zerai (NCA) found that in rural areas, it is always best to separate the sexes, for in the presence of men, the women do not speak. Age is another factor to consider – in the presence of older people, the younger ones keep quiet, as they have been taught to respect and listen to the older people. It is also often the case that when youngsters talk, they fail to influence the older people, Ms Zerai said.

In her experience, Ms Mehary (NCA) said that discussions on FGM and sexuality are usually free and people generally participate well. Ms Mehary concluded by saying that people who are fully aware of the complications resulting from FGM will not want to continue the practice.

Are uncircumcised girls ostracised within their communities?

Ms Zerai (NCA) explained that in Eritrea girls are traditionally cut between the ages of one week and one month. It is a private, individual treatment of girls. Hence it is very difficult to know if a girl has been circumcised. Ms Zerai pointed out that it is likely that very little information is available about girls who have not been circumcised. This would be the parents' decision in order to protect the girl from ridicule and insult. She also suggested that the girls themselves – particularly those below the age of 20 – might not be aware that they have not been circumcised.

Ms Mehary (NCA) said that the general tendency is that uncircumcised girls are not considered acceptable for marriage. She reported that NCA has begun to monitor the extent and severity of cutting in communities where they work, by asking how many girls have been born in a particular year. They also ask how many have been circumcised and how many have not. In some instances, people have moved from Type III to Type I. After the showing of a video on the harmful effects of FGM, people often also decide to stop Type I.

Information about the Diaspora

Message to those who wish to continue the practice

NUEW: "*This is a harmful traditional practice. It hurts the child as well as the woman. After each delivery, you also re-infibulate. You should not practise this – it is against our rights as women. The government of Eritrea is committed to observing and implementing the CRC and the CEDAW and is convinced therefore that we as women under the protection of these laws will "choose right" and not choose to circumcise. Let's stop the practice! Why are we against our own rights to protect ourselves, our communities and our families? We know also that the practice jeopardises women's health and puts them at risk of death. If a woman dies, this is an economic burden on the government, and on the community. Also mothers – women – are necessary key players in development."*

NCA: "*It is not acceptable to come here and cut. You need to fight with awareness.*"

UNICEF: "*It is a harmful traditional practice.*"

Ms Hoefers said one way to change the minds of parents would be to show them pictures of girls who have been cut or ask girls who have been cut to talk about their experiences and problems as a result of cutting. She felt this might be a method to convince parents that the practice is bad.

Do people in the homelands know about laws against FGM in European countries and the Diaspora?

Ms Zerai (NCA) said that in her opinion, very few people know laws exist in Europe and the Diaspora which prohibit FGM, and most people certainly are not aware of the details of these laws. She explained that in the 1980s, the Eritrean Liberation Front tried to pass laws. In reality, these laws did not work, as people who wanted to continue circumcising their daughters went to Sudan for circumcision and then returned to Eritrea. Ms Zerai does not believe in laws – because FGM is in the private domain. Her experience is that the Eritrean mother will also challenge the law by questioning what the law has to do with her daughter: "*She is my daughter, the government has nothing to do with my daughter*".

Ms Andehaimam (NUEW) reported that all training conducted by the union mentions that FGM is illegal in other countries.

Ms Mehary (NCA) was aware of laws in Europe prohibiting the practice of FGM. She defended the position of the government of Eritrea not to have a specific law against FGM at this stage. She felt it is crucial that people first become aware of the problems that FGM causes, are sensitised and informed, and before gathering evidence of behaviour change. If necessary, there can be laws after this process. She also said that NCA does mention that FGM is illegal in other countries in all training.

Ms Hoefers (UNICEF) did not believe that people know about laws against the practice in Europe.

Movement of girls from the Diaspora back to their homelands for circumcision

Ms Zerai (NCA) said that Eritreans who left for economic or political reasons are still very strongly influenced by their parents in Eritrea. These parents emphasise the importance of continuing to practise cultural and religious traditions with which the children (living in the Diaspora) feel obliged to comply. The parents at home would normally influence their children in the Diaspora to continue the practice of FGM. She added that the situation would be different for those in the Diaspora who had left Eritrea for education. These families, in her opinion, are less likely to be bound to obey their parents in Eritrea. They are more likely to consider other factors that influence their decision whether their daughters should be cut. She concluded that whenever parents from the Diaspora return to Eritrea with a newborn baby girl, they do circumcise her, the type of circumcision depending on the tribe.

Ms Andehaimam (NUEW) believes that whilst families do return, they do not come back to have their girls cut. She explained that there are usually quite a number of activities, tours, and festivals that take place over the summer holidays, when Eritreans living in other countries are more likely to return with their families. They tour historical places, there is a Youth Festival at Massawa, and one would expect that they are too busy to find people who will perform circumcision. In her view, she does not believe that when young Eritrean girls living overseas come back on holidays, they are cut. She was not concerned about girls from abroad being circumcised in Eritrea.

Ms Mehary (NCA) said that she had not heard of or seen Eritrean girls from European or other countries in the Diaspora coming back and being cut.

Ms Hoefers (UNICEF) thought parents cut their daughters to protect them, and it is particularly the older women who continue the practice. The pressure from grandmothers can be very strong in influencing the parents to cut their daughters. Parents are often not in a position to refuse. Grandparents hold very strong decision-making powers in families. The pressure to circumcise comes from grandmothers. Sometimes, grandparents act as caregivers when the parents go abroad and study, or when grandchildren are sent home for the summer holidays. In this scenario, even though parents would not want their daughters to be cut, it has been known for the parents to come back and find that their daughter has been cut.

Role of the Diaspora in ending FGM

Ms Zerai (NCA) felt that there is a need to raise awareness of activities taking place to stop the practice by those in the Diaspora. Through organised action groups in the Diaspora, people from Eritrea could exchange information and ideas about the practice.

Activities by organisations

Work with religious leaders

Ms Zerai (NCA) reported that although religious leaders assembled in workshops or seminars will agree that FGM is an unnecessary practice, they would often not take this message to the mosques or churches. Ms Zerai suggested that FGM needs to have a prominence and visibility in the churches and mosques, in the same way that HIV/AIDS has today in Eritrea.

The NUEW conducted a special campaign for religious leaders, which included training. Religious leaders agreed that there was no basis in either the Bible or the Koran for the practice of FGM. By 2003, both imams and preachers had started speaking out in mosques and churches against the practice. This was very good, as people began to understand that FGM was not a religious requirement, but was a problem of tradition and culture.

Ms Mehary (NCA) reported that NCA discovered that Type I was practised by people attending church. They conducted a workshop for 45 priests in the Orthodox Church entitled "*FGM and Gender*". This was held for two days in the Bishop's compound. The facilitator began by asking what a harmful traditional practice is, and about the nature of violence, and showed a video on the consequences of FGM. One of the outcomes was that the religious leaders agreed to take the message on FGM and its consequences back to their followers and talk about it. NCA continued their work with religious leaders by holding another workshop for religious leaders from 10 villages in Massawa over two days. The first day was directed at the sheikhs and imams; the second day at administrators and circumcisers about developing income-generating activities for the latter.

Work in the community with children and youth

The union (NUEW) conducted workshops for women and youth from each zone, training peer educators who were used to mobilise, advocate, and train the community. Assessment showed that some people had stopped the practice and circumcisers recognised that the practice was harmful. It also became apparent to the union that the community found it hard to accept isolated anti-FGM messages. The union thus decided to integrate FGM into other issues, such as reproductive health, safe motherhood and children, gender and development, and the health and rights of women and children. This approach was more effective, particularly as it included collaboration with the Ministry of Health.

Work with men and religious leaders

Ms Mehary (NCA) reported that NCA conducted a workshop entitled "*FGM and Community Development*". During debates, the men in the workshop said that women practised FGM; they in effect knew nothing about it. The religious leaders said Type III cutting (which they call pharonic) is a sin, but that Type I (sunna) is mentioned in the Koran. One of the recommendations of the workshop from the communities was that they wanted more training on FGM. As a result, therefore, two people were identified from each village, one male and one female. These people, 20 in all, were trained as mobilisers. The training – which was conducted by a Ministry of Health salaried, professional nurse _ was on FGM, its consequences, how it is performed, and gender and community development. The training lasted for two weeks, of which 10 days were dedicated solely to FGM. The mobilisers in turn provided training for various community members twice a week for one year. They were called to mosques, student groups, and women's groups. They also had access to MoH clinics to which they could refer women. The work of the mobilisers was monitored and assessed every three months by NCA. A video was made by NCA, in collaboration with the MoH, in which various people were interviewed. This video was then used as a tool to initiate discussions in the community after its showing. One of the outcomes of this was that some members of the community, who previously thought that Type I (sunna) was mentioned in the Koran, changed their minds and did not see the need to practise any form of FGM at all. NCA therefore felt that the video was very helpful for prevention, and powerful enough to convince people to stop the practice. The video has since been translated into four languages.

Work with the police and justice system

The union (NUEW) conducted workshops for members of the police and the justice system to which they invited girls who had problems as a result of FGM to speak. The aim of the meetings was to assist the police and justice system to develop ways of responding when matters relating to FGM were reported. The union believed the professionals in this group needed to know and understand the problems the girls faced. The onus was also on a community response, which would include religious and community leaders.

The workshop highlighted how FGM raised different issues for men and women.

Present activities by NUEYS

Mr Osman explained that the NUEYS has produced several posters, leaflets, and other IEC material, which have been used at national and sub-regional levels. The distribution of these materials has also been accompanied by training courses. A variety of information and communication means and channels is used for anti-FGM messages. Some of these include mass campaign activities, short radio messages, film, drama, and music. For youth workshops, they use folk media programmes, drama, music, circus, and puppetry.

Training has been provided for anti-FGM groups in junior and high schools. These clubs, run by students and teachers, form part of the schools' extra-curricula activities. The clubs run awareness campaigns, facilitate discussions and debates on FGM, and present video showings on case studies on anti-FGM work taking place in other countries.

Students will often comment that they are convinced that the practice has harmful health and psychological effects, but feel they have to continue the practice because there is a religious and social requirement to do so.

Present activities by NUEW

Ms Andehaimam explained that the aim of the union is to eradicate harmful traditional practices. The union started work on HTPs in the 1970s. It was not until 1996 that another activity was planned and executed with the UNFPA. As a result of this activity, the union decided to work with campaign leaders and other stakeholders in FGM.

In the beginning, they trained only women; schoolgirls, workers, and housewives as a group. But then they realised that it is the community that is responsible, not only the girl. There was much fear as people were not '*educated*' and felt that to be culturally acceptable, they had to bow to pressure and have their girls circumcised.

Ms Andehaimam reported that they are now developing a network with the MoH, the Ministry of Labour, and Human Workforce to develop NUEW activities with mothers, grandmothers, and extended family members. They are also working to advocate a gender and development policy from within the MoH. She added that there is now a good working relationship between union branches and health clinics in some of the southern regions where the NUEW operates, and that the MoH has provided FGM training in clinics for health promoters and other professionals.

Present activities by NCA

Ms Mehary explained that NCA started activities on FGM in the northern and southern Red Sea area, and near the border with Sudan. She explained that, initially, NCA was concerned about working against FGM, as this is a strongly Muslim area and they practise Type III. However, NCA already had a project in the northern Red Sea area on agriculture and water, which

has been going for some years. As there was already an existing relationship with members of the communities, the decision was taken to begin work against FGM. They began with 10 villages, working with administrators, police officers, and religious leaders, as well as women from women's associations.

Present activities by UNICEF

Ms Hoefers reported that UNICEF has been a donor to FGM projects in Eritrea and supports youth sensitisation programmes, implemented by the NUEYS, as today's youth are tomorrow's parents. She explained that university students work with their fellow students in training institutes, especially teachers and nurses, in sensitising and raising awareness about FGM and its consequences. This is run by the students for the students. The MoH and the MoE participate by providing funds for information, education, and communication (IEC) materials. This is part of the students' extra-curricula activities.

Conclusions

Apart from one particular ethnic group in the region visited, there is a general trend that shows a drop in the prevalence rate of the practice. It would appear that a combination of educating against the practice and consistent reinforcement messages amongst practising groups is effective in bringing about change.

There are unexpected outcomes of some interventions which still need to be addressed adequately, such as what should be done with ex-circumcisers; how to empower girls, mothers, and their families who decide that they do not want to be cut but face real ostracism or pressure from their communities to continue the practice; and what should be done for girls who often are under physical and other threats because they refuse to be circumcised.

In general, in the countries visited, there is little knowledge about laws in European and other countries. People – activists – working with FGM as an issue seem to have some idea that is it legally forbidden, but the general populace does not. Whilst the law provides a preventive backdrop for protecting uncut girls, it is generally believed that the law by itself is not adequate for ending the practice and protecting girls. It needs to be enforced in an environment of clear, consistent education and training about the practice and its effects, for target groups interacting with communities likely to want to continue the practice and these communities themselves, whilst encouraging the practising communities to find ways of addressing the real issues parents face in instilling cultural values and identity in their daughters. There is a real danger that laws in Europe are being circumvented as families in European and other countries choose to send their daughters back to their homelands for circumcision. Recent research documents appear to provide some evidence for this. This is worrying, as it suggests that communities are not convinced that they should end the practice, and instead find ways of avoiding legal punishment.

Those living in the Diaspora are often unaware of activities taking place in the homelands to end the practice. There appears to be a lack of information between groups working to prevent or end the practice in Europe and Africa. This area of activity was generally very weak, and where there was some activity, it was sporadic, almost anecdotal. Activities to prevent or end the practice in European and other countries would benefit greatly from continual feedback through established links with activities taking place to end the practice in home countries in Africa. Partnerships between anti-FGM groups in Africa and the Diaspora in order to nurture a constant flow of information through regular contacts and visits in both directions could be valuable in enabling change in the practice.

Finally, youth both in the Diaspora and the home countries seems more open to discuss issues of sexuality and FGM. This is a feature that could be advantageously used to bring about a change of attitude in the next generation to end the practice. It seems, however, that with the older generation,

activists seeking behaviour change should bear in mind that effective interventions to bring about permanent behaviour change occur with same-sex and same-age groups.

Appendix

Appendix 1

Contacts

Ethiopia

The National Committee on Traditional Practices (NCTPE)

Addis Ababa Fistula Hospital

The Ethiopian Media Women's Association

The Ethiopian Women Lawyers' Association

GTZ

Kenya

The Association of Media Women in Kenya

The Coalition on Violence Against Women (COVAW)

The Federation of Women Lawyers

The African Women's Development and Communication Network (FEMNET)

Ian Askew

UNFPA

UNICEF

Norwegian People's Aid

National Focal Point for FGM

Somali midwife

The World Bank

The Population Council

UNICEF, Somali

The MoH, Kenya and GTZ Collaboration

The ADRA

Equality Now

Norwegian Church Aid Somalia, based in Kenya

Eritrea

Social and Gender Consultant for Norwegian Church Aid

The National Union of Eritrean Youth and Students

The UNFPA

The Eritrea Union of Women

Norwegian Church Aid, Eritrea

UNICEF

Appendix 2

Questions Asked

FGM IN THE COUNTRY –OVERALL PICTURE

- Do you see any trend towards the prevention or the eradication of the practice?
- What has been the trend in the practice? Is it slowing down or ending, or are more girls and women being circumcised?
- What would you say about the movement to end FGM? What are your impressions of the work to end FGM in ….. by your organisation and others?
- Do you know that there is a law against FGM in European countries? Do you know what the law says?

WORK BY THE GOVERNMENT

- What policies are in place by the government, and which governmental bodies or institutions implement these policies?
- What is being done to prevent or end the practice?
- What has been the result of efforts and how has this been measured?
- What is the evidence of prevention or eradication of FGM?
- What has the government's position been, how has it worked to prevent or end FGM?
- What has the government role been in relation to grassroots organisations?

INFORMATION ON THE DIASPORA

- What do you know about people who return to …. from Europe or the Diaspora to have their daughters circumcised? Where do they go? Do you know whether they talk about the practice?
- What would you say to those in the Diaspora who want to continue the practice? (Especially those who return to Africa in order to circumcise their daughters?)
- What role do you think Diaspora community organisations play in helping to protect or provide care for women from their communities of origin? Do you think the Diaspora has a role to play, if nothing is currently happening?

DISSEMINATION OF INFORMATION ON FGM

- Gather information on media training concerning FGM or media policies in use by groups, organisations, and projects

Details for the specified groups in the Project Plan

Activity
School personnel • Has any work been done in schools? • Who were the target groups? • What information did you use and how was it presented? • How was it received by teachers, etc., and how was it received by pupils? • What have the results been? • Did you provide any training for those in the target groups? • Has any of the material been integrated into on-the-job training for school personnel? • Has any of the material been developed into material for teaching pupils, and if so, in what subjects? • Again, what have the results been of any of these activities?
National prosecutor and police authority • Has any material been developed and produced for use by the national prosecution service or the police? • If so, may we please have a copy to take with us? • Is training on FGM offered to the national prosecution service or police authority? • Is training part of their standard training at police academy or part of the training of prosecutors? ALIGN ON LEFT Are there any policy guidelines or procedure manuals that we can look at?
Religious leaders • Has any work been done with religious leaders? Muslim as well as Christian? • If so, what has the result been? • Has there been any debate on this issue by religious leaders? Do you know what their rulings are and how they have been received? • Do you know of any training that has been provided by religious leaders and what the results of these efforts have been? • Has any material been produced for religious leaders that we can have a copy of?
Girls who have not been circumcised • Do you have any details of what it is like for girls who have not been circumcised? • Are they ostracised in any way by their communities? • What strategies have you used to provide support and advice for them? • What have the results of your work been?