Vergleichende Studie zur Praxis weiblicher Genitalverstümmelung und Strategien zu ihrer
Beendigung in Kenia, Ghana und Ägypten

Dissertation

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A Comparative study of Female Genital Mutilation practices and abandonment strategies in Kenya, Ghana and Egypt

Dissertation

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1. Declaration

I hereby declare that this submission is my own work. To the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma of the university or other institute of higher learning, except where due acknowledgment has been made.

Idah Nabateregga

2. Acknowledgement

3. Dedication

This Doctoral thesis is a special dedication to the passed away souls: my late husband Moses Mpalanyi (died 24.10.2013) and my lovely Aunt - Ruth Nabateregga (died 07.11.2014). You are the living embodiment of John Wesley's words: 'Do all the good you can, by all the means you can, in all the ways you can…' You certainly have done the best for me and I am so thankful. May you both rest in Peace.

May the pains of this doctoral journey be translated into gains to my son and my whole family for their commitment, support, care and love.

COMPARATIVE STUDY OF FGM PRACTICES AND ABANDONMENT STRATEGIES IN KENYA, GHANA AND EGYPT

4. Table of Content

5. List of abbreviations

AAG-Action Aid Ghana
ACRWC- African Charter on the Rights and Welfare of Children
AMWIK-Association of Media Women in Kenya
AU- African Union
CBOs- Community Based Organizations
CBS- Central Bureau of Statistics
CPC- Children Protection Committees
CSO- Civil Society Organizations
DHS- Demographic and Health Surveys
ECOSOC- United Nations Economic and Social Council
EDHS-Egypt Demographic Health Surveys
EU- European Union
FBOs- Faith Based Organizations
FGM/C-Female Genital Mutilation/Circumcision
FIDA- Federation of Women Lawyers
GAWW- Ghana Association of Women Welfare
GHS- Ghana Health Service
GHS- Ghana Health Service
HRNGOs- Human Rights Non-Government Organizations
IAC- Inter African Committee on Traditional Practices Affecting the Health of Women and Children
ICPD-International Conference on Population and Development
INGOs-International Government Organizations
KDHS- Kenya Demographic Health Surveys
KHRC- Kenya Human Rights Commission
MGCSD- Minister of Gender, Children, and Social Development
MICS- Multi Indicator Cluster Survey
MOH- Ministry of Health
MPHS- Ministry of Public Health and Sanitation
MYWO- Maendeleo ya Wanawake Organization
NCCM- The National Council of Childhood and Motherhood
NGOs- Non-government Organizations
NHRC- Navrongo Health Research Center
PAI- Population Action International
UDHR-Universal Declaration of Human Rights
UNCRC- United Nations Children Rights Convention
UNDHR-United Nations Declarations on Human Rights
UNESCO- United Nations Educational, Scientific and Cultural Organization
UNICEF-United Nations Children's Fund
UNPFA- United Nations Population Fund
WHO- World Health Organisation

6. Abstracts

German

Kurzfassung zur Dissertation mit dem Thema

Vergleichende Studie zum Thema Praxis weiblicher Genitalverstümmelung und Strategien zu ihrer Beendigung in Kenia, Ghana und Ägypten.

Weibliche Genitalverstümmelung ist eine traditionelle Praxis, die die teilweise oder vollständige Entfernung weiblicher Geschlechtsorgane (bzw. die Verletzung dieser) aus kulturellen und/oder nicht-therapeutischen Gründen bezeichnet (WHO 1998, 2008). Sie beinhaltet Praktiken des Verschließens und des Entfernens der Geschlechtsorgane und der Klitoris, und ist eng verkettet mit Identität, Sexualität, Geschlecht und Macht. Etwa 3 Millionen Mädchen jährlich, insbesondere am Horn von Afrika, sind von Beschneidung bedroht. Die Praktiken sind nicht nur in Afrika in hohem Maß verbreitet, sondern finden auch im Nahen Osten Anwendung. Des Weiteren wird Mädchenbeschneidung auch in Europa, den USA und anderen Teilen der Welt zu einer Praxis (und Problematik) bestimmter kultureller Bräuche und Identität.

Wie die Traditionen des Füßebindens (zum Erzeugen des sog. Lotosfußes) im ehemaligen chinesischen Kaiserreich, der Heiratsaussteuer und der Kindshochzeiten, repräsentiert auch die Beschneidung ein Mittel gesellschaftlicher Kontrolle über Mädchen und Frauen, mit dem Effekt der Aufrechterhaltung normativer Geschlechterrollen, welche Mädchen und Frauen gegenüber Jungen und Männern benachteiligen und ungleich machen (Macky Gerry 1996). Mütter sozialisieren ihre Töchter kontinuierlich dahingehend, den Brauch beizubehalten und die Verstümmelung nicht als Strafe anzusehen sondern als Ausdruck von Liebe wahrzunehmen, der dazu verhelfe, ehefähig zu sein, ‚Ehre' und Jungfräulichkeit zu bewahren; der aus hygienischen Gründen ausgeübt werde, als Initiationsritus auf dem Weg zum Erwachsensein, etc. (Comfort Momoh 2005; Abusharaf 2006) – also für ein gutes Leben relevante Begründungen. Verübt an Minderjährigen vor der Pubertät, ohne jegliche Zustimmung des Kindes, verletzt weibliche Genitalverstümmelung das Gleichstellungsrecht der Mädchen und setzt sie gesundheitlichen Risiken aus. Folglich werden so die menschenrechtlichen Prinzipien von Gleichstellung und Nicht-Diskriminierung gebrochen.

Derzeit lassen sich verschiedene Varianten und deutliche Rückgänge unter praktizierenden Ländern (laut DHS- und MICS-Daten von 5% auf 3,8% in Ghana, von 32% auf 27,1% in Kenia, zuletzt von 97% auf 91,1% in Ägypten) beobachten, jedoch bleibt die Fortsetzung der

Praxis unverständlich. Der Versuch, Mädchenbeschneidung endgültig zu beenden, wird immer mehr zu einem Aufgabenschwerpunkt von Präventionskampagnen vor allem in Afrika. Zahlreiche Studien bestätigen den Schaden durch die Praxis, und stellen zugleich Wege zu ihrer Beseitigung vor. Weibliche Genitalverstümmelung ist auch von den Vereinten Nationen als Teil der Millennium-Entwicklungsziele priorisiert worden, mit dem Ziel, die Förderung der Gleichstellung, allgemeine Förderung von Frauen und die Verbesserung der Gesundheit von Müttern voranzutreiben (UN 2005). In den in ihrer Veröffentlichung "Weibliche Genitalverstümmelung: eine statistische Exploration" dargelegten Empfehlungen der UNICEF (2005) werden Gegner der Praxis aufgerufen, die Veränderung von Denkweisen als eine Möglichkeit programmatischer Intervention zu berücksichtigen. Im Ergebnis verfolgen kultursensible Bemühungen zur Beendigung der Frauenbeschneidung, wie die der NRO TOSTAN im Senegal, den Ansatz alternativer Übergangsriten, welcher sich in Kenia als erfolgreich erwiesen hat. Doch trotz seit fast zehn Jahren laufender Kampagnen mit starker Spendenfinanzierung wird weibliche Genitalverstümmelung in vielen afrikanischen Ländern nach wie vor intensiv praktiziert.

Das Hauptziel dieser Studie ist es daher, Strategien zur Aufgabe der Mädchenbeschneidung zu analysieren sowie Schlupflöcher zu identifizieren, die mutmaßlich zum Fortbestand der Praxis (trotz großer Anstrengungen zur Bekämpfung) beigetragen haben. Dazu werden vor allem verschiedene Wege zum Verzicht auf weibliche Genitalverstümmelung untersucht und ihre Wirksamkeit beurteilt. Auch die Rolle von Nichtregierungsorganisationen, deren Projektabwicklung und Wirksamkeit werden analysiert, um Erfolge und Schwächen in der Umsetzung der Projekte zu identifizieren. Zudem setze ich den Schwachstellen mit der Einführung eines **akkommodierenden und teilnehmenden Ansatzes: „Netzwerkübergreifende Projekte mit der und für die Gemeinschaft"** etwas entgegen. Der Projektrahmenansatz wird als empfohlene Maßnahme gegen Ende der Arbeit vorgestellt. Aufgrund begrenzter Zeit und Ressourcen für die Forschung und der limitierten Seitenanzahl wird lediglich eine einführende theoretische Perspektive angeboten. Allerdings beabsichtige ich, diesen Ansatz in meiner weiteren Laufbahn auszubauen. Für die Studie wurden Diskurse um die Praktiken weiblicher Genitalverstümmelung und Strategien zu ihrer Beseitigung in Kenia, Ghana und Ägypten vergleichend untersucht. Theoretische Diskurse werden mit Hilfe der Erkenntnisse aus der Feldforschung in empirische umgewandelt, um sie zueinander in Beziehung zu setzen und der Frage zu begegnen: **"Warum gibt es trotz umfangreicher Maßnahmen keine signifikante Veränderung in Richtung Beendigung der Praxis?"**

Die Arbeit ist in drei Teile gegliedert. Teil I (Einführung), Kapitel 1 führt in das Thema weibliche Genitalverstümmelung ein und beschreibt Verbreitung sowie Art und Weise der Praxis. Teil II beschreibt die theoretischen Rahmenbedingungen in den Kapiteln 2 bis 5. Kapitel 2 - die feministische Soziologie weiblicher Genitalverstümmelung - zielt darauf ab, zu enthüllen, wie die Praxis im sozialen Gebilde innerhalb der Gemeinden funktioniert. Kapitel 3 legt den ganzheitlichen Menschenrechtsdiskurs sowie andere Ansätze zur Diskussion von Mädchenbeschneidung dar. Kapitel 4 behandelt einschlägig aktive NRO. Kapitel 5 zeigt Gründe für den Fortbestand der Praxis auf. Teil III beschäftigt sich in den Kapiteln 6 bis 11 mit der empirischen Analyse. Kapitel 6 gibt einen Überblick über die methodischen Verfahren, die in der Studie verwendet werden. Es folgen Länderfallstudien: Kenia in Kapitel 7, Ghana in Kapitel 8 und Ägypten in Kapitel 9. Kapitel 10 umfasst die vergleichende Analyse der drei Fallstudien. Kapitel 11 löst Diskussionen und neue Erkenntnisse auf, stellt den "akkommodierenden Ansatz: Netzwerkübergreifende Projekte mit der und für die Gemeinschaft" vor, und hat Raum für abschließende Bemerkungen.

Methoden: Die Studie verwendet sowohl qualitative als auch quantitative Forschungsmethoden. Für den theoretischen Rahmen kam einschlägige wissenschaftliche Literatur aus internationalen und nationalen Datenbanken, wissenschaftlichen Studien einschließlich Zeitschriften, Büchern, Online-Dokumenten und anderer relevanter Literatur zum Einsatz. Die empirischen Perspektiven speisen sich aus mittels Interviews, Fragebögen und Gruppendiskussionen gesammelten Informationen.

Umfang: Wesentlicher Bestandteil der Arbeit sind empirisch erfasste Ansichten von Männern und Frauen ab 15 Jahren in Kenia, Ghana und Ägypten. Zusätzlich stütze ich mich auf Perspektiven von NRO sowie die der Regierungen der untersuchten Länder. Die Auswahl der Länder erfolgte stellvertretend a) für die Regionen Ost-Afrika, West-Afrika und Nordafrika, b) für die folgenden Prävalenzraten: Gruppe 1 (80% und mehr, hier Ägypten), Gruppe 2 (25% - 79%, hier Kenia) und Gruppe 3 (1% - 24%, vertreten durch Ghana). Folgende Gemeinden wurden in Ägypten untersucht: Fayoum (Salakhana und Gharb Tarbawiyat), Beni Suef (Busch-Gemeinschaft), Kairo (Marg Jadida Gemeinschaft) und Assiut-Zentral. In Ghana wurde die Forschung im oberen Ostgebiet, in den Gemeinden von Sirigu, Kandiga und Manyoro durchgeführt. In Kenia wurden Feldstudien in Nairobi, Namanga, Kajiado, Maisikisha, Ibisil, Mailwa, Longoswa, Narok, den Illchamus in Marigat und Garisa in den Gemeinden von Maasai und Somali vorgenommen.

Hinsichtlich der sozialdemografischen Variablen waren die meisten Befragten verheiratet, sehr wenige waren ledig, geschieden oder verwitwet. Alle waren 15 Jahre oder älter. In Kenia wurden 73% Frauen und 25% Männer schriftlich befragt (2% der Befragten gaben ihr Geschlecht nicht an), in Ghana 96% Frauen und 4% Männer, in Ägypten 73,04% Frauen und 26,96% Männer. Die meisten der Studienteilnehmer hatten entweder ihr gesamtes Leben oder aber mehr als 10 Jahre in dem Gebiet verbracht, in dem sie befragt wurden.

Ergebnisse: Die Anzahl der Frauen, die sich der Genitalverstümmelung „unterwerfen", schwankt je nach folgenden Faktoren: a) Familienstand: Im Vergleich zu ledigen Frauen sind Verheiratete häufiger beschnitten. b) Alter: Unter jungen Frauen ist das Thema weniger verbreitet als bei Frauen höheren Alters. c) Bildung: Mit steigendem Bildungsniveau sinkt der Anteil der beschnittenen Frauen. d) Arbeit: Erwerbstätige Frauen haben höhere Chancen, der Genitalverstümmelung zu entgehen. Des Weiteren gibt es Unterschiede im Umfang der Beschneidung; so findet die Infibulation (das Verschließen der Geschlechtsorgane) hauptsächlich in Kenia Anwendung, die Exzision in Ghana, und Klitoridektomie (das Entfernen der Klitoris) in Ägypten. Auch der Rahmen der Durchführung unterscheidet sich von Gemeinde zu Gemeinde. In Kenia wird in verschiedenen Gemeinden eine bestimmte Art der Genitalverstümmelung aus bestimmten Gründen in verschiedenen Altersstufen durchgeführt, während Gemeinden in Ghana und Ägypten die Praxis - unabhängig von der Art – gleich begründen. Die oben genannten Punkte c) und d) sind in Ägypten weniger relevant; hier wird weibliche Genitalverstümmelung unabhängig von sozialem Hintergrund, Bildungsniveau, geografischer Lage usw. praktiziert. Die Befragten hielten Beschneidung in Kenia zu 49% für immer noch üblich, in Ägypten zu 53.04% und in Ghana zu 0% (4% ohne Angabe). Nur 37% der befragten Frauen in Kenia waren beschnitten, verglichen mit 74% in Ghana und 83.33% in Ägypten. Zum Zeitpunkt des Eingriffs waren die Befragten in Kenia meist 11 bis 14 Jahre alt, in Ghana 18 Jahre und älter, und in Ägypten zwischen 4 und 10.

Allen drei Ländern gemein ist, dass der Verzicht auf Beschneidung zu schlechteren sozialen Beziehungen einerseits, zu weniger Familienstreitigkeiten andererseits führt. Genitalverstümmelung wird als Teil der Kultur vor allem durch traditionelle Beschneiderinnen praktiziert. Die Durchführung wird in Ägypten eher religiös begründet, in Ghana eher mit dem Einfluss umliegender Staaten (z.B. Burkina Faso). In Kenia wiederum können keine genauen Ursprünge genannt werden; lediglich der Einfluss früherer Generationen wird angeführt. Nur Ägypten hat einen hohen Anteil medizinisch ausgebildeter Personen unter den Beschneidern; in den anderen Ländern wird eine medizinische

Entwicklung nicht angegeben. Die Entscheidung zur Beschneidung fällt in der Regel innerhalb der Familien, wobei in Ghana fast die Hälfte der Befragten angab, sie selbst getroffen zu haben. In Kenia und Ghana berichtete ein großer Teil der Befragten von medizinischen Komplikationen, während in Ägypten die Mehrzahl angab, keine erfahren zu haben. Der Zeitpunkt der Durchführung ist unterschiedlich: in Kenia findet sie hauptsächlich im vierten Quartal des Jahres (Oktober, November, Dezember) statt, in Ghana im dritten (Juli bis September), und in Ägypten im zweiten (April bis Juni).

Bezüglich der allgemeinen Einstellung zum Thema zeigen die meisten Befragten – vor allem in Kenia und Ghana – Unterstützungen für ein Ende der Beschneidungspraxis. In Ägypten sind die Meinungen gemischter, obwohl ein Verzicht auf die Praxis etwas mehr Unterstützung findet als ihre Beibehaltung. Unter den Männern sprachen sich in Kenia 60% für eine Beibehaltung aus, in Ägypten nur 27,27% und in Ghana keiner. Was die Frauen betrifft, waren in Ghana 93.75%, in Ägypten 45.24% und in Kenia 24.19% gegen eine Beibehaltung weiblicher Genitalverstümmelung. Hingegen unterstützten von den selbst Beschnittenen in Kenia 33,33% eine Fortführung, in Ägypten 60%. Ghana hat (unter den Befragten) auf keiner Seite Unterstützerinnen für eine Beibehaltung. In allen drei Ländern werden allgemein gemischte Fortschritte angegeben, in Kenia zu 34 % als „ausreichend" bewertet, in Ghana zu 89.58% und in Ägypten zu 37,39% als „gut" bezeichnet.

Vor allem in Kenia und Ägypten wurden die Aktivitäten von NRO im Kampf gegen weibliche Genitalverstümmelung begrüßt, in Ghana findet besonders das staatliche Anti-Beschneidungs-Engagement Beachtung. Es existiert umfassendes methodisches Werkzeug zur Abschaffung der Praxis, das verschiedene Arten der Verhaltensänderung zu bestimmten Zeitpunkten ermöglicht. Ansätze, die von den Gemeinschaften ausgehen, sind zielführender als der Menschenrechtsansatz allein; das gilt vor allem für Ägypten mit seinem islamischen Einfluss, wo jener als ‚westlich' und gar ‚kriminell' konnotiert ist. Gesundheitsorientierte Kritik lief Gefahr, die Praxis einfach nur medizinisch zu professionalisieren, erreichte aber einen Durchbruch in der Diskussion. Sensibilisierung und die Schaffung von Bewusstsein waren Ziel aller untersuchten Ansätze. Die Beobachtungen ergaben einen kontextsensiblen Einsatz unterschiedlicher Interventionsmodelle in Kenia, hingegen eine begrenzte Flexibilität in Ghana und Ägypten. Mögliche Gründe sind Unterschiede in den weiblicher Genitalverstümmelung zugeschriebenen Faktoren, im Umfang, in dem sie praktiziert wird,

etc. NRO trafen laut Berichten auf meist wirtschaftliche, aber auch soziale Herausforderungen in der Umsetzung einschlägiger Projekte und in ihren Strategien.

Größere Wirksamkeit wird u. a. durch den begrenzten Umfang erschwert, in dem Maßnahmen dokumentiert und evaluiert werden. NRO dokumentieren selten a) den Prozess, dem sie in der Umsetzung der Maßnahmen folgen, b) ihre Stärken und Schwächen, c) Schwierigkeiten bei der Umsetzung, und wie sie zu überwinden sind. Die meisten Interventionsmethoden sind auf Sekundärziele wie Information und Steigerung des kritischen Bewusstseins gerichtet, nicht auf ein vollständiges Ende der Praxis oder die Nachhaltigkeit der veränderten Einstellungen. Zeiträume und Budgets für Interventionen sind begrenzt – die Veränderung solch ‚chronischer' sozialer Normen erfordert jedoch Geduld, vor allem im Umgang mit sehr konservativen Gemeinschaften oder Interessengruppen. Ferner garantieren auch auf die Veränderung von Einstellungen und Verhaltensweisen ausgerichtete Interventionen keine tatsächliche Abschaffung. Viele Umfragen zeigten beispielsweise eine positive Veränderung der Einstellungen zum Verzicht auf Mädchenbeschneidung, jedoch bestanden konkrete Absichten der Durchführung an Minderjährigen fort: aufgrund sozialen Drucks, um Traditionen und soziale Normen zu wahren, und um Stigmatisierung und den Ausschluss aus sozialen Beziehungen zu vermeiden. Weitere Probleme wie politische Instabilitäten, die Unterstützung gesundheitsgefährdender Bräuche von Regierungsseite (z.B. in Ägypten), und die kulturellen Implikationen der Genitalverstümmelung unter eingefleischt Traditionsbewussten unterminieren die Effektivität einschlägiger Projekte.

Fazit: Die Strategien im Kampf gegen weibliche Genitalverstümmelung sind informativ, es besteht aber eine Notwendigkeit angemessener Projektauswertungen und der Dokumentation angewandter Verfahren, um feststellen zu können, welche Methoden funktionieren, welche nicht, und warum. Des Weiteren muss eine nachhaltige Beurteilung der Veränderung gewährleistet sein; unter Berücksichtigung der Kooperation der Gemeinschaften. Verschiedene Gruppen, auch solche, die zunächst nicht einschlägig relevant scheinen, müssen an Bord genommen werden. Die Botschaften gegen Mädchenbeschneidung müssen einfach, aber eingängig und in einer für alle Gruppen (z.B. Kinder, Alte, Analphabeten, Taube, Stumme, Blinde) verständliche interaktive Landessprache gehalten sein. NRO, die sich gegen die Praxis engagieren, sollten mit den Gemeinschaften zusammenarbeiten, um eine Entfremdung zu vermeiden. Auch sollten sie ihre Forschungen mit und direkt in den Gemeinden und Gemeinschaften sowie ihre Projektarbeit im gemeinschaftlichen Kontext

durchführen. Wichtig sind die Offenheit der Projekte und die Übertragung der Verantwortlichkeiten auf die jeweiligen Gemeinschaften. Dies sollte netzwerkübergreifend, in verschiedenen zivilen Institutionen und auf verschiedenen Ebenen ausreichend begleitet werden. Unnötige Doppelarbeit ist zu vermeiden, die effiziente Nutzung der begrenzten Mittel und Budgets zu gewährleisten. Eine Zusammenarbeit zwischen den einzelnen Projekten ist empfehlenswert, jedoch nicht allein auf finanzieller Ebene, sondern auch mit Blick auf die Vermeidung von Rückschlägen im Kampf gegen weibliche Genitalverstümmelung und auf allgemeinen Erfahrungsaustausch zur Optimierung der jeweiligen Projektarbeiten.

Alle möglichen Wege gilt es zu erforschen, um Verhaltensänderungen zu erreichen, die die Rechte aller Menschen gleichermaßen respektieren.

FGM is a traditional practice that involves the partial or total removal or other injury to the female genital organs for cultural or other non-therapeutic reasons. The practice that involves procedures of infibulations, excisions, or clitoridectomy (types of FGM) are interlinked to identity, sexuality, gender and power (Rahman A and Toubia N 2000; Comfort Momoh 2005). FGM is not only observed by the African communities at a highest rank and the Middle East and Southeast Asia to some extent, but it is also becoming a common practice and a concern in Europe, the USA and other parts of the world. Citizens of countries where the practice is highly done have mainly attributed to this occurrence, due to the increasing rates of immigration. 140 million women and girls have already been affected. In Europe alone estimates of those affected are 500.000 and at risk 180.000 among only registered immigrants (EIGE 2013). In Africa, 3 million girls are said to be yearly at risk of undergoing FGM. Like foot binding in China and the practice of dowry and child marriage, FGM represents society's control over women and has the effects of perpetuating normative gender roles that are unequal and harm women (Mackie Gerry 1996). Mothers have continuously socialised their daughters into upholding the custom not as a punishment, but out of love due to the perceived benefits such as marriage-ability, fidelity, virginity purposes, hygienic reasons and rite of passages to adulthood; which reasons, to practicing communities, signify a good life. Performed on minors before the puberty stage and without victim's consent, FGM violates the girls' freedom of choice to do otherwise and exposes them to health risks thus violating the human rights principles of equality and non-discrimination (Green Fiona 2005, UNICEF 2005; Comfort Momoh 2005). As initiates, girls swear into secrecy so as not to discuss the pain and ordeals associated with the procedure of FGM, particularly with non-excised women. The use of songs and poems derides non-excised girls away; but also, the instilled fear of the unknown through punishment by God, ancestral curses, and other supernatural powers enforces conformity (WHO, 1999:5).

Currently accounting for different variations and marked declines among practicing countries (i.e from 5% to 3.8% in Ghana, from 32% to 27.1% in Kenya and from 97% to 91.1% in Egypt as seen in the DHS and MICS sources [WHO 2008; El-Zanaty F, Way AA. 2000]), the continuation of the practice remains baffling. With an attempt to end FGM, the practice is increasingly becoming a focus of abandonment campaigns especially in Africa. Numerous studies have thus lent support and criticism against FGM, while establishing ways to eradicate the practice. The United Nations Organization as part of its Millennium Development Goals

aimed at promoting equality, empowering women and improving maternal health (UN 2005), has also prioritized FGM. In recommendations made by UNICEF (2005) in its publication "Female Genital Mutilation: A Statistical Exploration", opponents of FGM are called upon to consider attitudinal change as one of the ways to package FGM programmatic interventions. As a result, tremendous culturally sensitive abandonment efforts such as those of Tostan in Senegal, alternative rites of passage approach in Kenya, etc. (Diop N, Moreau A and Benga H. (2008); Diop N, et al. 2004; Jane Njeri Chege, et.al 2001) have stemmed up and proved to be successful. However, despite almost a decade of eradication campaigns amidst heavy donor funding, FGM is still highly observed in many African countries. Not even laws or political interventions have helped to rectify the problem.

The main objective of this study is to analyze FGM abandonment strategies put forth, and identify loopholes that have likely led to the persistence of the practices (among other factors), despite incredible efforts dedicated towards ending FGM. The study achieves this, by looking at mainly several ways/strategies existing towards FGM abandonment and gauging their effectiveness. The study also considers NGO roles and their project delivery effectiveness, thereby examining success and challenges in project delivery and implementation. Finally weaknesses identified are addressed by suggesting - **accommodative and participatory "network-alliance projects with and for community"** – which was developed in this study based on the findings **-** as a contribution towards accelerating FGM abandonment. The network model intends to bring together all organizations working against FGM to genuinely collaborate together to achieve a common goal (end FGM) rather than acting as competitors for - public space, project and financial acquisition, profit yielding (etc.). This all may be seen as selfish ambitions for making ends meet, without taking the repurcussions of such institutional behaviors into consideration - towards hinderance of real objectives of project designs and implementation, namely sustainable behavioral changes at grassroots. The network model also integrates <u>not</u> pseudo but active/genuine community participation into project design and implementation. Hereby, encouraging working with local stakeholders to reinforce culturally instigated contexts of dealing with FGM in local conditions and finding combined solutions to sustain behavioral changes. This whole doctorate project offers comparative discourses surrounding FGM practices and abandonment strategies in Kenya, Ghana and Egypt. However, findings are not only limited to the studied countries, rather can be applied elsewhere to achieve abandonment.

In the study, both theoretical and empirical discussions aim at addressing the question — **"why is there no significant behavioral changes towards ending the practice despite of the remarkable abandonment measures to address FGM?"** This dissertation is an empirical work consisting of extensive researches in countries – Kenya, Ghana and Egypt. Divided into three major parts, the *first part* –the introductory part of the study gives an insight about the topic by looking at the state and art of FGM. Examples are also taken from other countries to enrich this chapter. The *second part* discloses the theoretical frameworks, consisting of chapters 2-5. The *third part* (chapters 6-10) is the core of the dissertation, providing the methodology of the empirical research, case-study findings and comparative analysis of the countries. Chapter 11 discusses the findings, highlights on the network alliance model against FGM and eventually gives conclusion remarks. Bibliography and appendix are lastly presented in chapter 12. The summaries of single chapters are given as follows. In *Chapter 1(introduction)* - the state and art of FGM – puts forth background information about FGM to include; what FGM is, social-behavioral patterns, possible root causes, perpetuation, impacts, documentation, prevalence rates, emerging trends and medicalization. In *chapter 2*, the feminist sociology of FGM aims at revealing the social structure (man-made order), tamed behaviors, attitudes and actions, the gender concept towards family structures and women subordinations, socialization, social controls, cultural influences and the communal conception of society. Most of these themes show the social dynamics of FGM. *Chapter 3* reveals the human rights holistic discourses addressing FGM abandonment. It shades light on international politicization of FGM, Relativists and Universalism debates, the human rights violated by the practice, legal binding and country profile frameworks, law enforcement dissemination and application, benefits of the approach and its challenges/ limitations. The very chapter also embodies other ways of abandoning FGM, because of the extent of rights context grown in several of them. *Chapter 4* addresses roles of different institutions particularly those with FGM projects in the campaign against FGM. Successful examples are shown as depending much on cooperation at local/grassroots levels – taking into consideration specific contexts. Analyzing intergenerational differences in a historical context shows a shift towards behavioral changes within the younger generations. However; measuring goal-success may be limited by reliability on self-reported studies without medical proof – as offered by very few clinical studies and requirement of costly panel studies. *Chapter 5* generates reasons for FGM persistence as interlinked with cultural traditions and identity, definition of women's role based on marriage, resistance against imperialism, etc.

Chapter 6 reviews the methodological procedures. A triangulation model is used consisting of secondary data (analyzing already existing researches) and primary data - quantitative (questionnaires) and qualitative (Interviews, group discussions, observations and participation e.g. in sensitization forums and abandonment declaration ceremonies) research. Field study lasted almost 10 months all together, observing inclusivity from a variety of participants. Using a statistical program STATA for the quantitative interviews, data is represented in both univariate and bivariate forms. In order to address different themes of the research question, various perspectives are used, from (grassroots communities, NGO and government personnel) respondents (males & females) aged above 15 years. In *chapter 7* (Kenya) first field studies round took place in 2011 (in Nairobi, Namanga, kajiado, maisikisha, Ibisil, Mailwa, Longoswa, Narok, the Illchamus in Marigat, and Garisa) among mainly the Maasai and Somali communities. Selecting randomly, a total of 100 study participants were targeted. *Chapter 8*: The second field study followed in 2012 in Ghana. Research in the upper east region took place in Sirigu, Kandiga, and Manyoro communities located in the Kassena-Nankana district, where a total of 50 study participants were recruited. *Chapter 9*: Research in Egypt carried out in 2013 included 115 randomly selected participants from Fayoum, Beni suef, Cairo and Assuit. *Chapter 10* offers a comparative analysis of the three case studies. A total of 265 participants from the three countries indulged in this research. Kenya contributed 100 (38%), Ghana 50 (19%) and Egypt 115 (43%) participants. A total sum of 77% Females (205 females from a total of 265 participants) analysed include 27% Kenyans (73 females = 27 circumcised, 32 not, 14 non-responses), 18% Ghanaians (48 females = 37 circumcised, 11 not) and 32% Egyptians (84 females = 70 circumcised, 14 not). Males often distanced themselves from the study, implying that FGM was a women's issue, hence the gender disparities. The choice of countries represents a) regions - East Africa (Kenya), West Africa (Ghana), and North Africa (Egypt). b) Prevalent rates - group one (80% and more e.g. Egypt), group two (25%-79% e.g. Kenya) and group three (1%-24% e.g. Ghana).

Results: Social-demographic variables indicate most respondents aged 15 years and above being married, very few were single, divorced or widowed. Participants included 73% females and 25% males from Kenya (2% did not indicate their sex); 96% females and 4% males from Ghana and 73.04% females and 26.96% males from Egypt. The formally employed participants in Kenya made up 59%, in Egypt 55.65% had no employment and in Ghana 84% had informal employments. Most participants had lived in studied areas either for all their lives, or for over 10 years. FGM varies given; a) marital status- most married women are

circumcised compared to those still single, b) generational trends – girls of lower ages between 8-14 years are increasingly escaping FGM nowadays c) the higher the education levels, the lower the practice, d) employed women stand better chances of escaping FGM. Points (c) and (d) are highly insignificant in Egypt because FGM is universal. In other words, no matter the social-economic status or geographical location, every Egyptian woman must undertake FGM as a cultural routine. This is where Ghana and Kenya divert from, because for them, FGM is only common under particular ethnics and therefore not expected from all women countrywide. There are several other variations that the study identified including, Infibulations being common in Kenya, Excision in Ghana, and Clitoridectomy in Egypt. While excision (type II) cuts across all the three countries, infibulation cases trace feet only in Kenya. However, the type practiced, reason for performance, and age at which FGM takes place also differ from one community to another. For example, Somalis (Kenya) practice type III particularly on young children less than 7 years for mostly purely Islamic reasons, whereas Maasai (Kenya) commonly undergo type II or I as a rite of passage to adulthood for girls approaching adolescent ages. In both Ghana and Egypt, given the differences in ages of performing FGM, same reasons (both cultural and religious) nearly cut across different communities no matter the type practiced. Ghana is the only country (as per the study) where FGM practices are performed on adults of 18 years and above, who even ignite their own decisions (40%) into the process as compared to family inspired decision-making (42%). Egypt on the other hand shows the highest levels of FGM performances on children aged 4-10 years. In Kenya, despite the differences in age per individual community, the general ages captured for FGM performances range commonly from 11-14 years. Though Kenya is presented with the history of 'Ngaitana' (meaning I will circumcise myself) following the ban against FGM in 1956 by the colonialists (Lynn M Thomas 1996; Bettina Shell-Duncan & Ylva Hernlund 2000), this survey shows Kenya as the only country without self-made decisions to perform FGM currently, yet Egypt has less than 1%.

Towards FGM abandonment, the survey has practically shown that FGM is still common, as observed by 49% from Kenya and 53.04% in Egypt with exception of Ghana – 0% (whose 4% did not answer). Females who had undergone through FGM included 37% in Kenya, 74% in Ghana and 83.33% in Egypt. Common in the three countries is that not undergoing FGM leads to mostly ill social (community) relations at a higher extent and family wrangles to a lower extent. This indicates that though individual families are willing to let go of FGM, community as a whole is less likely to welcome the idea, hence undermining abandonment.

Traditional practitioners (circumcisers) for mainly cultural reasons, mostly perform the practices mainly in the August holidays and the fourth quarter (October- December) of the year in Kenya; third quarter (July-September) in Ghana and the second quarter (April-June) in Egypt. Egypt's FGM practices are generally much more justified on religious grounds with traces of higher medicalization, just like the Somali communities in Kenya. However, unlike Kenya where the government is critical about health personnel performing FGM to the extent of threats of losing medical licenses once found, Egypt government seems to be reluctant about such follow-ups. Ghana on the other side almost has no cases of medicalization, as observed from the survey Indeed, as Ghana and Kenya admit the existence of medical complications related with the practices, majority participants in Egypt highly distanced themselves from any such complications. FGM in Ghana is more of a boarder boundary influence from Burkina-Faso, as communities interviewed were bordering the country and sharing the same religion (Islam) and cultural-traditional ways of living. Egypt's practice almost traces its origins in Egypt from their ancestors in the pharaoh eras, where the name - pharoanic circumcision - is also driven. Kenya's practices on the other hand have no specific historical connections, apart from infibulations among the Somali communities that stem from Somalia. Other than that, other ethnics also derive the practices from their ancestors, and hence FGM in Kenya justified preceding untold generations.

All respondents in Ghana were against FGM and supported abandonment. Participants in Kenya and Egypt express mixed attitudes. For instance, males who express maintenance attitudes are 60% in Kenya, 27.27% in Egypt, and none in Ghana. Abandonment attitudes under female participants represent 93.75% in Ghana, 45.24% in Egypt and 24.19% in Kenya. Circumcised females who nevertheless support continuation of FGM include 33.33% in Kenya, 60% in Egypt, and none in Ghana. In Egypt, most formally employed participants highly support FGM in contrary to the informally occupied participants in Kenya. Generally the best rates of progress against FGM has been 'fairly' gauged by 34% in Kenya and as 'good' by 89.58% in Ghana and 37,39% in Egypt. Community-participants in Kenya and Egypt applauded mainly NGOs activities for advocating against FGM, in contrary to government support in Ghana. However NGOs perspectives show increasing government support in Kenya, whereas in Egypt and Ghana NGOs have criticized their governments for reluctantly failing to cooperate against FGM. This is because in Kenya, government supports policy formulations and bill passing whereas NGOs are the final project implementers at community levels. In Egypt, government cooperation is surely minimal for Islamic-political

reasons, political instabilities and the suspected western influence. In Ghana, the two perspectives (Community and NGOs) have shown contradicting results because community seem to have lacked clarifications and demarcations of government projects currently being implemented at community levels for general health reasons (and not particularly FGM) and the 2005 FGM projects that government shared with NHRC which have likely remained of impact (until recently) in individual lives.

There is a rich and sufficient methodology used towards FGM abandonment that allows various behavioral changes at particular times across all countries. However, community based approaches, as methods of abandonment are most favorable and attain a certain degree of effectiveness. In Kenya, during interviews, Christin Ochieng - the UNFPA-UNICEF joint programme coordinator at the national level reported on one model (of the kind) gaining prominence being the alternative rites approach used by MYWO among the Maasai and the religious oriented approach among the Somalis. The World vision program coordinator in Kenya also aired another empowerment –education model out. The project implementer in Namanga area meant that the education oriented approach sponsored by World vision, is prominent among especially the Maasai (due to their low levels of education attainment brought about because of their pastoralists' way of life). The model targets mostly younger girls in particular, with the aim of empowering them through sponsoring their education until higher learning levels. The target is for sponsored girls to promote change in their own communities as role models, at a later stage and encourage parents to invest in equal education for both girls and boys, since girls' education is disfavored. Christine Ochieng noted that UNFPA-UNICEF joint programmes have sponsored girls - prolonged stays in schools during school holidays amongst the Maasai and Kuria communities with the aim of girls' to escape FGM (commonly done in school holidays). These models are slowly gaining momentum in reducing FGM in Kenya. In Egypt a combination of religious-, sensitization- and legal approaches are favorable by grassroots organizations like EBESCO and CEWLA. The legal approach however, was of less influence by the time of research (2013) among the Egyptian communities, because of its association with foreign pressure to conform to international standards while disregarding Islamic religious cultures. In Ghana, the development/empowerment approach as used by the NHRC in the past was of impact to the communities. However, in 2012, GAWW was capitalizing on sensitization and awareness model while working with community stakeholders to influence change. Generally, sensitization and awareness model characterized all the approaches examined. The human

rights model as a standalone approach did not achieve much support within communities particularly in Egypt, because of the Islamic influence. Besides when used straight forward, the human rights model faces criticisms of being an influence from the West and often times associated to criminalization. Nevertheless, when critically examined, several other strategies combine the human rights approach to some extent, in one way or the other. Meanwhile, the medical approach suffered dangers of 'medicalization' of the practice, yet the model offered a breakthrough into discussing the topic and was favorably used in all the three countries. Generally, according to field experience and observations, Kenya's models of interventions are various and context based given variations in reasons for performing FGM, whereas those used in Ghana and Egypt are limited and multi-sectorial. This is so, because as earlier stated, Kenya's various ethnics practice FGM for different reasons, hence the different context based strategies, whereas in Egypt, there is no ethnic divisions (all have the Arabic background) and religion mainly instigates the practice. In Ghana, given the variations in ethnicity, only 5% perform FGM, almost for similar reasons.

Not without challenges, the implementation of abandonment projects are increasingly facing economic (financing), social and political problems leading to limited effectiveness. General challenges facing effectiveness include first, the limited extent of documenting and evaluating interventions. NGOs seldom document; the process they follow in implementing interventions, strength and weaknesses of interventions, difficulties of implementation and solutions. Most intervention methods aim at secondary outcomes of increasing knowledge and critical awareness, but not total abandonment and sustainability of changed attitudes. The second point, there is limited budget and time frame work within which interventions take place, yet behavioral changes of such a 'chronicle' social norm require patience to be uprooted and a substantive budget to sustain abandonment periods, especially when dealing with the most conservative communities like those in Egypt or Somali. The third point, although some intervention methods aim at changing attitudes and behaviors, this does not guarantee abandonment. Many surveys including this one, for instance find that FGM attitudes are positively changing. However, the actual intentions of performing FGM on minors still exist because of the social pressure to uphold traditions and social norms, and to avoid stigmatization and exclusions from social relations. Lastly, different organizations fighting for the common cause implement different programs, which show a lack of unification on that matter. For example instead of advocating for total abandonment, some NGOs like woman kind in Kenya (as noted in the interviews) have proposed and supported

the gradual changes of abandonment while campaigning for lesser cuts instead of total abandonment among the Somali communities. Yet, other NGOs working within the same communities have propagated different messages of total abandonment. Mixed messages addressing gradual change on one side and total abandonment on the other side not only perplex the audiences they target, but also undermine total abandonment. Apart from creating another problem, there is no guarantee of passing through such gradual changes to total abandonment. Besides, such projects are a waste of resources and time because at a certain point, activists have to revisit the very communities spreading again messages - now advocating for total abandonment from a lesser cut.   Other challenges such as political instabilities and government support of harmful cultures (e.g. in Egypt) and the cultural implications of FGM among the traditional die-hard undermine FGM project effectivity.

In conclusion, whereas FGM abandonment strategies are informative, there is a need for appropriate project evaluations and documentation of implementation procedures in order to identify what approach works, what does not and why. This way, activists will ensure sustainable assessment of change. Meanwhile, messages abandoning FGM must be kept simple but striking and in an interactive local language (signs, pictures or photos, art pieces, local writings etc.) for all groups of people (including children, old, illiterate, blind, deaf, dumb, etc.) to clearly understand. Besides, as indicated in *chapter 11* under the network alliance model, NGOs advocating against FGM ought to work 'with' the communities (avoid alienation) for community good/benefits. There is also urgent need for several institutions working against FGM to converge and work out unifying ways of tackling FGM in a transparent and accountable manner, rather than working against each other. This will ensure advocacy, project updates, eliminate manipulations, throw out briefcase NGOs, avoid unnecessary project duplications, find solutions to half way-done projects (due to limited time framework and budgets), avoid setbacks in behavioral changes and will ensure that limited funding budgets are maximally well used. There must be the exploitation of all possible avenues, to sustain behavioral changes in a manner that respects human rights.

COMPARATIVE STUDY OF FGM PRACTICES AND ABANDONMENT STRATEGIES IN KENYA, GHANA AND EGYPT

1   INTRODUCTION TO THE ART AND STATE OF FGM

FGM is a collective name given to several different traditional practices that involve the cutting of female genitals (Nahib Toubia 1995); in particular *"all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs for non- medical reasons"* (WHO 2008;1). FGM largely confines to Africa, although small groups practice it in Yemen, Middle East, parts of Asia, Europe, USA and Canada. Yemen adopted the practice relatively recent (20th century) because of contacts with communities in the Horn of Africa, where the practice ingrains in the local culture (Caldwell et.al 2000). The practice symbolizes cultural identities, social- and power –relations. An estimation of 200 million girls and women worldwide has undergone some form of FGM (UNICEF 2016). The practice is affecting about 60% Muslims and nearly 40% Christians (John C. Caldwell, I.O, Orubuloye & Pat Caldwell 2000).

In Egypt, FGM is universal and accounts for over 90%. Social-economic variables like education, incomes or geographical locations do not play any significant role, given its distribution patterns. Common types include I and II (Mohammed A Tag-Eldin et al 2008; Yoder et al. 2004). **In Kenya**, estimation of the practice is 27%, done by all ethnic groups apart from Luo and Luhya. Types practiced and prevalence rates vary according to ethnicity (UNFPA 2011). Type III for example is most common among the Cushitic Borana, Rendille, and Samburu and Somali communities. It is typical in rural communities of Northeastern Kenya (like Gariisa and Isiolo). Type II is frequent among Maasai, Kalenjin, Meru, and Kuria. Type I is widely spread among Kisii, Abagusii and Kikuyu. **In Ghana**, FGM prevalence is below 5% and type II is commonly performed. FGM concentrates mainly in Northern Region, widely spread among: - Kussasi, Frafra, Kassena, Nankana, Bussauri, Moshie, Manprusie, Kantansi, Walas, Sissala, Grunshie, Dargati and Lobi (A.R Oduro, P Ansah, et.al 2006; Jackson E F, Akweongo P; et.al 2003; US Department of State Archive 2001-2009).

1.1 What is Female Genital Mutilation (FGM)?

In many African countries, FGM is a cultural practice that symbolizes a way of life (Leininger, M 1994). This social behavior derives its roots from a complex set of belief

systems that has existed for many generations. Women who have undergone the practice are highly regarded within practicing societies. Meanwhile, non-circumcised women living under circumcising communities have on several occasions become social outcasts (i.e., face rejection and stigmatization from peer-groups, family and community), lost their sense of security and marriage support (Gibeau AM 1998). "*Women receive their status of full wife upon bearing a child, emphasizing the importance of fertility in defining a woman's role. Without being excised, a woman can never bear legitimate children or achieve a full status of womanhood…*" (Bettina Shell-Duncan, et.al 2000:119). Not undertaking the practice may disqualify women as potential adults, marriage-able and capable of bearing 'normal' or legal children. John S Mbiti (1989) argues that in an African set up, a complete woman must fulfill these steps.

Marriage reunions and status in an African set up is usually achieved after a list of marriage requirements have been fulfilled, especially by the girl (females). The same requirements may not necessarily apply for males. Though conditions for marriage differ from community to community (see Radcliffe Brown; Alfred Reginald and Forde, Daryll 1950 – African systems of Kinship and Marriage, Oxford University Press) and may entail observing particular norms and traditions (like FGM, skin burnings, teeth removal, seclusion), not fulfilling such requirements is likely to deprive females of adulthood-status, power and security (see also Johannes Jütting, Christian Morrisson 2005). Chances are thus minimal for females born into such traditions of belief systems; to escape traditional practices and social norms expected of them, if not with family support, education and changing behavioral attitudes.

In the case of FGM, women and girls are forced to 'willingly' submit into FGM to 'fit' into their respective communities (belongingness). It should be noted that in many African strong patriarchal societies; many females lack autonomy, power and status, sources of income and education. FGM has been traditionally used as a resourceful weapon to achieving any of those apart from education. Though FGM in this sense fulfills power relations, social interactions and achieves identities – the practice however disregards human rights and health of women and girls.

Thanks to globalization, that the social-economic gender gaps and human rights situations across different regions or continents have been exposed, compared and contrasted. Also, different reasons underlying such contrasts have been offered by analysists, researchers and academicians. The globalized space has made such gaps highly recognizable, debatable and contested. Also, worsening capitalistic conditions and high corruption levels have awakened

African women to work hard by all possible means to better their conditions. Consequently, many African women are struggling to become more economically autonomous, socially empowered, independent in decision making and highly revolutionary (e.g. against harmful traditions like FGM that threaten women empowerment- and human rights status). This is changing women status quo in relation to their expected gender roles.

Despite the changing status quo; social-economic and political restrictions are very much in reality and sometimes institutionalized. These restrictions aim at maintaining the traditional norms, especially amidst current rapid changes. On the local levels therefore, because of its cultural, social, economic, religious and political impetus: decision makers have found it very difficult to eliminate FGM (Birch/Abril, Nicholas 2008-01-04). Also, anti-imperialistic movements (Jomo Kenyatta 1962:128), victimization, criminalization and condemnation (Morruzi.N, C 2005:205; Obioma Nnaemeka 2005) attitudes/strategies have hampered eradication efforts.

1.1.1 FGM Terminologies

Indigenous populations use a variety of terms in local dialect to describe the different practices. For instance in Egypt-'tahara', Sudan-'tahur' and Mali-'bolokoli' are local terms used to imply purification or cleansing (Rahman A and Toubia N 2000). Khifad, tahoor, qodiin, irua, bondo, kuruna, negekorigin, and kene-kene (Abusharaf, M. R 2006) are further local synonyms of FGMs used elsewhere. Local terminologies vary widely among countries and communities.

On a standard basis; the term 'circumcision' is predominantly used and preferred by communities where FGM is practiced or among women who have undergone the practices (FGM survivors). According to E. Boyle (2002: 41&65), when international community first took up the issue in the 1960s, 'FGM' was generally referred to as female circumcision. 'Circumcision' as a term relativizes the perceived harm and minimizes the severity of the practice (Baden, 1992:15). Although the term 'female circumcision' shows a degree of accommodation and understanding of other traditions and customs, to UNICEF (2005), the term only draws a direct parallel with male circumcision and creates confusion between these two distinct practices. Optional terms like 'traditional female genital surgeries' or 'female genital operations' refer to a woman being either open or closed in local terms, (Lane S.D and Rubinstine 1996).

Women health and human rights activists have embraced the term 'female genital mutilation' to stresses the negative implications, human rights abuses (WHO 2008; UNICEF 2005; Morrone, A., Hercogova, J & Lotti, T., 2002) and also to accommodate political and lobby activities. *"The use of the word "mutilation" reinforces the fact that the practice is a violation of girl's and women's rights, and thereby helps to promote national and international advocacy for its abandonment"* (WHO 2008:22). The expression `female genital mutilation` gained growing support from the late 1970s. In 1990, the term was adopted at the third conference of Inter- African Committee on Traditional Practices Affecting the Health of women and Children (IAC), in Addis Ababa, Ethiopia. In 1991 WHO recommended that the United Nations adopt this term (Alexia Lewnes 2005).

Critics however argue that; *"parents do not set out to mutilate their daughters; they simply want to circumcise them"* (Bonny Ibhawoh 1999:65; Obioma Nnaemeka 2001). Even though FGM is a purification act among certain communities, some feminist scholars see these practices only as brutal, acts of dominance, violence and transgressions (Abusharaf R.M 2005). Moreover, while 'circumcision' neutralises the practice, 'mutilation' implies a value judgement and biases the discussion in favour of those opposed to the practice of traditional forms of 'genital surgery' (Bonny Ibhawoh 1999).

A consideration for revision of the term has been taken into account since 1999 by the UN Special Rapporteur on Traditional Practices. The special rapporteur draws attention to the risk of "demonizing" certain cultures, religions and communities, and suggested that 'cutting' be used to avoid alienating communities (UNICEF 2005). Currently, mutilation, circumcision and cutting are interchangeably used as follows – Female Genital Mutilation/Cutting.

Given my 2011 research experience in Kenya, during the pilot study, the term 'FGM' faced contestations from some NGOs and community officers working at grass root levels. For purposes of ethnic respect and field study cooperation, I was advised to change the terminology to either *Female Circumcision (FC) or Female Genital Cutting (FGC)*. Also recommendations were further suggested upon certain wordings that seemed to negatively connote the practices (e.g. '*anti FGM strategies',* which I then replaced with '*FGC abandonment strategies').* While I adopted '*FGC*' only in the field for research purposes, FGM has been retained in writing this thesis for purposes of activism.

1.1.2   Descriptions of Types[1]

Four major types of FGM are classified by World Health Organisation (WHO, 2008).

Type I (Clitoridectomy) involves the partial or total removal of the clitoris and/or the prepuce (clitoral hood). Susan Izett and Nahid Toubia (1998) describe that; *"the clitoris is held between the thumb and index finger, pulled out and amputated with one stroke of a sharp object. Bleeding is usually stopped by packing the wound with gauzes or other substances and applying a pressure bandage. Modern trained practitioners may insert one or two stitches around the clitoral artery to stop the bleeding."*

Type II (Excision) includes the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

Type III is referred to as Infibulation with excision, contains the narrowing of the vaginal orifice with creation of a covering seal by cutting and repositioning the labia minora and/or the labia majora, with or without excision of the clitoris (also referred to as pharaonic circumcision). In a study of infibulations in the Horn of Africa, Pieters et.al (1997) describes the procedure as involving extensive tissue removal of the external genitalia, including all of the labia minora and the inside of the labia majora.

According to Toubia N (1999) and McCaffery (1995) *"Elderly women, relatives and friends secure girls in a lithotomic position and then a deep incision is made on either side from the root of the clitoris, to the labia majora and labia minora. Bleeding is profuse, but is usually controlled by application of various poultices, the threading of the edge of the skin with thorns or clasping them between the edges of a split cane. A piece of twig is inserted between the edges of the skin to ensure the flow of urine and menstrual blood."*

A small opening of the hole of 2-3mm left, for purposes of urine and menstruation (Abdulcadire Jasmine; Margairaz C; Boulvain M 2011). The lower limbs are bound together for 2-6 weeks to prevent them from moving and to allow the healing of the two sides of the vulva or to ensure the union of two sides (Pieters et al 1997). Healing takes place by primary intention.

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[1] Due to the variety of forms that the practice can take, the WHO is reviewing its current classification of types of FGC. See UNICEF (2005b) for a draft form of the forthcoming classification scheme. UNICEF (2005b) Changing a Harmful Social Convention: Female Genital Mutilation/Cutting. UNICEF Innocenti Research Centre. Florence.

Infibulation procedures are usually followed by De-infibulation and Re-infibulations. According to Hanny Lightfoot-Klein, those men who do manage to penetrate their wives (De-infibulations: re-opening the virgina) do so often with the help of the "little knife", to create a tear. The husband rips the tear gradually, until the opening is sufficient to admit sexual intercourse (Hanny Lightfoot-Klein, 1989). During childbirth, scissors are used to create an opening sufficient enough for child-birth. Some women after childbirth ask to get re-infibulated or re-closed (Jasmine; et al. 2011). Suggestions of re-infibulations may also take place after divorces, in preparation of elderly women for death and in cases where husbands are away from home for a longer period of time (Serour G.I, 2010).

Raqiya, D. Abdalla (2006:187) discusses infibulations basing on Dahabo Musa's poem – the 'three feminine sorrows' – explaining a) the procedure itself, b) the wedding night when the woman has to be re-opened for sexual intercourse and c) at childbirth when the woman has to be cut again. Mackie.G and John LeJeune (2009: pp, 6-7) remain puzzled about women's support and their active involvement in such procedures and explain this as a belief trap that cannot be easily revised due to associated costs and benefits. Lynn Thomas (2000:131) explains such adherences as efforts to preserve the bargaining tools with which to negotiate subaltern and enforce women complementarity with men, by maintaining the process that differentiates females from various ages. Bettina Shell-Duncan, et.al (2000) express FGM as a response to complex social concerns, with dynamic social conditions.

Type (III) is the most extreme and dangerous of all types. It accounts for 10% of all FGM procedures carried out in Africa (WHO 2000).

An illustration of the types of FGM (Rainbo 1997)
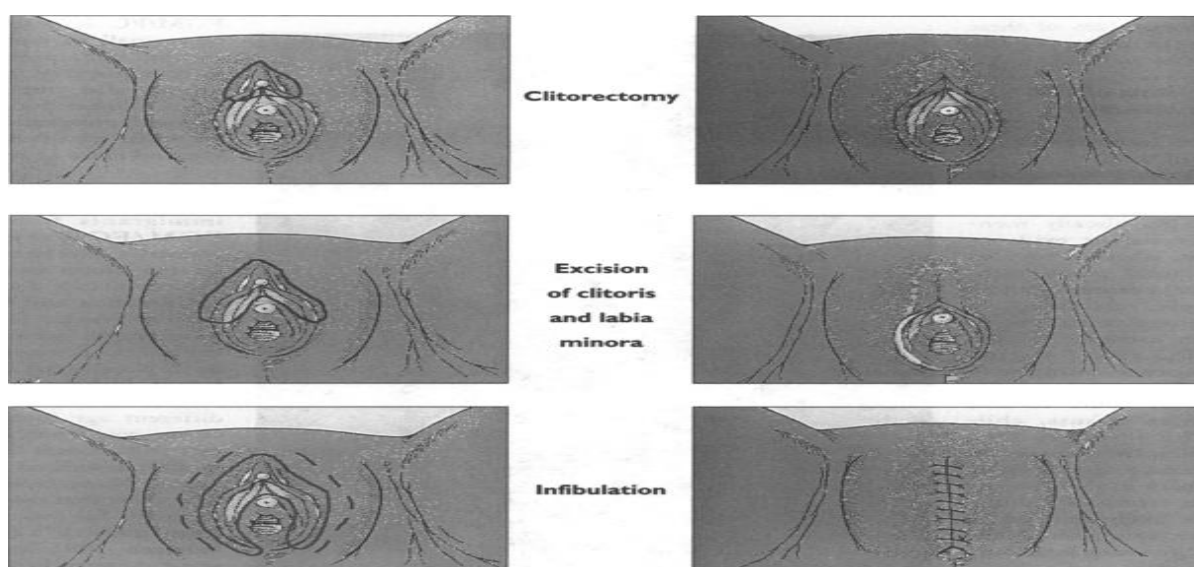
Type IV, also common in Europe**,** involves all other harmful procedures like pricking of the clitoris with the needle or piercing, incising, scraping and cauterization (WHO 2008:10). Inclusive are also burning or scaring the genitals as well as ripping or tearing of the vagina.

1.1.3 The procedure

Once done, the practice is irreversible. The procedure is generally performed on pre-pubescent girls, commonly before marriage. Specific indicators like the growth of breasts, beginning of menstruation cycles (Hernlund Y, Shell-Duncan B 2007; Shell-Duncan B, Hernlund Y 2006; Njue Carolyne and Ian Askew 2004) influence FGM practices and decision-making. These characteristics usually signify the readiness of a girl to become a woman (Okoko Tervil 2000). Variations however are evidenced per ethnicity, country, type, age, reasons and circumciser. For example in Egypt, common age is believed to be 9 - 12 years (UNICEF 2010) justified on religious ground. In Ghana, mostly affected ages are 10-14 years (US Department of State) purposely for marriage preparations and rites to womanhood. In Kenya, FGM usually takes place between 12-16 years (28 Too Many: 2013) mainly as rites of passage to adulthood. In other countries like Senegal and Mali FGM is sometimes performed on babies as young as one month old (Easton, P., Monkman, K. & Miles, R. 2003), or a few days after birth and as late as just prior to marriage or after the first pregnancy (Rahman A, Toubia N, 2000).

Variations in ages of FGM may depend very much on ethnicity and sometimes family decisions, given particular situations. For instance, given my experience in field-study, women who get circumcised during pregnancies (shortly before or after giving birth) usually come from ethnic groups that have no FGM customs. However, when females get married into communities that practice FGM, they may either be forcefully circumcised before childbirth or give in willingly into FGM in order to gain a sense of belongingness into host communities that they have been married into (e.g. in Kenya). In other cases, some females may belong to communities that practice FGM, but for various reasons, their families/parents spared them from undertaking FGM. However upon marriage, they may be mocked by the husband's family, hence giving in willingly to FGM for the sake of harmonious living with the in-laws and co-wives (e.g. in Ghana). Also myths such as – a non-circumcised woman produces stubborn babies (in Ghana), long clitoris may strangle the baby on its way out (Maasai in Kenya) or bring bad luck (among the Kalenjin in Kenya) enforces circumcision

without consent of pregnant mothers, shortly before giving birth (see also interview: K – Ministry – No 3).

Meanwhile, the decision to circumcise under age children may depend on the degree of criminalisation threats in countries where FGM is officially illegal. The higher the criminalization threats, the lower the ages affected by FGM. Young girls cannot file cases or press charges against their parents once FGM has been undertaken. Secondly, the degree of sensitization of girls under threat matters. Higher sensitisation and empowerment levels of risk groups (e.g. 12-16 years) or older generations could be followed by lower risks towards FGM, depending on options available (e.g. rescue homes once girls decide to run away from home due to pending FGM, FGM counselling & prevention centres, legal implications, education opportunities, etc.). When effective protection mechanisms are in place, younger girls of substantial ages are given alternatives and choices to say no to FGM.

Recent reviews suggest that one reason for the limited success in eliminating FGM is an insufficient understanding of the decision-making process (Hernlund Y, Shell-Duncan B 2007). As such, some studies particularly address this shortfall and develop theoretical models of behavior change, used to assess readiness for change and factors motivating change (Shell-Duncan B, Hernlund Y 2006).

Getting back to the procedure, girls may be circumcised alone or with a group of peers from their communities. Sharing same experiences strengthens group/peer relations and identities. The implication of this is stigmatisation of those without common experiences or who have not undergone through FGM.

Circumcisers usually come from families that for generations have performed the procedures within the communities. Therefore it is a hereditary position, passed on from one generation to the other. Christin Ochieng of UNICEF-UNFPA's joint-programme coordinator at the national level in Kenya explains that in rural areas, not just any one performs the practice. She adds that families that carry out the procedures are usually well known in rural areas and are targeted for sensitization. Where health centers do not exist, circumcisers also usually act as Traditional Birth Attendants (TBA). For that matter, it becomes easier to identify pregnant women who have not been circumcised and eventually circumcise them, with or without their consent given their powerless position.

Circumcisers attain their knowledge and expertise not through education or training, rather through several practical experiences of FGM cases. Many years of experience means less

associated risks during the procedures, thus assuring safety. The procedure is usually carried out using crude tools and instruments (e.g. razor blades, surgical blades, knives and scissors) as long as they are sharp. As herbs; eggs, Gum Arabica, salt lick and saliva are applied to assist in the healing process. When a girl is cut open in cases of infibulations, threads and needles or thorns are commonly used for closing up the opening.

A circumciser displaying off her tools for FGM and healing position after infibulation

(Taken from Lethome Ibrahim's power point presentation in Kenya)

However, an upcoming trend in the urban areas is the increasing involvement of medical personnel in the performance of FGM procedures. Sterile equipment and anesthesia is used to minimize infections (McCaffery M 1995). Njue Caroline and Ian Askew (2004) show that medical personnel cut less tissue nowadays (e.g. in Kenya), and the procedure is less painful because it is just a symbolic cut. Sheikh Maryam, Evelia Humphres, et.al, (2007:4) confirm a difference in the cut per generation from sever to milder FGM practices. UNICEF (2005b) expresses concerns about difficulties in describing the procedures especially in cases of self-reporting by girl cut at tender ages. Bettina Shell-Duncan and Ylva Hernlund (2000:5) report that pricking of the clitoris was at one time proposed, instead of infibulations (among the Somali immigrant women), although this was intensively blocked by FGM activists. An organization called Woman Kind in Kenya still advocates for mild cuts as a gradual process towards total abandonment (Kenya interviews). Majority Kenyan activists have criticized such NGOs and messages for undermining the FGM 'total' abandonment campaigns and instead being in favor of gradual abandonment. Activists criticizing such moves have argued that communities targeted get confused about the different change behavioral messages

dispersed off by activists, which may not eventually guarantee abandonment and hence resource wastage.

Medicalization trend is a result of health risk approach of FGM, pinpointing the crude instruments used, conditions of circumcisers (e.g. old age, sight problems and competences without training) and environment under which FGM is undertaken. WHO, International Federation of Gynecology and Obstetrics, the Inter- African Committee and USAID have made explicit statements and warned against medicalization of the practice (WHO, 2001d; Njue Carolyne, Ian Askew 2004).

1.1.4 Evolutionary theories of FGM

Though FGM dates about 2000 years back, where and when the practice first took place is not clear. Nevertheless, speculative but plausible assumptions that explain its evolution include:-

The Marriage theory

This suggests that FGM was a fidelity measure used for marriage purposes into high classes in ancient African empires. Examples of highly stratified empires of the time included for instance the Nubian (Sudan) and Malian empire. In these empires, the practice was related to *"women subordinations amidst extreme resource inequality, polygamy, and hypogyny"* (Mackie Gerry & John Lejeun 2009:12). Women to escape poverty married men (the emperor, nobles) in higher social strata, who later demanded fidelity of their female cohorts. This instigated innovation and imposition of control practices like FGM among others. In Mackie's (2009) explanation, it was better off to be a second or third 'wife' of a rich man, than the first and only wife of a poor man.

Accordingly women did not care being concubines or apart of polygamous marriages, as long as economic-social stability and better care of children could be assured. Thus in earlier societies, the more cohorts/wives (few) rich and elite men possessed, the higher they demanded/applied measures to discourage female-infidelity practices. 'Female' - infidelity was most likely triggered off as a result of (e.g. polygamous) males spending less time with their wives/cohorts. Taking into consideration the males' nature of employment, job – locations (long distanced) and number of wives/cohorts/family. Each of these most probably demanded males' presence and attention, which must have been difficult to fulfill. Polygamous males thus divided their reserve time according to the number of households or

wives or families they had. Limited time (for families) however, must have caused fears of wife-infidelity and thus the various control/protective measures to control female sexuality.

Application of fidelity measures was different over the world (Mackie Gerry & John Lejeun 2009). In China, it was foot binding. In south west Asia - seclusion of women and enforcement of very modest dressings was used. In Africa – clitoridectomy (to suppress female desire) and Infibulation (for complete control of chastity) was invented. Also, the building of enclosures and eunuchs was a further applied means to safeguard females in some areas.

Some of these measures (e.g. FGM, modest dressing & foot-binding) were adopted by families in the lower strata to move their daughters into the emperor's palace or to seal marriages into higher social classes. The spread of FGM from the ruling class to the lowest class (Lighfoot-Klein 1989) achieved a high concentration at each social stratum and became later a conventional prerequisite for marriage (Mackie 2009). FGM or fidelity control measures were exaggerated over time and diffused differently in the cultures of indigenous peoples and to those foreigners who encountered earlier empires. It is no wonder that the practices today fulfill different objectives in different communities or even countries, as shall be shown later on.

The Pregnancy control theory amongst female slaves

Meanwhile; Phoenicians, Romans, Hittites, undertook this practice to avoid pregnancy amongst women slaves. Romans for instance used a technique involving slipping of rings through the labia majora of female slaves to prevent them from becoming pregnant in ancient Rome (WHO 2006). Perhaps, controlled pregnancies were necessary for (slave) productivity purposes (pregnancy and child care would affect woman's productivity). A pregnant slave was undesirable on 'market' and yielded less profits in the capitalist economy. Crusaders brought the chastity belt to Europe during the twelfth century.

Egypt theory

Simultaneously, the first historical reference of FGM can be found in the writings of Herodotus, who reported the practice's existence in ancient Egypt in the 5th century B.C.[2] However, Herodotus was not sure whether the custom's origin is Ethiopia or Egypt, due to the fact that it was practiced amongst both Phoenicians and Hittites. Further arguments

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[2] Hanny Lightfoot-Klein, Prisoners of Ritual: Some Contemporary Developments in the History of Female Genital Mutilation. Paper Presented at the Second International Symposium on Circumcision in San Francisco, April-30 – May 3, 1991. http://www.fgmnetwork.org/Lightfoot-klein/prisonersofritual.htm, Retrieved on 07.08.2015

show that FGM was practiced in ancient Egypt, as a sign of distinction among the aristocracy. Also, the pharaohs' wives are believed to have practiced FGM and hence the term 'Pharaonic[3] circumcision' (Comfort Momoh 2005). Evidences of infibulations have been traced on the Egyptian mummies (Izett S & Toubia N 1999; Elchalal U, Ben-Ami B, Gillis R, Brzezinski 1997). Also, a Greek papyrus in the British Museum dated 163 B.C. mentions FGM being performed on girls at the age when they received their dowries. Greek physicians who visited Egypt described the procedure and explained its purpose as the reduction of the female sexual desire caused by enlargement of the clitoris from its rubbing on the women clothing (Comfort Momoh 2005).

In a paper presented at the second international symposium on circumcision in San Francisco in April 30 – May 3, 1991, in paragraph 14, Lightfoot-Klein observes that *"From its probable origins in Egypt and the Nile Valley, female circumcision is thought to have diffused to the Red Sea coastal tribes, along with Arab traders, and from there into eastern Sudan"*[4]. Lightfoot-Klein made this observation basing on the writings of Modawi S. (1974). In paragraph 15[5]; L. Klein reports further about 18th and 19th century travelers observing infibulations upon slave girls along the Nile (see also; Assaad N 1979 & Wallerstein E, 1980). L. Klein highlights Niebuhr, the sole survivor of the first European scientific expedition to Arabia and Egypt who reported about FGM in 1767 and Sir Richard Burton (1954:108), a British explorer and scholar who also lectured extensively on FGM. The author (Lightfoot-Klein) also asserts in her 1989 publication that the Nubian region (Egypt and Northern Sudan) is responsible for the origins of the custom.

Given the assumptions above, a correlation may be drawn between the Egypt theory and high prevalence rates of FGM there (UNICEF 2013; UNFPA Egypt). This theory may also help explain why in the African-Arabic/Islamic countries and communities, FGM-prevalent rates are higher than in African-Christian countries and communities. Moreover, whereas history shows cultural motives, economic roles and power play; FGM amongst particularly Islamic countries or communities continues to be highly misinterpreted and for that matter justified as a religious practice. This shall be illustrated later on in the discussions.

Pathological- theory

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[3] Pharaonic comes from the word Pharaoh, which means the rulers of ancient Egyptian dynasties.

[4] See footnote 2

[5] Ibid

Besides, some gynecologists employed FGM in the West in the 18th, 19th and early 20th centuries to treat pathological female conditions like nymphomania, insanity, and other 'female disorders (Caldwell et.al 2000:239; Sanderson L.P 1981: 28-30). In the UK and the USA for example, there is evidence that *"in the 19th century, the surgical removal of the clitoris was an accepted technique for the management of epilepsy, sterility and masturbation"* (Kandela, P., 1999:353. See also WHO 2006; Assad, N., 1979:12 & Wallerstein, E., 1980:173).

1.2 Understanding FGM perpetuations

Cultural and sometimes religious codes of conducts outline appropriate behaviors that regulate a wide range of activities. Many anthropologists have reached a conclusion about human rituals (like FGM) by focusing their attention on the collective nature of human ritual ceremonies, whose primary function is to maintain the group solidarity through reinforcing the cognitive and emotional substrates of individual commitment to group ideals and values.

Durkheim argues that no knowledge of the world is possible without humanity in some way representing it. Given his sociology of knowledge, many, if not all facets of an individual's thought and conception of the world are influenced by society. Accordingly; not only are our common beliefs, ideas, and language determined by our social milieu – but even the concepts and categories necessary for logical thought such as time, space, causality, and number, have their source in society.

Taking his explanation into consideration, society is thus not just a group of individuals living in a particular geographical location. Rather, society consists also of a collection of ideas, beliefs and sentiments realised through individuals. When individuals interact with one another, a reality is produced. Durkheim uses the term *conscience collectiveness to* refer to this kind of psychic reality. In short, sociology explains society and social phenomenon as fusion of individual consciences, which once created - follows its own laws (social norms).

Social facts are a key to what constitute and express the psychic reality that is society. Through social facts, individuals acquire particular traits like language, values, ways of dressing, religious beliefs, monetary system, technologies, etc., that they would never have had living in total isolation. These mentioned traits fall under *operative order*, which is one of the two *(and structural order* – concerns with demographic and material conditions of life) different classes of social facts explained by Durkheim (1982) in *Rules.* Nevertheless, the term *social fact* remains flexible to include any and all social phenomena. Moreover, to find

commonalities between different societies and their social facts, Durkheim saw the comparative historical approach as the core of the sociological methods. He also argued that contemporary social facts be understood in relation to the social facts preceding and causing them. Here, digging into history may explain the past, whereas the cause and function of social facts even when changes occur over time, is left to sociology.

1.2.1 Social solidarity Theory

Durkheim (1995) claims that ritual performance minimizes individual distinctions and emphasizes the unity of the group. Therefore, collective rituals like FGM perpetuate social orders and enable the expression and reaffirmation of shared beliefs, norms, and values. They are essential for maintaining communal stability and group harmony. A passage occurs when individuals leave one group to join the other. A passage requires a ceremony or ritual, hence the metaphor rite of passage. These rituals may be a sexual separation between men and women, between ages, or the magical religious separation between sacred and profane (secular). Three stages (as explained – a, b, c) cover the rites of passages. a) Separation: People withdraw from their current status and prepare to move to another status. Turner (1995) observes that the temporary removal of adolescents from society during rites of passage increases a sense of 'communitas', thus strengthening social bonds and solidarity within the group or a community of ritual performers. This stage comprises of a symbolic behavior such as cutting off hair, genital circumcision, 'jungendweihe', scarification, confirmation etc. b) Transition. One has left the former self, but has not yet joined the next phase of life. In some communities, individuals may be put in isolation with the aim of teaching values of group attachment/belongingness or unity. c) Incorporation. Having completed the transition stage, a new identity is achieved. Here a sacred bond exists with group members, which increases the feeling of affiliation. As a psychological effect, rewards are used to those who progressively go through transition stages and punishments or ostracism for those who fail.

The performance of these costly behaviors signals commitment and loyalty to the group and the beliefs of its members, thus enhancing trust. However, social bonding is not cost-free. Communities that have initiation rites such as genital mutilations, isolation, food and water deprivation, body markings/tattooing, etc. have costs that include pains, sufferings, deprivation of important food nutrition, and death risks (Glucklich A. 2001; Tuzin D. 1982; Whiting J, Kluckholn R, Anthony A. 1958; Yong F 1965). Sosis R (2003) has argued that

believers are likely to perceive the costs of ritual performance as being less, given the intended benefits such as a pleasant life and assured good social relations. Performances of rituals such as FGM hence mistakenly guarantees long term benefits, as perceived by communities who conform to such practices, hence their willingness to pay the perceived short-term costs.

Mackie Gerry recognizes that harmful practices including FGM result from social conventions and social norms (Mackie, John LeJeune 2009). Individuals and families acquire social status and respect, yet exclusion and stigmatization meets anyone departing from these societal norms. Social convention theory explains why the decision of a family to continue these cultural practices depends on the decision of others to do so. Thus to abandon such behavioral practices is likewise interlinked with independent family decisions.

As a solution, Mackie Gerry introduces the game theory model to explain how to drop such traditional-cultural behaviors. He firstly describes the game-model as the study of interdependent decision making where by *"the choice made by one player depends on the choice of another player. In an interdependent larger group, the choice of each member depends on the choice of all members (...) If a girl in one family is to be circumcised or not, her choice largely depends on the status of all other girls in other families"* (Mackie Gerry 2009:17). Therefore, individual abandonment would jeopardize daughter chance of marriage, and family status, whereas collective abandonment would maintain marriage chances and family status without risks of any kind. Mackie elaborates that the collective decision to abandon a socially upheld practice such as FGM requires a process of deliberation, where members of the community share concerns about the negative consequences of the practice and over time commit to ending it. When groups publicly manifest their agreement to abandon the practice, they make their intention visible to others, thereby making each other confident that they are not alone in their commitment to abandon and therefore do not risk their daughters' future.

Stable situations to Mackie are; a) Best scenario- when all families decide not to cut, b) worst scenario- when all families decide to cut (Mackie Gerry 2009; UNICEF 2008c; UNICEF 2005). Actions supporting the public dialogue process can serve to expand the dialogue across communities and even beyond national boundaries, which is likely to eventually lead to abandonment.

1.2.2 Behavioral theory

Explaining the complexity of human behavior is a difficult task. The theory of planned behavior places the construct of perceived behavior control within a general framework of the relations among beliefs, attitudes and intentions. Azjen in his theory of planned behavior, which is his extension of the theory of reasoned action (Ajzen & Fishbein, 1980, Fischbein & Ajzen 1975, Icek Ajzen 1991), explains the individual's intention to perform a given behavior as a central factor. Intentions to him capture the motivation factors that influence a behavior. The stronger the behavior, the more likely the performance, only with exception if the behavior in question is under volitional controls (the power of choosing). Ajzen (1991:181-182), further shows that attitudes equally influence human behaviors. Attitude towards the behavior is influenced by subjective norms (back and forth) and individual intention finally lead to the actual behavior. Beliefs about the consequences of a behavior in question (FGM) determines behavioral attitudes, the normative consideration consists of social pressure to perform or not to perform a given behavior. In cases of FGM, the subjective norms (social pressure) seem to be stronger than individual intentions. However, if the social pressure to perform FGM within communities were less, most likely individual intentions (to undergo the procedures) would have been limited, given the choice to do otherwise.

To solve the problem, suggestions of concepts of behavior control include; facilitating factors such as the context of opportunity, resources, or action control (Trandis 1977, Sarver 1983, Liska 1984, Kuhl 1985), as seen in Ajzen (1991). In cases of FGM, behavior controls would imply rendering people with the opportunities of choice to perform or not, facilitating them with counselling before performing the procedures so that females can make their own informed decisions and choices. Other activities such as introducing empowerment schemes through education and employment opportunities would help towards controlling the actions.

1.2.3 Psychological process

Meanwhile, the concentration on social institutions and particular environments psychologically instigate FGM practices. *"social and personality psychologists have tended to focus on an intermediate level, the fully functioning individual whose processing of available information mediates the effects of biological and environmental factors on behavior"* (Colin F Camerer (2003:4; Ajzen 1991). Accordingly, institutions like family, schools, media, churches and work places socialize information on cultural practices and

norms such as FGM differently given gender descriptions. For instance; a) the way particular knowledge is passed on to children born in wealthy families or environments may differ from that of poor families, which is also likely to influence the behavioral attitudes of both kinds of children. This is so because the environment in which they grow up, the people they associate with in their daily lives, and each institution they go through; is quite different and influences gender behavioral attitudes differently. b) Children from families where domestic violence is high are likely to reproduce also the same kind of behaviors elsewhere because they are used to that. c) Likewise, FGM behavioral attitudes also have similar psychological explanations based on environment or institution models that replicate particular gender roles.

1.3 Underlying factors/possible root causes for FGM

Polygamy issues: Giorigis maintains, *"The origins of the practice can be traced to the patriarchal family system, which dictated that a woman could have only one husband although a man could have several wives"* (Giorigis 1981:28). While women's sexuality was strongly questioned, male sexual behaviors went unchecked with evidences of polygamy that permitted the dispersion of men's sexual libidos within confined circles (Charles E. Welch & Paul C. Glick 1981; Lourdes Benería & Gita Sen 1981). Whereas it was crucial for men to take on several wives publically (polygamy) in order to demarcate their sexual boundaries and to avoid destabilizing social orders due to cross-sexual encounters; it should be noted that polygamy underestimated women' sexual behaviors, as sexual satisfactions was only a husband's obligations to his wives. Polygamy also threatened sexual obligations; as a man could not equally divide his presence in all his households/ to all his wives, when his presence to each of his wives was crucial. Therefore cutting women sexual organs guaranteed less sexual libidos of wives and dealt with risks of women having love affairs (cross-sexual contacts) outside marriages – hence assuring female fidelity.

While men were the strength of social orders, cross-sexual affairs on the female side would disintegrate those social equilibriums – by bringing men at confrontation/loggerheads – if say their wives had affairs with husband's 'relatives or friends'. That is why it was crucial that men demarcated their sexual boundaries by publically declaring their wives to the whole community. This partly explains the big wedding ideas associated with community presence (in big numbers) in most African communities.

Strong patriarchal systems fostered female 'circumcision' in order to **restrict female sexuality and preserve male lineage.** Wilson agrees, contending that the primary

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motivations for FGM practices are the limitation of women's excessive sexual desire to ensure their premarital virginity and marital fidelity (Wilson, T. D. 2002). FGM is thus one way through which patriarchy exercises dominance over women (Donald.B, Barstow 1999; Hosken FP 1995). In the gender power relations, men's greatest desire is to control and manipulate women's sexuality to their advantage. In a speech given by the U.N. human rights chief Navi Pillay FGM was addressed as a way to exercise control over women (Reuters; by Robert Evans Mon Jun 16, 2014). In retrospect, it is difficult to establish cultural constructions that limit male sexuality across different cultures. Human rights discourse face challenges arising from such impressions. The claims of rights of cultural self-determination is incompatible with the rights of the women with regard to those cultures that may be threatened by the loss of control over women's sexuality, where such control may be the part of the manner in which such cultures identify themselves.

DNA assurances: FGM practices also ensured that children born (of wives) belonged to husbands and not 'lovers', which ensured fatherhood and maintained patriarchal lineages. Men in the past left their homes for longer periods to embark on wars or for employment, leaving their wives and children alone (Colin Murray 1981; Catherine Clinton and Nina Silber 1992). This created insecurities in families as contacts were rare. FGM practices thus assured husbands that their wives were safe and intact on periodical sexual encounters.

On the other hand, it was abomination in the past for women to bear children outside marriages. Punishments were extreme which included expulsion of a woman and her child from the community. It was also shameful for a man if such information-questioning child's DNA leaked out to the community. This implied that a husband could not fully fulfill his sexual duties to his wife, hence being a laughing stock in the whole community. FGM practices thus meant to protect the husband's honor and family position in society through assured fatherhood and continuous child bearing and raising.

Female Virginity*: Meanwhile, for girls that were not yet married, it was important that they remained virgins until their wedding nights, to avoid unwanted pregnancies (see John W, M Whiting, Victoria K Burbank, Mitchell S, Ratner, 2008). Through FGM, fathers guaranteed the preservation of daughters' virginity until marriage (A, Shack W, 1974; Elizabeth Castelli, 1986), since they were far away from home to keep an eye on daughters' behaviors. Yet, the male dominated community opinions less trusted single mothers in bringing up their children, especially the daughters.

Virginity being an important transaction for marriage ensured high bride price in return and guaranteed dowry payments. Yet, not being a virgin on the wedding night upon sexual intercourse, brought shame to the whole family, especially the mother. This led to the collections of already-paid-dowries back, in exchange to a 'free' bride. In other words, the bride stayed married, but dowries often demanded back. Rarely did the husband return the bride upon confirmation that she was not virgin. It should be noted that virginity was (and still is in some communities) a pre-requisite of marriage for females and not males.

Rahman and Toubia (2000:5-6) write that the aim of FGM in Egypt, Sudan and Somalia is on curbing premarital sex, whereas in Kenya and Uganda the purpose is to reduce a woman's sexual desire so that her husband can more easily take several wives. In both cases, the aim is to serve the interests of male sexuality. Therefore, in traditional African communities where FGM is visible, the strong distinction between 'good' women (sexually passive) and 'bad' women (sexually active), provided women the knowledge that in order for them to avoid stigmatization, maintain a good reputation in their societies and the social cohesion, they have to adhere to FGM, get married and finally take on home roles. This is not only a typical ideal condition of femininity but also a form of social control, coupled with sets of conformity mechanism such as beliefs in myths about the spiritual world, death of babies at birth, long growing clitorises, etc. These conformity measures ensured FGM practices and their observance.

1.4 Common justifications for FGM

Various reasons advance the continuous practicing of FGM. These range from cultural, religious, to socio-economic and political reasons.

Rite of passage: FGM is believed to be an important rite of passage to womanhood, through which cultural values and adult expectations are conferred to the initiates. Many supporters regard it as *"a central coming-of-age ritual that ensures chastity and promotes fertility"* (Abusharaf 2006a:1). In Kenya, non-circumcised girls are ridiculed and addressed as children (Gwako, E. L. Moogi 1995). In Ghana, they never get to perform certain important ceremonies attached to their mother's funerals (Akwaengo P 1999). In Egypt, their marriage chances decrease because they are not potential adults (Population council). The process of becoming a woman contributes to the maintenance of the custom by linking the girl to the community's lifestyle. FGM represents an act of socialization into cultural values and a connection to family, community members and previous generations

Social pressure: Anika Rahman and Nahid Toubia (2000:6) describe, *"In a community where most women are circumcised, family, friends and neighbors create an environment in which the practice of circumcision becomes a component of social conformity",* due to fear of community judgement and of not getting a husband. Therefore FGM's continuity is justified by its necessity for social homogeneity.

Marriage-ability: Gerry Mackie (1996:999) suggests that the primary reason why FGM continues is that it is a *"self-enforcing convention"* maintained by *"interdependent expectations on the marriage market."* Female sexuality in practicing communities is within contexts where girls' **virginity** is an absolute **pre-requisite for marriage**. As the practice greatly enhances the chances of marriage for girls, it also attracts high bride price for particularly circumcised girls, as self-reporting within the Maasai in Kenya have identified. Marriage market and bride price thus have continuously acted as a push and pull factors. In some instances, marriage can never be complete without the cut. Marriage thus bestows the power to transact and participate in important community rituals.

Economic factor: FGM is also economically relevant for women due to the power imbalance and social structures found in majority of African countries. Women find themselves in a compromising position due to constrain by the gender world, in which men have a greater degree in the control over access to resources and cash. For that matter and in relation to the already seen marriage factor above, many women have for instance undergone and forced their daughters to undergo FGM in preparation for marriage.

a) Marriage is a woman's way to survival because it provides security, stability, authority and to some extent wealth. In conforming communities, where FGM is a requirement for marriage, a non-circumcised woman is an outcast, impure, and therefore does not meet the marriage-ability standards. Research experiences in Kenya show that circumcised girls provide an additional income to the girls' families through dowry price, compared to the uncircumcised girls.

b) The more females a particular homestead has, the more economic security families can count on through marriage exchanges – accomplished by undergoing circumcisions among practicing communities.

c) When families give away their daughters for marriage, it cuts back family expenses in terms of feeding, clothing, health and education.

d) For circumcisers, performing FGM may imply status in own community. Besides, it is one of the very few 'sustainable' female sources of incomes that may be available in traditional African communities – since women are not expected to work.

e) Medical personnel have also increasingly been engaged in the practice because of the economic incentives.

However, women who form part of an emerging bourgeoisie find themselves with a greater degree of control over the choices that are open to them, because of their less reliance on the male networks that peasant women depend on for existence.

Psychosexual factors: Psychosexual factors include the belief that the clitoris is an aggressive organ, which threatens the male penis by making men impotent and may endanger the baby during childbirth. So many other myths associated to FGM fall here.

Controlling sexuality: In order to suppress women's sexual desires, many communities embark on cutting and stitching women sexual organs (A Rahman and N Toubia 2000). This is one way of ensuring that sex for pleasure is discouraged before, during and outside of marriage. Excision and infibulations are necessary in order to protect women from their innately 'over-sexed' nature. Infibulation almost guarantees virginity before marriage because of the pain associated with sex and the difficulty of opening the infibulations without discovering it. In some communities, a woman is re-infibulated to enhance the sexual pleasure of a husband after giving birth or after divorce (Van der Kwaak, A (1992). Beliefs from communities show that uncircumcised women are easily aroused and may therefore behave in ways that are culturally inappropriate (Momanyi Mokaya 2001), hence FGM.

Religious doctrines: Interpretations of some doctrines by male religious leaders have given the impression that FGM is a religious requirement. In some societies, Islamic religious leaders have reinforced the practice by teaching their followers that FGM has religious significance such as cleanliness and purity, hence associating it with Islam (Toubia N 1995; A Rahman and N Toubia 2000). Communities like the Somali, Borana, Orma, Wardey, and Boni in Kenya and most women in Egypt regard FGM as a religious requirement. The clitoris is *haraam* (impure) and must be removed (Lovel H., N. Bedri, Z et al. 2004). However, examinations of the Quran teachings reveal that there is no such requirement in Islam (Lethome Ibrahim 2008). Even in strongly associated Islamic nations like Saudi Arabia, Arab emirates, there is no such practice.

Cultural identity: Almost all communities that practice FGM consider it a sign of ethnic identity (Richard A Shweder 2002; Nahid Toubia 1995). FGM bonds the community together and community may perceive those who do not cut as traitors or impostors (Comfort Momoh 2005). The practice instills morals and social values in girls, which are necessary for their respect and acceptance as adult women.

Political dimension: FGM is responsible for the maintenance of social and political cohesion of the society. Any attempt to stop it is likely to destroy the relationship between the central political government and the traditional community leaders. This may cause a threat to the central political system because; *"there is a reciprocal interest of maintaining power between the protectors of traditions and cultures and the protectors of political institutions and power. In some cases, these are the same power holders"* (Rasheed Akinyemi 2000). Jomo Kenyatta, Kenya's first president identified and protected the indigenous (FGM) cultures, at the same time he was a central political figure (see Jomo Kenyatta 1989; mentioned also in the KHRC interview in Kenya).

Taking into consideration the political realities of Africa, people live in the domain of two political systems; a) the indigenous one, which many Africans identify with and commands loyalty – because it is not imposed and does not use force for recognition, b) the contemporary central political systems whose reverse is true (Rasheed Akinyemi 2000). These two systems contradict each other because the latter protects the cultural values and traditions, whereas the former promotes modern and sometimes western values. This partly explains why political leaders in Africa have shown less or no political will to engage in abandonment campaigns; let alone have defended and used such cultural practices to gain political power (see Kenyan interviews-MGCSD). Upholding FGM has thus shown that political central legitimacy in some African countries highly depends on respect for the indigenous cultures and traditions. These still regulate up to 80% of the populations' lives. The contemporary modern political systems on the other hand, regulate the remaining 20% of lives especially in urban centers (Rasheed Akinyemi 2000).

1.5 Associated risks/consquences of FGM

FGM has no benefits, even though positively justified in prevalent communities/countries. Depending on type done, related consequences range from health, to psychological and social related problems as seen below.

Health complications: Studies undertaken by UNICEF (2005) and WHO (2006) reveal that there are serious complications that stem from FGM, which include - severe pain; bleeding; reduced urinary retention; abscesses, painful cysts and keloids which can cause problems during pregnancy and childbirth and infertility. A WHO study undertaken in six African countries reveal that FGM is associated with an increased risk of obstetric complications, including caesarean section, postpartum hemorrhage, and extended hospital stay, the need for infant resuscitation, stillbirth, and early neonatal death (WHO 2006). However, these consequences differ by type depending on severity (C.M Obermeyer 2005).

In the case of FGM type III, complications are severe; *"the birth canal becomes constricted when the wound heals resulting in obstruction or tear. When obstructed pregnancy occurs, obstetric fistula may form. This condition is particularly debilitating, involving perforations inside the vagina, bladder or rectum and leading to chronic condition. Tears on the other hand can cause the girl to bleed uncontrollably which may result in death if there is no emergency medical care."* (WHO 2006:367).

In some FGM prevalent communities, such health consequences are rarely attributed to the practice itself – but rather evil spirits, mothers' infidelity, and procedures having been witnessed by a menstruating woman. This calls for sensitization and awareness raising of factual health consequences, especially at the grassroots levels

Sexual complications and trauma: Girls and women, who have undergone FGM, may have trouble during sexual intercourse (refer to KHRC and Ibrahim Lethome interviews in Kenya). This is especially so in cases of infibulations where the small opening left causes destructive pains, bleeding and psychological disorders (Toubia N 1995; 1994). Such complications may extend also to the male sexual organ as described by the study taken in Sudan by L Almroth, V Almroth-Berggren, et.al (2001). Some women end up denying their spouses sex due to unspeakable pains and threats of obstructed labor pains (see H Lightfoot-Klein 1989; A Elnashar, R Abdelhady 2007). Since the whole idea of FGM is to stem down the sexual urge for women, FGM is thus likely to result in emotional and sexual damage (e.g. type III) leading to marriage break ups.

Marriage breakups and or polygamy: Failure to undertake expected feminine roles and marital duties, increases risks of marriage breakups through divorces. A Kenyan lawyer informed in interviews of 2011, that he had handled about fifteen Somali divorce cases in about two years because of husband dissatisfactions of the marriage life. He also added that

infibulated women were not happy in either way, which caused their husbands to take over second-non-circumcised wives. Although men file easily divorce cases, for women it is complicated because culture does not necessarily support women wishing to divorce (Denise Paulme 1963; HK Schneider 1964). As a result, women become double victims of FGM and marriage failures.

Early- marriages and associated problems: While circumcision demarcates marriage eligibility and adulthood (Ross, Susan Deller 2008:473), communities that perform FGM as a rite of passage – usually arrange early marriages for girls before the consent age of 18 years (N J Diop, A Moreau, H Benga 2008; J Boyden, A Pankhurst, Y Tafere 2012). Early marriages follow early pregnancies and parenthood, which roles young girls are not physically or mentally ready for. Sequences that take place in a girl's life after FGM and early or forced marriages – have negative implications on a girl's physical, developmental, psychological and social-economic wellbeing (see FORWARD 2002-2014; UNICEF 2005; Elimu Yetu Coalition 2005; G H Elder, R C Rockwell 1976).

Men who marry these girls are sometimes big enough to be their fathers or grandparents. Because of the age difference in these marriage institutions, domestic violence cannot be ruled out. Girls cannot claim their rights and often times fail to speak against their 'husbands' deeds (K D O'Leary, J Malone, A Tyree 1994; KD O'Leary 1999; JC Babcock, J Waltz, NS Jacobson 1993). Problems that occur from marriages of unequal partnership are often non-officially attended to (they stay out of court), because they are regarded as family issues, supposed to be solved within family institution. It should be noted that in most patriarchal societies, men are rarely condemned. Rather, women deeds, which instigated the husband's reactions are capitalized upon and judged in favor of the man (see KHRC interview recordings).

School dropouts: According to Woman Aid International, in Kenya, *"circumcision of girls makes them feel grown up, they have no qualms having sexual relations with adult men, and grown men also view them as mature women ready for sexual relationships. In areas where girls are circumcised, there are higher rates of teenage pregnancy and school dropouts. Teachers report that there is a noticeable drop in school performance soon after circumcision"* (Women aid International.org). At the Illchamus anti-FGM declaration ceremony, one informant observed that in some cases, the girls may want to continue with their education, but after they get circumcised, their parents forcefully marry them off – as circumcision and marriage go hand in hand. One Maasai parent commented that, *"once girls*

are circumcised, they are now big enough to be on their own, and take up motherly roles. Two adult women cannot leave or cook in the same house." Implying, the mother and the circumcised daughter cannot still share the same roof after circumcision. The daughter has to get out (marry) and start her own life.

Early school drop outs has consequences such as increased illiteracy rates, lack of employment, women increasingly being dependents in all aspects of life, inferiority complex, women increasingly taking less decisions in matters that affect them, etc. All this keeps the vicious cycle of FGM in play because a particular community keeps on reproducing the same people who are less empowered.

In such communities, education may play a big role towards empowerment. According to Ban Ki Moon Education is central to ending FGM (The Guardian, 18.02.2014), because it paves way for enlightened decision making, informed choices, broadens contacts, job opportunities, etc. Indeed, evidenced in Kenya shows that FGM is less likely to be performed by the wealthy, and educated as compared to the poor and illiterates (Malini Morzaria and Zeinab Ahmed - UNICEF website). Campaigns are put forth to strengthen education in order to eliminate FGM.

1.6 Documentation of FGM

Several studies in different African countries have provided information about the practice (MICS-DHS 1997-2006; Hosken F, 1978; Toubia N, 1994; WHO, 2008). Since the 1950s, physicians and gynecologists have undertaken small studies, using clinical records or direct interviews with patients (Morrone A, Hercogova J and Lotti T, 2002; Khama Rogo, Tshiya Subayi, Nahid Toubia, 2007). Early European travelers and missionaries also informed about FGM practices in their earlier reports (Widstrand C.C, 1965; Lightfoot Klein-H, 1989). Snow (2001) argues that until recently, the source of much prevalence data on FGM were the global mappings from Hosken (1978/9), used as a major source of global estimations and citation (see also Khama Rogo, Tshiya Subayi, Nahid Toubia 2007:4).

However, Hosken's reports have been criticized for not specifying the exact methodology by which data were collected (Morrone, A., Hercogova, J. and Lotti, T. 2002), use of anecdotal accounts and generalization of data from small studies (Snow R C, 2001). Hosken's reports have been compared to Nahid Toubia's 1994 study, which seems more rigorous due to citation of the difficulties of population estimates and confidence intervals provided in estimations (Morrone, et.al 2002). In "Female Genital Mutilation: A Call for Global Action"

first published in 1993 and later revised in 1995, Toubia modified Hosken's figures based on more recent country studies and reports.

Demographic and Health Surveys[6] in various African countries since 1993 have further provided more recent scenarios of FGM practices, representing estimates of 16 countries in Sub-Saharan- and North Africa (Khama Rogo, Tshiya Subayi, Nahid Toubia 2007). These sources however underscore the variations between ethnic groups within the same country. In countries where there are no DHS conducted, FGM estimates are from national surveys, or studies conducted by local organizations. Also, WHO and the US department of state have estimated prevalence based on anecdotal evidences in countries like Cameroon, Chad, Liberia, Ghana and Senegal without DHS/MICS data (Khama Rogo, Tshiya Subayi, Nahid Toubia, 2007). Most recently, UNICEF is also actively participating in nationwide FGM data collection or updating of existing country level data on FGM in prevalent countries

However; because most surveys rely on self-reporting, problems such as variations in type or severity of FGM is typical. Addressing such a problem is not an easy task, as proof can only be provided by clinical studies, which are few and cannot be generalized on an ethnic- or country level. Although unethical, the safer way of trusting self-reported studies (regarding whether FGM was performed or not, and if so, which type) would be by individual/ case observations to confirm evidence. However, this is quite impossible in terms of research ethics and individual manners. Further shortcomings include; a) difficulties in extrapolating several data to give a genuine national picture about FGM per country while taking ethnicity and type description into consideration, b) Incomplete existing data, c) missing data and information, and d) generalization of ethnic data from sample studies for country reports. Therefore generalizations about the validity of self-reporting should be taken cautiously.

1.6.1   Prevalence of FGM in Africa

Studies by WHO and UNICEF have indicated that FGM is widely practiced in the 29 African countries at varying magnitude. The practice is most common in a band that stretches from Senegal in West Africa to Ethiopia on the East coast, Egypt in the North and Tanzania in the South of the stretch. The prevalence varies considerably – between and within regions and countries – with ethnicity as the most decisive factor (WHO 2008; UNICEF 2005).

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[6] "DHS are nationally representative house hold surveys with large sample sizes of between 5000 to 30,000 households. They provide data for a wide range of monitoring and evaluation indicators in the areas of population, health and nutrition. The national Demographic and Health Surveys are prepared and organized by Macro.International Inc. USA." (Khama Rogo, Tshiya Subayi, Nahid Toubia 2007:4)

Infibulation for instance is said to be widespread in Somalia, northern Sudan, and Djibouti. This same type has also been reported in Gambia, Egypt, Ethiopia, Eritrea, northern Kenya, some parts of Mali and northern Nigeria (Morrone, A., Hercogova, J. and Lotti, T. (2002). UNICEF (2008) has broadly categorized prevalent African countries in three groups.

- Group 1 is made up of countries like Egypt, Sudan, Mali, Eritrea, Guinea and Ethiopia where nearly all women have undergone FGM (80% or more).

- Group 2 consists of countries such as Kenya, Chad, Cote d'Ivoire, Central African Republic and Mauritania among others; where only certain ethnic groups practice FGM (25%-79%) with varying intensities.

- Group 3 entails countries like Tanzania, Benin, Ghana, Niger, Uganda, Yemen, etc. where only a few ethnic groups practice FGM, affecting say 1%-24% of the total population.

Countries within each group show similarities in the way FGM is practiced and in inter-regional prevalence variations

Map showing prevalence of FGM in Africa and Yemen for women aged 15-49 years
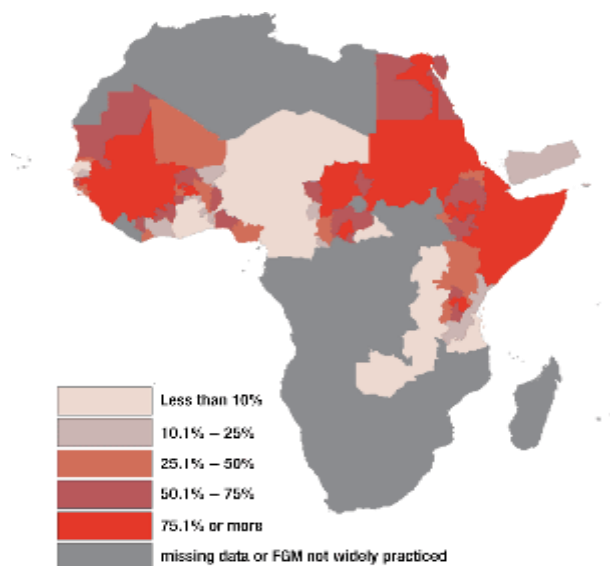
"Source: MICS, DHS and other national surveys, 1997-2006. Map developed by UNICEF, 2007" (WHO 2008).

1.6.2 Prevalence of FGM in Egypt, Kenya and Ghana

The 2005 **Egypt Demographic and Health Surveys** (EDHS) show that 96% of ever-married women in Egypt aged 15-49 years have been circumcised (El-Zanaty, Fatma and Ann Way. 2006). Although improvement to 91% have been represented in the EDHS 2008 (El-Zanaty, Fatma and Ann Way. 2009); convictions of practicing FGM are still high. Since FGM is

almost universal in Egypt, social-demographic variations such as geographical locations (urban-rural), marital status, education levels, wealth, etc. are almost insignificant variables with limited scope of influence. According to the WHO Bulletin, *"In Upper Egypt governorates – the prevalence is high in Luxor city (85.5%) while in Assuit and Beni Suef rates are 75.5% and 73.1% respectively. In Lower Egypt governorates, the prevalence rates of FGC are reported to be 49.8% and 73.9% in Dakahlyia and Sharkia. The lowest rates of FGM were seen in Port Said, Demiatta and North Sinai with prevalence rates of 17.9%, 21.5% and 25.3% respectively"* (Mohammed A Tag-Eldin , Mohsen A Gadallah, et.al 2008). Given these estimates, FGM is higher in the Southern part of Egypt. Given the 2008 EDHS, data on circumcision status of girls aged between 0-15 years was captured for the first time and showed a slow and steady decline in the rate of FGM in this age set (Ghada Barsoum, Nadia Rifaat. et.al, 2009).

The **Kenya Demographic and Health Surveys (KDHS)** on the other hand represent ethnic variations and country wide systematic reductions of FGM. This is represented in most recent UNICEF (2010 & 2014) studies, indicating abandonment progress. Recent prevalent rates are estimated at 27%; in comparison with the 32% (KDHS, 2003) or 38% (KDHS, 1998) reported cases of affected women and girls in the previous years (see also CBS, MOH and ORC 2004).

Significant regional variations ranging from 4% in the west to 99% in the North east are stated (UNICEF 2005:5). Ethnically, the practice is *nearly universal* among Somali (97%), Kisii (96%), Kuria (96%) and Maasai (94%) women; *common* among Taita/Tayeta (62%), Kalenjin (49%), Embu (43%) and Meru (41%); *low* among Kikuyu (33%), Kamba (27%), Turkana (12%) and Mijikenda/Swahilki (6%) and *almost non-existent* among Luhya and Luo women – each having less than 1% (see KDHS (2003). Even in communities like Samburu, the Njemps and the Borana, prevalence rates-estimates are as well almost universal (Masheti Masinjila, Miles, and O.W. 2008).

Research carried out by Population council indicates that the proportion of women cut decreases steeply with age, from nearly one-half of women aged 35 years and above to 26% of those aged 15-19 years. This is particularly pronounced among the Kalenjin, Kikuyu and Kamba (Njue Carolyne, Askew Ian 2004:2).

In Ghana, an estimation of only 5% of the women aged 15-49 years have undergone through FGM (Ghana Statistical Services 2003), as compared to Egypt and Kenya. In 1996, Amnesty International Ghana and Association of Church Development Projects – estimated excised

cases at 76% in the Upper East, Upper West and Northern regions. Affected communities in these regions include: Kassena-Nankana, Bolgatanga, Bawku East and Bawku West (located in Upper East Region); Bole, Mamprusi, West Wale wale and Zabaugu-Tatale Kotokoli (Northern Region); Wa and Nandom (Upper West Region) and Kodjebi, Worawora and Jasikan (northern Volta Region) - (GAWW 2005).

FGM data collected in 1995 by the Navrongo Health Research Centre (NHRC) indicated the largest-ethnic practicing groups as Nankana and Kassene, with 77% prevalence among women aged 15-49 years (Akweongo, P, E. Jackson, et.al Forthcoming; NHRC 1998). There are marked differences in generational trends in Kassena-Nankana district. Namely, 94% of women aged 35 years and above have been circumcised, compared to 26% of ages 15 to 19 years. Further declines were noted in 2000, with 83% dropping prevalence among the older group and 8% declines among younger generations (Elizabeth F Jackson, P.Akweongo, et al. 2003:7).

Although recent evidence in the three countries suggests that the practice is undergoing a major decline, accurate measurements of individual status possess practical and ethical challenges. This is due to denial among respondents associated with criminalization of the practice in recent years (Oduro, A.R. et.al, 2006:87). In Ghana for instance, the study conducted on women aged 15-49 years in Kassena Nankana district compared the self-reported circumcision status of women interviewed in 1995 with status reported when the same age group was interviewed in 2000. Results showed higher denials of FGM status in the later (2000) study (Elizabeth F Jackson, Akweongo P, et al, 2003:7). Explanations for Self-denials have been associated with the FGM law passed in 1994. This law was not yet wide spread by the time of the first study in 1995. In 1996, a jailed-circumciser (under the FGM law) sent a signal to many communities. This shows that the law against FGM and its associated impacts (i.e. criminalization) eventually gained prominence, hence denials of self-reported FGM status in the second study in 2000 (Elizabeth F Jackson, et al. 2003).

The limited availability of such reports in many countries does not rule out the fact that such challenges occasionally exist. If not identified, self-denial reports cannot be re-evaluated, which affects project reports and results, hence the need for back up studies in order to identify and address such challenges.

1.6.3 Factors influencing the prevalence rates of FGM

Different factors account for the variations in the prevalence of FGM within and outside geographical boundaries.

Type: Current estimates indicate that around 90% of female genital mutilation cases include Types I, II and IV, and about 10% are Type III (WHO 2008). In Egypt alone, type II accounts for 72%, type I for 17% and type III for 9% (Rahman Anika and Toubia Nahid 2000). In Ghana, type II is commonly practiced (Rahman Anika and Toubia Nahid 2000). In Kenya, type II accounts for 83%, type III-13% and type I only 2% (KDHS 2008-2009). Type II-excision is the common across the three countries, while infibulations are generally prevalently less. An increasing trend towards the "lesser cut" is evident in Kenya and Egypt, replacing extreme forms (PATH 2005). It is clear that this change is not abandonment, but a subsequent shift caused by awareness. Whether this will lead to shifts towards total abandonment or stagnations of FGM is difficult to tell. However, in my opinion, dispersing messages of total abandonment is advisable for pragmatic actions.

Education levels: DHS and MICs data allows the presentation of FGM prevalence among women according to their education attainment (UNICEF 2005:13). Generally, the mother's level of education attainment not only appears to be a significant determinant of the FGM status of daughters, but education especially of women, can play an important role in safeguarding the human rights of both women themselves and those of their children. Data from the 1989 Sudanese survey for instance show that 80% of women with no education or only primary education support FGM, compared to only 55% of those with senior secondary or higher schooling (DHS 1989/90:121). In Kenya, 58% of women with no education reported having been circumcised; compared to only 21% of those with at least some secondary education (GTZ 2007). Levels of FGM practices amongst daughters of the mostly educated Kikuyu ethnic women are lower, compared to the uneducated Maasai women's daughters (GTZ 2007). As for Egypt, although FGM is universal and such variations are hardly remarkable, nevertheless 92% of the mothers of circumcised daughters are illiterate, as compared to 69% of mothers of uncircumcised girls (Sayed G H, Abd E1-Aty M A, Fadel K, A 1996).

In addition, daughters of educated women are more likely to have received less severe forms of FGM compared to daughters of uneducated women (UNICEF 2005:9). Generally, the

levels of education attained, affects the ways of thinking and dealing with FGM issues. The higher the education levels, the lesser the risk towards FGM and the vice versa is also true.

Ethnicity: Among all socio-economic variables that affect FGM distributions, ethnicity appears to have the most determining influence within a country. Whereas FGM serves as an ethnic marker or identity, the variation is however largely explained by the presence of diverse ethnic communities with differing attitudes and practices. This demonstrates the given variations in FGM practices within geographical locations, across the continent and among communities. Egypt in this case is exceptional, because variations per ethnicity are insignificant/nonexistence (populations mostly have Arabic background and FGM is universal) unlike the cases in say Kenya, Ghana, Sudan, Nigeria, etc (Rahman Anika and Nahid Toubia 2000).

Urbanization, whereas women leaving in rural areas are more likely to perform FGM, those in an urban set up escape the practice easily, because of less pressure from their surroundings. According to UNICEF (2005), out of the 18 countries covered by DHS or MICS, 12 demonstrate a higher prevalence of FGM in rural areas than in urban areas. In Kenya for instance, the 2003 KDHS noted a higher proportion of rural - than urban women who underwent FGM (GTZ 2007). Figures by MICS in Ghana also suggest a 4% difference in FGM prevalence between girls and women who live in urban and rural areas (MICS 2006). In Egypt, Ethiopia and Guinea, urban and rural differences are very small or nearly identical (UNICEF 2005) because FGM is almost universally practiced. In exceptionally four cases (Burkina Faso, Nigeria, Sudan and Yemen), prevalence in urban areas is higher than in rural parts of the country (UNICEF 2005).

The likely explanation for the rural-urban differences is firstly a phenomenon that explains effect of ethnicity. Secondly, women in rural areas tend to concentrate within their ethnic compositions, hence sticking to their traditional ways of life that govern their communities for social relations. Thirdly, given a multi-cultural set up in urban areas and a very different set up in urban ways of living, practices like FGM are irrelevant. Conformity is not necessary and does not determine social relations like the case is in rural areas.

Religion: UNICEF (2005) also notes that in the six countries where data on religion is available (Benin, Cote d'Ivoire, Ethiopia, Ghana, Kenya and Senegal), Muslim population groups are more likely to practice FGM than Christian groups. Reason being that FGM is supposedly a religious requirement (UNICEF 2013). However, in some cases like Niger,

Nigeria and Tanzania, the prevalence is also greater among Christian groups (UNICEF 2005). Given the fact that there is no mentioning of FGM in either the bible or the Quran (Dellenborg, Liselott 2004), even the fact that the practice does not uphold in pure holiest Islamic cities like Mecca and Medina in Saudi Arabia (Mackie Gerry 1996), religion still very much influences FGM. These relations are drawn simply from religious teaching of female modesty and chastity.

Wealth: Traces of FGM determinant can also be associated with the wealthiest and poorest sectors of society. While FGM normally affects poorer women living in rural areas with most likely lower levels of education, the prevalence seems to decrease among women of 'richer' household, who could be born into wealth, married into it, or worked hard for it (UNICEF 2005:12). In Egypt for instance, FGM levels steeply drop according to wealth levels (UNICEF 2010). Although this correlation is not consistent, nevertheless, women have several compelling economic reasons for perpetuating the practice, many of which are pronounced power imbalance between genders.

Age and reason: The average ages at which girls undergo FGM vary greatly from one country to another. According to UNFPA (2010), the majority of FGM cases are performed between 4-14 years. In Kenya for instance most girls undergo FGM in their adolescent ages, in preparations for the rite of passages to womanhood, which is immediately followed by marriage or marriage proposals (Gruenbaum Ellen 2001). About 90% of girls in Egypt are cut between the 5-14 years (EDHS 1995 & 2000) for chastity, cleanliness and moral purposes, but also eventually for marriage purposes. However, in southern Egypt girls undergo the procedure at very infant ages of one or two years. In Ethiopia, Mali and Mauritania, more than 60% of girls surveyed underwent the procedure before their fifth birthday (DHS). In Yemen, the Demographic and Health Survey carried out in 1997 found out that 76% of girls underwent FGM in their first two weeks of life (UNICEF 2005).

According to the DHS and MICS surveys, the median age at the time FGM takes place has dropped substantially, and hence operations take place on very young children, infants, and toddler. Reasons for the decline in age of FGM performance includes; FGM on infants can easily be hidden from the authorities than mature ages; the desire to minimize the resistance of the girls themselves due to exposure to sensitization and awareness- raising campaigns and interventions; the belief that younger girls heal faster, etc.

1.6.4   Emerging trends

The practice is currently taking on different characteristics because of strengthening abandonment procedures, coupled with criminalization in both conforming communities within a geographical boundary and within receiving countries in cases of immigration.

Negative

Shift in age: Girls are subjected to the practice at much younger ages or even as babies *than* previously. This trend is common in Burkina Faso, Côte d'Ivoire, Egypt, Kenya and Mali (UNICEF 2005). Affected communities in Kenya are Kisii and Maasai (Interview recordings by the national gender coordinator of World vision).

Shift to a mild cut: Increasing trend towards 'milder or lesser cut' has nowadays replaced the severe forms. This may be indicative of shifts in awareness and subsequent change of practice within communities such as those of Somali and Borana in Kenya, who have commonly practiced infibulations. These shifts do not guarantee abandonment. Moreover, complications and human rights abuses still occur.

Medicalization: There is increasing clinicalization of FGM due to fear of health complications of FGM either directly associated with the FGM procedures themselves or the unhygienic surrounding, critics on old age and possible sight problems of circumcisers, crude instruments used without anesthesia, lack of trainings, etc. However, in whichever form, conditions and place FGM is practiced, it should strictly remain forbidden because of its human rights violation and health risk impacts.

Cross boarder FGM: In communities where criminalization of FGM is highly observed, parents have resorted to sending their girls to neighborhood communities, with less criminalization and enforcement mechanisms (KHRC interview recording). In Namanga (at the boarder of Kenya and Tanzania), some Maasai are crossing borders to Tanzania to have FGM performed on their daughters. Recorded interviews with MGCSD in Kenya indicate that the Sebei practicing communities in Uganda are crossing over to Kenya to have their children excised. Also in Ghana, Burkina Faso and neighboring communities in northern Ghana interchangeably have girls circumcised in different territories or communities to escape criminalization.

FGM underground: Besides, strengthened eradication campaigns and criminal policies have shifted the procedure from openly taking place. Public ceremonies or functions associated

with FGM are of lately rarely performed, for fear of trigger of arrests. While these developments are typical among some Maasai communities of Kenya, in Egypt, FGM denials remain higher, even though the number of victims and those who support its continuation are persistently common. Likewise, research carried out by Elizabeth F.Jackson; Akweongo P, et.al (2003) in Ghana has also shown self-denials in northern Ghana after the 1994 legislation against FGM and its associated impacts. It should be noted that: it is hard to account for underground prevalence; which directly affects results that gauge declining levels of FGM practices. Studies usually do not include the number of cases still upholding the practice in hidden – while at the same time publically denouncing FGM.

Adaptations: Other ethnics adopt the culture for integration purposes. This is so for example in Northern Sudan, where minority groups such as the Berti who did not traditionally practice FGM, are now adopting it, *"in pursuit of identification with Sudanese high culture"* (El-Tom, Abdullahi 1998:169).

Asylum seekers: Today, FGM has taken on a political dimension of being reasons for seeking Asylum in the West. Although it is a protective measure undertaken, it only takes into consideration immigrant communities, while under looking the whole saga from indigenous countries. Piot Charles (2006) gives an example of a Togolese woman who sought and won political asylum in the USA in order to escape FGM and forced marriage. Although there may be limited evidence to prove the reality and validity of such cases, granting asylums does not tackle the problem at its roots. It only manages to protect a handful of victims who have managed to cross overseas, while leaving the majority of girls at risk in countries where FGM is highly prevalent. The problem should be tackled at its roots before escalations!

Positive

Laws among receiving communities: Apart from countries where FGM is originally prevalent, western countries have also come up with laws, regulations and policies to curb FGM amongst immigrant communities. For example in the USA, in 1996, the congress passed several legislative measures related to FGM (Rahman Anika & Nahid Toubia 2000: 236-241), where by fifteen states including California, New York, Colorado, Texas, Tennessee, etc have already criminalized the practice. In USA's section 116 of the illegal immigration reform and immigration responsibility act of 1996, section a part b, FGM of any form is punishable by a fine, or an imprisonment of not more than 5 years, or both (Rahman Anika & Nahid Toubia 2000). In Denmark, "the Danish medical women's Association proposed to the ministry of

health a legislation prohibiting FGM. The ministry of justice responded by stating that FGM could be prosecuted under existing criminal code provisions." (Rahman Anika, Nahid Toubia 2000:136). In Germany since 2013, FGM is punishable under section 226a of the criminal code (StGB) and it is an offence as well since 2015, once carried out on German residents in foreign countries. It should be noted that in Europe, 500,000 women and girls are affected and 180, 000 at risk (EIGE 2013). The higher the number of immigrants from originally prevalent countries, the higher the risks of those affected. FGM is also sometimes carried out within the EU or during holidays in countries' of origins. The existence of high prevalence in the EU is a negative trend by itself since FGM was originally not practiced.

Generation trends: Additionally, FGM is declining among younger generations, although still persistent in the older age groups. Nevertheless, younger generations are the future of tomorrow, hence a likely possibility of curbing down FGM in generations to come

Preference for abandonment: Given variations in behavioral attitudes, a practice once a taboo has gradually changed. Communities are increasingly accepting abandonment due to increasing grass root campaigns against FGM and community involvement.

Cooperation of cultural and religious leaders: There is also an increasing involvement of community leaders, especially those who are well known for keeping cultural values and traditions ongoing. These have influenced their folks towards abandonment through either leading by examples, or speaking against FGM instead of enforcing the practice

1.7 Medicalization of FGM

Today, FGM has been highly medicalized in several countries. WHO condemns medicalization of any form of FGM and calls upon health professionals to denounce its performance. Accordingly, *"FGM entails the cutting of healthy functioning body organs to comply with a traditional ritual that has no justification on health grounds. Two of the most important principles of professional health ethics are to do no harm and to preserve the healthy functioning of the body organs at all costs unless they carry life-threatening disease. It would be unethical for a health professional to damage a healthy body in order to prevent destructive human behavior. They are definitely no medical reasons to perform FGM,"* (WHO, 1998:15).

'Medicalization' of FGM refers to performing of FGM practices by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere (WHO 1997;

WHO 2008). Due to increasing awareness of the medical complications of the practices and the intention to minimize such risks, FGM practicing communities, especially the educated and urban-based populations, have increasingly preferred the carrying out of FGM under health facilities with medical attention. However, in health terms, the removal of any normal genital tissue interferes with the natural functioning of the body and still causes physical, psychological and sexual complications. According to the World Medical Association's Declaration of Helsinki 1964, it is the mission of the physician to safeguard the health of the people. Health professionals who perform any type of FGM violate right to life, right to physical integrity, right to health and above all the fundamental ethical principle of 'do no harm' (WHO 2008).

History of condemnation

WHO first condemned the medicalization of FGM in 1979, in the first international conference on FGM held in the capital of Sudan. The World Medical Association made further condemnations in 1993 and later by numerous other medical professional associations, including the International Federation of Gynecology and Obstetrics. In the Joint WHO statement (1997) and the interagency statement (2008), nongovernmental organizations (NGOs) and single governments have gone further to condemn the act. African countries have also implemented policies prohibiting health care providers from performing the practice. Nevertheless as part of modernizing the practice, girls are increasingly cut by trained personnel in many African countries because it if deemed safer for daughters (Yoder S, et.al 2004; UNFPA 2010)

Country facts about medicalization

Girls are three times more likely to be excised by physicians-55%, than were their mothers-17% (Kishor S, K. Neitzel, 1996). According to UNICEF (2005:18), 61% of FGM cases in Egypt had been carried out by medical personnel in the year - 2000. After the death of two young girls in summer of 2007 in Egypt, the Ministry of Health passed a decree (No. 271 in 2007) that banned FGM in all clinics, public and private hospitals (Ghada Barsoum, Nadia Rifaat, et.al 2009). This overruled the1996 decree that had justified conditions of operation.

Procedures performed by medical personnel are also relatively high in Kenya (34%) (UNICEF, 2005). According to KDHS (1998), a health worker reported that one third of all circumcised women in Kenya; perform the practice under medical care. A Kenya ethnic study carried out by the Population Council in 2001 found that either a nurse or doctor cut 70% of

circumcised Abagusii girls in Nyanza Province, whereas traditional circumciser had cut virtually all of their mothers (Kishor S, K. Neitzel 1996). Kenya's history of medicalization traces its roots in the colonial era, when colonialists (Methodist missionaries) in Meru and Embu districts passed resolutions in 1931-1932 restricting severity of operation and giving directions to the new procedure in order to reduce the extent of the harm (Gwako 1995; Bell 1998). Currently however, the Kenyan ministry of health prevents medical professions from performing FGM in government run hospitals and clinics. Nevertheless, nurses resort to performing the procedure at the initiate's home when on leave or during Christmas holidays (Bettina Shell-Duncan (2001:1019).

Background factors for medicalization

Activists and early feminists' scholars assumed that a health perspective could provide an easy entry point to address the sensitive issue of FGM. Hosken for instance noted that the focus of the medical approach was on presenting the subject of infibulations primarily as a health issue in a bid to remove the discussion from its religious and cultural connotations (Hosken F P 1993). A point that is well natured by GTZ (2001:12), *"the health aspects are our principal argument, the thing that can make people listen to us. Health is by far the most important issue in Africa and it is easier to relate to something everyone accepts and understands."* Having authoritative individuals and groups warn about the health risks associated with FGM, has acted as an 'eye opener' to practicing communities, thus increasing their desire to opt for better conditions and facilities under which FGM can be practiced.

Additionally, an anthropological scholar—Shell-Duncan (2001) has advocated for the clinically performed milder and (or) less radical forms of FGM to be an intermediate solution to improve the health and welfare of women. The scholar disagrees on the general assumptions made against the medicalization of FGM and argues that there is a lack of empirical evidence; thus arguing scholars to *"assess whether (and if so how) medicalization influences anti-circumcision efforts"* (Shell Duncan 2001:126).

Also, individual countries have promoted medicalization of FGM through their policy strategies, although not without consequences. For instance Dorkenoo E (1994) has showed that in Djibouti, the official policy was to promote less radical forms of FGM performed in clinics as a first step towards eradicating the practice altogether. However, grandmothers complained that the procedure was incomplete and thereafter had the girls re-infibulated.

Likewise, the 1996 Decree passed in Egypt allowed FGM in hospitals for cases approved by doctors (Ghada Barsoum, Nadia Rifaat et,al 2009), which partly formalized the practice in health facilities and led to increasing parents seeking medical genital operations for their daughters. According to Yoder,P. Stanley, evidence shows that one-year before the Egypt 1996 decree, traditional circumcisers accounted for 79.5% and health personnel 17.3% of circumcisions. After the decree, in 2000, medical personnel offered 61.4% of circumcisions and traditional circumcisers - 38.3% (Yoder, P. Stanley and et.al 2004:37).

I argue that positive justifications of medicalization are likely to compromise abandonment efforts. Such justifications do not rule out women subordinations facts, sexuality control issues, violence done on females and other gender related issues inhabited by the practice, later on threats posed by FGM. It is therefore absurd for activists, scholars and politicians to compromise with certain approaches that relativize FGM instead of total abandonment.

Effects of medicalization

Positive arguments in support of medicalization include; hygienic conditions under which procedure is performed, use of anesthesia, application of painkillers and use of anti-tetanus vaccination, in combination with trained personnel. This is associated with decreased health risks associated with the FGM.

Medicalization of FGM has led communities to associate the practice directly with medical care and thus rely more heavily on doctors, some of whom are strong advocates of the practice. Health-care providers have supported FGM practices especially because of the economic incentives, despite the fact that the practice is against the medical ethics (Leye E, et.al 1998). Medicalization of FGM has resulted in disbelief about the harmfulness of the practice, especially among some excised women who have not experienced any complications that are usually dramatic especially in type III. In cases of infibulations, there is indeed an increasing medicalization of FGM than in any other form.

Medicalization only provides reasons for health providers to begin performing FGM. It does not discourage traditional circumcisers to stop the practice. Medicalization also fails to address the underlying motivations for FGM perpetuation, thereby preventing the development of effective and long-term solutions for ending FGM. There is no justification for medicalization, in whatsoever the case may be. Focus should therefore be put on total abandonment of the practice without any room for compromises.

2   THE FEMINIST SOCIOLOGY OF FGM

Using sociological perspectives throws more light and offers explanations to deep embedment of FGM within prevalent communities. The practice has been met with approval of its adherents for thousand years across time and localities. Studies of social customs show that behaviors under considerations must pass through the needle's eye for social acceptance. Therefore viewing history in its widest form can give accounts of these acceptances and rejections. Like seen in Rogaria M Abusharaf (2006:7), *"To chart an episteme or a configurationally interpretation of these practices, we must analyze the particular contexts within which such practices come to be accepted and upheld (...). Insofar as culture is a society's repertory of behavioral, cognitive, and emotional patterns, (...) it is self-evident that decisions affecting peoples' lives are not taken at random"*.

It should be noted that social structures produce a various doctrine of human nature, an imaginary of individual development. In a bid to seek any order, even if it is near to chaos, there must be lists of characteristics (of social structuring) to follow. First, there must be a language to serve as medium of mental exchange. Secondly, acknowledged unifying moral code that conducts order, regularity and gives direction. Thirdly, there must exist some kind of belief in supernatural, faith, or utopia, which shifts morality to devotion and gives life significance. Fourthly, some technique of transmission of knowledge be it primitive or not through imitation, initiation, or instruction. Fifth, there has to be transmitters of cultural heritages, such as mother; father; priest or teacher, down to the children. These five points characterize today each society, however different. Therefore there is interrelatedness among the constituent elements of complex human organizations and the constraints on choices about particular rules and procedures, which result from pressures to maintain consistency and compatibility within the larger structure. This may explain why FGM is very persistent even in the 21st century.

A consideration of the suitability of applying the phenomena of institutions in this study, leads to some critical qualifications of the analogies drawn between institutions and human organizations throughout the discussion. To Douglass C. North - "institutions, institutional change and economic performance, Cambridge University Press 1990", institutions are thickened norms, having been perpetuated again and again. They are generally defined as "rules of the game", or "humanly devised constraints that shape human interactions".

Institutions reduce uncertainty by providing a structure to everyday life. They are a guide of human interactions on how to perform various tasks (whatever we know or can learn easily). As institutions differ (say per country or community), they also define and limit the set of individual choices. Institutions thus include any form of constraint that human beings devise to shape human interactions. Constraints that institutions impose on individual choices are pervasive and may include; a) what individuals are prohibited from doing and b) conditions under which individuals are permitted to undertake certain activities – "rules of the game" – thus giving a framework of human interactions.

Distinguishing them, institutions can either be formal (e.g. creation of rules or constitutions – written down) or informal (e.g. simply evolve over time/unwritten, like common law – conventions and codes of behavior that underlie and supplement formal rules). Both are a creation of human being and can therefore be altered by human beings. Usually, informal institutions (e.g. family, kinship structures, traditional practices and social norms) are stronger and of great importance, whereas the state is more peripheral. While informal institutions are generally not codified, they are widely accepted as legitimate. They are (informal) rules in use rather than just (formal) rules on paper or in force. Informal institutions are socially sanctioned norms of behaviors (attitudes, customs, taboos, conventions and traditions). More so, they are extensions, elaborations and modifications of formal rules outside the official framework. Their enforcement characteristics are accompanied by self-enforcement mechanisms of obligations, expectations of reciprocity, internalized norm adherence, gossip, shunning, ostracism, shaming, threats and the use of violence. Unlike formal rules that may change overnight as a result of political or judicial decisions, informal rules or constraints deeply embedded in customs, traditions and codes of conduct are hardly impenetrable to deliberate policies. This distinction drawn between both institutions can be used to explain why the co-existence of both institutions may undermine – in this case – political attempts to abolish FGM.

Nevertheless, informal institutions might be forced to accommodate formal institutions, when the latter are stronger. North argues; institutions are not resistant to change, but the process under which change is effective or may take place could be complicated. Usually, institutional changes are influenced by organizational roles protesting 'traditional' institutional informal frameworks. Therefore the interaction between institution and organization is fundamental that Institutions generally are the underlying rule of the games and organizations as primary agents of institutional changes. Consquently, the complexity of FGM and its embedment into

social life despite current global changes is traced partly in the understanding that history matters so vitally to the form and functioning of human organizations and institutions. It deals with the role of historical experiences in forming mutually consistent expectations that permit coordination of individual behavior without centralized direction.

2.1 Towards social structure and order

The inescapability of social conflicts generates the anxiety for legal order based upon mechanisms of dictatorship or tyranny on one hand, and widely accepted values and norms on the other hand (C Douzinas and A Gearey 2005:40). As R.K Merton (1968:188) elaborates, in the beginning there are man's biological impulses that seek full expression, which have to be tamed by a social order—an apparatus for managing impulses or for the social processing of tension. Social order in terms of Laws goes beyond that, which has been laid down, fixed or prescribed, to also imply (outside legal terms) the laws of nature, that capture the fixity or normativity of the natural order (Joanne Conaghan 2013:9).

Functionalists believe that certain functional requirements must be satisfied if a society is to survive at a given level (Nancy Kingsbury and John Scanzoni 1993; McIntyre 1966). Survival is what fundamentalists call the greater good. Functionalists assert that the whole (group or society) to which the actors belong must survive (McIntyre 1966:63). To create survival, functional subsystems must exist. A family is an example of a subsystem that operates for the survival of the society (the whole). Hence, the function of the family is to oversee survival of the society through procreation to replace the dead, and socialization to train human replacement (Nancy Kingsbury and John Scanzoni 1993). In that sense, society gets its definition as social systems, which survives its original members and replaces them through biological reproduction (Winch 1963:8). Children must be born of families and socialized to conform to society values (Kingsbury and John Scanzoni 1993:196). For functionalists, the subsystem family satisfies the physical and psychological needs of its members, and maintains the society as a whole through transmission of values and norms from parents to children

The term social system is crucial to functionalists because, it is a broader construct under which structure is subsumed right from family level, to society as a whole. McIntyre (1966:58-59) observes four major properties that define a system. The first one is a family, with specialized kinds of roles. The second is society relations – where-by roles are organized around cultural values and norms that establishes ones' rights and obligations towards

another. The third is boundary maintaining, where internal actors are more tightly bound to one another than to external actors. Finally, the fourth is a system, which has to be firm, built on some mechanisms that operate to hold it steady over a period. While Parson (1965:38) believed in solidarity for adequate functioning of social system, Durkheim postulates that the main functions of moral values is to restrain man's wants and claims, as social stability is ensured at the expense of flexibility. In other words, the range of alternative behavior permitted by a particular culture is limited. Indeed sociologists have theorized that people follow norms to avoid sanctions as doing otherwise may provoke sanctions. Yet, norms may provide repertoires as well as restrictions, resources as well as constraints, which contribute to either social welfare or harm social welfare.

Emile Durkheim has made remarkable contributions on understanding how society functions (1915; 1933; 1938) and how stable society fosters individual happiness. His major concern was how social stability requires a balance between social regulations and personal freedoms. In his suicide publication, Durkheim argues that too much freedoms or regulations cause suicides. When behaviors are so confined in social institutions, people feel trapped leading to fatalistic suicide (1951:276). He further states that too much freedom and too little regulations leads to anomic suicide (p, 258). Anomie in this case implies feelings of being disconnected from society, which can occur when people do not have access to institutionalized means of achieving their goals. For instance, in practicing communities, everyone/families want status, honor and participate in the usual society activities (good life). However, institutionalized or legitimized means of achieving such goals in case of women is through marriage, which status cannot be easily gained if girls or women do not conform to community set standards such as undergoing through FGM practices. Failure to achieve such goals may lead to anomic suicide (Durkheim 1951) or deviant behaviors/manners (Durkheim 1915, 1995).

Durkheim argues that deviance is a normal and necessary part of social order as it fulfills affirmation of cultural norms and values (for example a life sentence of imprisonment to a murder affirms that killing is wrong); clarifies rights and wrong; unifies society (a sense of patriotism); and promotes social change by encouraging the dominant society to consider alternative values. However, considering alternative values imply that norms can be updated as actors observe or experience new people and confront new situations. Eric A Posner (2000) states that the way towards changing social norms in a wished direction is to self-consciously violate them in public and in decisive ways. Eric further reaffirms that social norms' existence

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is a historical accident (Eric A Posner 2000) that rational self-interested individuals will not act in their accordance to achieve a common interest (Elinor Ostrom 2000).

Examples can be taken from the game theory of the case of prisoner's dilemma, where rational individuals may act in deviant manners even if in their best interests (Kaushik Basu 1994; Armin Falk, Urs Fischbacher 2006). Such deviant behaviors are what Robert K Merton (1968:188) describes as biological impulse which from time and again breaks through social control and as being part of original nature. Likewise, Durkheim's (1951) work on 'suicide' also gives a hint on such behavioral deviations.

2.2 Taming behaviors, actions and attitudes

Harrison and Huntington (2000) have argued that psychological mechanisms tame behaviors according to a given environment, to the extent that even when individuals in one generation are replaced by another generation, they will still reproduce the same characteristics of behaviors. This value orientation (individualism or egalitarianism) technique is inculcated through early socialization. Major agencies like family, schools, and workplace, shape the personality structures and goal formation join to provide the intensive discipline required in order to rich the goal (Robert K Merton 1968:212). Through daily actions, behaviors and conversations that children are exposed to, these mentioned institutions (especially the family) serve as transmission belts for a group value of which they are part. For instance, in the American culture, where wealth is increasingly taking on a symbolic cast, Americans especially the youth are encouraged not to be quitters (Robert K Merton 1968:195) in order to achieve the 'American dream'. In addition, practices like FGM continue existing, with a belief of securing a good future of girls and psychological preparations are made right from childhood. Behavior patterns of the like tend to come from individual orientation. However, such positions have been criticized for lacking the social perspective of individual interactions with other/s (group members), which reshapes individual behaviors in relation to group members (Sherif M, 1936) through external forces such as conformity mechanisms.

Alternatively, social norm that interlink groups have been argued to be the main shapers of behaviors. Apparently, no society lacks norms governing conduct, the difference is "the degree to which the folkways, mores, and institutional control are effectively integrated with the goals which stand high in the hierarchy of cultural values" (Robert K, Merton 1968:188), while prestigious representation of society reinforces the cultural emphasis. Once sanctified by cultural values, social norms often continue to be binding even when changed conditions

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render them obsolete. Eric A Posner (2008:8) describes social norms as "labels that we attach to behavioral regularities that emerge and persist in absence of organized, conscious direction by individuals." As people interact with each other in pursuit of their everyday interests, social norms emerge and influence individual thinking as well as taming their behaviors. They have become effectively rooted and legitimized in the conscious of man by certain modes of control such as the belief in super natural, religious beliefs or Utopia, ostracism, insults, etc. hence achieving moral consensus.

Looking at the self-legitimized, non-coercive and informal moral codes of conduct; social norms are complex, but explain why some cultural patterns (like FGM) persist unchanged across many generations, while others (say foot binding) shift dramatically within a generation (see Mackie Gerry 1996). As they "transcend the muddle of everyday life, occupying a separate unattained realm which is peculiarly legal and almost entirely self-legitimating" (Joanne Conaghan 2013:11), social norms represent fundamental themes and are goal directed. Scholars like Cialdini, Robert B; Trost, Melanie R (1998:152) "consider social norms, conformity, and compliance in terms of a fundamental theme: that the behaviors they comprise are goal-directed. These goals include: to behave effectively, to build and maintain relationships, and to manage self-concept", hence contributing towards social order. Indeed, institutionally prescribed behaviors become ritualized and conformity becomes a central value, reckoned in terms of product and process, and in terms of outcomes and activities (Robert K Merton 1968:212).

Conformity to legitimized norms must be compensated with socialized rewards i.e. through distribution of statuses. Statuses or rewards ensure satisfaction of individuals conforming to cultural constraints of any kind (Robert K Merton 1968). However, such rewards are not bias-free taking age, sex, or race into consideration. To tackle problems of bias, J. Conoghan (2013:11) using the works of Henry Maine (1917) wrote that; law's development from primitive to modern form portrays a movement from relations of status to contract, which easily supports presentation of laws as unbiased. While the idea of law/social norm as a distinctive way of ordering and interpreting human conduct still hold, the rightness or wrongness of legal/moral decisions depends on the degree of conformity to the prescribed doctrinal framework.

2.2.1 Authoritarian vs. self-enforced laws: Explaining the social norm

Some authority, such as a king, a legislature, can generally impose from above laws, or a Supreme Court or law can develop from down (the ground) as customs and practice evolve. 'Authoritarian' law imposed from the top typically requires the support of a powerful minority, whereas customary law developed from the bottom up requires widespread acceptance. Customary law is recognized, not because it is backed by the power of some strong individual or institution, but because each individual recognizes the benefits of behaving in accordance with other individuals' expectations, given that others also behave as he or she expects.

If minorities coercively impose 'authoritarian' law from above, then that law may require much more force to maintain social order than is required when law develops from the bottom through mutual recognition and acceptance (i.e. anti-FGM laws in individual countries). Customary law might thus best be described as a language of interaction, accomplished with recognition of clear (although not necessarily written) codes of conduct enforced through reciprocally acceptable, well established adjudication arrangements accompanied by effective legal sanctions. For self-enforcing laws, offenses are treated as private wrongs or injuries, rather than crimes as perceived in authoritarian law cases. Howard notes that in traditional African societies, the development and integration of say human rights is problematic because cultural norms and customs of such societies come first before any other laws. He suggests that for any law to grow and be productive, it must be rooted in the culture and tradition as well as the realities of the people to whom it is made (Rhoda E Howard, 1986).

2.3 Towards Gendering

The pervasiveness of gender as a way of structuring social life demands that gender statuses be clearly defined, thus creating society's 'sameness taboo' (Lorber. J, 1994). Women recruits in the US Marine Corps are required to wear at a minimum a lipstick or eye shadow, and are required to take classes on beauty; which is a deliberate process of feminization in order to distinguish the male marines from the women marines (p.27). Gender is a product of social and cultural institutions, for much of what is characterized as feminine or masculine behaviors, values and attributes are products of social and psychological influences.

In disciplinary terms, gender is *"a way in which men and women are bought into discursively: socially and culturally constructed gender norm act upon subjects to compel their compliance with gender expectations within the broader context of social arrangements in which gender*

features as a category of significance" (Joanne Conaghan 2013:18). Pre-modern conceptualizations posit female bodies either as part of male bodies, given the biblical account of Eve being created from Adam's rib (Genesis 2, 21-23) or as a deformed version of the male body (Aristotle 1943:175). Although, real differences between male and female bodies exist, it is misleading to presuppose that what falls into the category of sex is biologically fixed and what is assigned to gender is culturally negotiable. Gender is constantly created and recreated out of human interactions, out of social life, and is part of the order of that social life (Lorber. J, 1994:13).

As people act out of gender norms and societal expectations through interactions, they are constructing gendered systems of dominance and power, which children eventually pick up. Right from birth, children are gendered through socialization and selective learning of gender norms and roles. These are projected into adult behaviors in families, schools, churches, and workplaces (Lorber. J, 1994). Gendered institutions continuously and deeply shape our lives to the extent that even though we act out of our conscious, we may fail to notice that we are doing gender. Reflections of gender signs and signals are for example typical at birth, when we ask for the baby's sex, followed by the dressing code we adorn to it and the systematic color choosing in the baby's dressing code, specific gift selections in particular color tones (i.e. blue and pink) or figures (e.g. Barbie, Cars, etc.) that match babies' gender. For adults, gendering is embedded in dress codes, particular roles attached to both sexes, speaking tunes, walking ways, etc., which all seem 'normal'. Lorber J (1994:7) describes such actions *as "a process of social construction, a system of social stratification, and an institution that structures every aspect of our lives because of its embedment in the family, the work place, and the state, as well as in sexuality, language and culture."* Individual actions construct social institutions that create unequal social and political relations in society, whereas, a change in such behavioral attitude can deconstruct social institutions.

Apparently, men's exploitation and subordination of women in many institutions and societies, is a salient feature of gender (Lorber, J 1994). Domestic violence at family level; women inequalities in employment, education institutions, and political spheres are manifestations of the social institution of gender inequality. In Saudi Arabia for instance, women are not allowed to drive (Tariq A. Al maeena, www.gulfnews.com). However, empowered women staged a drive in demonstration that resulted to eight hours of questioning by the police, harassments by the religious authorities and also loss of jobs (Lorber J 1994:10). Likewise, in most Muslim countries women wear a burqa, hijabs, niqabs and or

abaya in public places in order not to expose their bare skins. Many cultures go beyond clothing and gesture to inscribe gender in bodies. In Africa, girls undergo FGM before puberty to preserve chastity and ensure marriage-ability. While FGM as the rites of passages at puberty makes girls fully gendered, in China, mothers used to bind their daughter's feet into three-inch stumps to enhance their sexual attractiveness. Likewise, women in the west perform all kinds of beauty surgeries to highlight their femininity. Such behavioral restrictions, particularly those done without choice; are what Lorber J (1994) describes as paradoxes of gender, for they are evidences of sexual construction and impacts of social norms.

The status of women is usually held in lesser esteem than the status of men, though this varies per society. However, these inequalities go beyond race, class, religion, country, occupation, name it. Members of the favored group command more power, prestige, property, than those disfavored. In any social groups, men are advantaged over women. Even in societies like the West where gender discrimination is highly discouraged, many roles are still gendered, and gender segregations are highly evidenced even in the public spheres. Men usually dominate positions of authority and leadership in social, economic, and political fields. In societies that create greater gender differences, women are kept behind scenes and have no civil rights. For instance; given my experience in Egypt, women are not supposed to go to mosques (public space) for prayers – but do the praying home (private space) – while men enjoy such religious rights without limitations.

Marxist feminists explain the gender inequality in terms of demeaning women's abilities and keeping them from learning valuable technologies that may make them competitive at job markets. Liberalist and Marxists feminists see women subordination as a deviation from the general norms of equality and justice for all individuals and believe that sexual inequality can be rectified if women are integrated in public sphere instead of being confined in the domestic spheres (Asoka Bandarage 1984) for roles such as production, procreation, child rearing. Marxist feminism also recognizes that women patriarchal domination by their husband at home goes hand in hand with their exploitation as workers in a capitalistic market place; while to psychoanalytic feminists, patriarchy is a symbolic rule of the father through gendered sexuality (Lorber Judith 1994:3). Unless the pervasiveness of the social institution of gender and its social construction are made explicit (Lorber J 1994), change is unlikely to be deeply rooted – as real change requires conscious re-ordering of the organizing principles of social life.

2.3.1   Gender roles in family politics: the subordination of women

Myra Marx Ferree (1990:868) explains that, while sex role model assumes a certain packaging of structures, behavior and attitudes, the gender model analyses the construction of such packages. In the gender context, the conflict theory suggests that men (as a dominant gender) subordinate women in order to maintain power and privilege in society (David B Brinkerhof, Rose Weitz, Suzanne T. Ortega, 2012). For the conflict theorists, the basis of interaction bases on constraints, power, and competition. Because of the inability to support themselves, women have relied on economic support from men in exchange of sexual availability through either prostitution, or marriages (p.12). In FGM practicing communities, girls are given out for marriage without consent or choice at early ages (without fully developing their lives and instigating FGM practices), making them vulnerable to men's authority and increasing their dependency. Girls' young bodies act as their most marketable resources in terms of sexual activities, procreation (giving birth to children), and home welfare. In such unequal relations, social problems are very likely to occur when dominant groups use their authority over subordinate ones.

While certain gender roles may have been appropriate in hunter-gatherer societies, they do not match with today's social order. To conflict theorists, such roles persist because the dominant group naturally works hard to maintain their power and status (David B Brinkerhof, Rose Weitz, Suzanne T. Ortega, 2012). Philosophers from Hobbes, Locke, and Rousseau have drawn upon contemporary accounts of 'savages' as starting point for speculation about life in the state of nature, and what constitutes a good society (Richard B.Lee and Richard Daly, 1999:7), where role play and gender division of labor was significant in creating stability. In hunter-gatherer societies where men are perceived to be the hunters and women the gatherers (Richard B.Lee and Richard Daly, 1999), women were responsible to reproduce both children and the whole society's materiality (Alice B, Kehoe, 1999:39). Women created camps, fed, clothed, and sheltered everyone, while men belonged to the outside by offering protection and hunting food (social and economic welfare of kinship). Mailhot Jos (1999:53) addresses from the examples of 'the Innu of Quebec and Labrador' that *"if relations were egalitarian between individuals and groups, they were not so between men and women,"* hence recognizing the male domination over women in domestic spheres. Rosaldo (1974:41) suggested, *"The most egalitarian societies would not be those in which males and females are opposed, or are even competitors, but those in which men value and participate in the*

domestic life of the home." The division of adult roles into 'instrumental' and 'expressive' thus expresses a kind of dominance in family politics.

While instrumental activities were assigned to the husband or father by dominant values and norms – out of biological necessity (Nancy Kingsburg and John Scanzoni 1993), men specialized in being the breadwinners or sole providers of the socioeconomic needs and protector of the family. At the opposite side, women's (wife or mother) expressive roles included emotional relations among family members and the integrative focus of the home (McIntyre 1966:60). Gender role specialization maintained family equilibriums, which eventually created stability and existence of the whole system (Nancy Kingsburg and John Scanzoni 1993; Parson 1995). Deviance from these gender roles would lead to family disorganization and disorder in restructuring, hence rendering the whole system helpless. The enforcement of social control mechanisms such as punishments and rewards were meant to maintain family equilibrium in a stable state. For example if the husband fulfilled his instrumental goals of providing and protecting as expected, his wife would reward him with affection and deference (Nancy Kingsburg and John Scanzoni 1993). Not performing his duties fully led to sanctions of low affection. This would in return motivate husband to increase on his role obligation, although on the other hand, such unstableness in a woman's affection would also be punishable by divorce from a husband's side.

Indeed, the discovery that the USA had the highest divorce cases triggered conclusions that family was in disintegration because of increasing working mothers, rebellious youths, falling birth rates, and increase in adultery and premarital sex habits (Nancy Kingsbury and John Scanzoni 1993:202). To create an equilibrium state at family level, conservatives advised people to conform to traditional patterns regarding marital permanency, sex, children, women's role, etc. For progressives, solution was endorsed through legislative programs that enhanced the economic and physical wellbeing of families (Nancy Kingsbury and John Scanzoni, 1993). While conservatives failed to recognize a gambling or struggle towards women empowerment through forceful ways of entering public spheres – that may have partly accounted to the mentioned problems in USA, conservatives however recognized the important role played by women in maintaining social orders from disintegrating. More so, by pointing at working mothers as causes of family disintegration without necessarily noticing the role of the working fathers in creating disequilibrium, conservatism has 'mistakenly' emphasized women subordination roles and gender distinctions.

2.3.2 Patriarchal dominance

Though women-subordination is everywhere, in Africa or developing countries, the trend is exceptional. Maternal obligations confine most women to domestic or private domains. There is no doubt that some cultures articulate a much stronger domain as others, given the social-economic and political structures at display. However, in many African societies women have been characterized as *"jural minors"* for most of their lives falling under guardianship of first their fathers, and secondly their husbands (Hutter B and Williams G, 1981:12). Examples borrowed from Lotta Ambunda and Stephanie de Klerk's (2008) research about women and custom in Namibia summarize that women are regarded as dependents, and are supposed to follow decisions made by the man. Basing on the Bambara culture in Namibia, a woman is seen as a foundation of the house, the keeper of the house, the one whose efforts and character hold everything together (L.Ambunda and Stephanie de klerk 2008). On the other hand, as the head of the household, the man's position gives him absolute power and control over everything. A man as either the father or husband is thus bestowed upon total respect in all aspects of life at all costs, while females (as mothers and wives) are entitled to comply.

Female compliance or conformity is based on beliefs that traditionally, men are supposed to earn a living to support their families, they are to be aggressive and in charge (Hetherington, E.M; Parke R.D 1999). Women on the contrary are to be submissive and weak, and home makers – cooking, cleaning, bearing and caring for children (Hetherington, E.M, and Parke R.D 1999; Pateman, Carole. 1997). Marxist feminists argue, *"Housework is a key element in the process of reproduction of the laborer from whom surplus value is taken. Women are articulated into the surplus value nexus of capitalism"* (Gayle Rubin, 2006:89), which explains the genesis of women oppression beginning from private spheres protruding into public circles. Rosaldo and Lamhere (1974) observe that, women's roles as wives and mothers are associated with fewer powers and prerogatives than are the roles of men. Men predominate in the public domain and are better positioned to form extra family alliances, to dominate the political and religious activities, as well as to control valuable economic resources.

Symbols have also been used to describe the genders' strength or weakness; for instance among the Oshiwambo speaking communities of Namibia. An axe for example symbolizes a man as an indispensable tool, whereas a pot of clay symbolizes the physical weakness of a woman (L.Ambunda and Stephanie de klerk (2008). This constructs femininity around

notions of dependency, irrationality, lacking self-control and in need for protection. Hutter and G. Williams (1981:12) argue, *"The image of a 'normal' woman employed, time and again, is of a person with something of a childish incapacity to govern her-self and in some need of protection – a kind of original sin stemming from Eve's inability to control her desire to seek new knowledge."* Durkheim (1893:61), as seen in Judith K, Brown, *"with the "progress of morality," women became weaker and their brains became smaller. Their independence on men increased and division of labor by sex cemented the conjugal bond…"* (Judith. K, Brown 1970:66). Durkheim insinuates that women compensate their lost competences elsewhere by being committed to their roles in marriage. However, in my view, the masculine domain is threatened by the women gifted competences and their close attachments to nature. Such constructed thoughts about women are only meant to fight their powerful characters in a male constructed world.

Therefore constructed appropriate and acceptable female behaviors (not male) are evidences of threats to women competences both in public and private spheres. Any deviation from these standards has mobilized a whole set of control strategies (Hutter and G. Williams 1981), whose purpose has been to navigate and normalize the deviant female back into her ascribed role. For instance in the *"Amazon valley and the New Guinea highlands, women are frequently kept in their place by gang rape when the ordinary mechanism of masculine intimidation proves insufficient"* (Gayle Rubin, 2006:89). Ethnographic records show various practices such as men's cult, secret initiations, male knowledge, foot binding, chastity belts, FGM, whose effect is to keep women in their place. Social-political movements of such kinds according to Hobsbawm E., Ranger, T. (1983) is testified as invented traditions enacted by society and ascertain legitimacy.

Gruenbaum Ellen (2006) testifies a correlation between female genital cutting and patriarchy and explains that the necessary conditions for the perpetuation of this practice are the social and economic subordination women and children adhere to, in patriarchal societies. Packer.C, attests that attitudes are determined by beliefs about the consequences of a particular behavior (2005:224), having outweighed the benefits and disadvantages, considering community relations. I argue that women's choices are constrained by the poor social-economic structures, and weak and ineffective formal institutions. Many African women thus converge to marriages for fulfillment of their needs, which structures are already gender biased by the very social order that they serve.

2.3.3   Marriage and bride wealth: Women value in traditional African Societies

Emphasizing women importance within a certain frame of reference is what Hutter B and Williams G (1981:12) identifies as the idealized concept of femininity, constructed around dominant discourses of domesticity, respectability, motherhood, sexuality, and pathology. Reflected in the traditional African societies, women values (unlike men) were framed in their roles and commitments towards society as mothers and wives, with marriage as a qualification that cemented the gap of daughters to be qualified as adult (from daughter to being a mother and wife) (J.S, Mbiti 1989). A series of religious and cultural initiation rites were arranged to qualify children into adulthood, the state of maturity and responsibility, with expectations and privileges (p.131). Initiation rites introduced young people to matters of sex, marriage, procreation, and family life, only when the rites stage was over, were these young adults ready for marriage.

Lévi C. Strauss discusses marriage in relation with "Elementary structures of kinship – republished in 1971 by Beacon press". Levi discovers that the basic human traits of ordering nature, controlling it to procure food and the means for survival are carried out through the organization of human individuals into groups (e.g. families, tribes, clans and moieties). Instruments of organization are rules of incest, marriage, endogamy and exogamy, and gifts. Accordingly, elementary structures of kinship are those systems that prescribe marriage with a certain type of relative. These structures describe all members of the society as relatives, but finally categorize them into possible spouses and prohibited spouses. Marriages between sisters, brothers and first cousins are for example prohibited; whereas marriages between cousins by marriage and between crossed matrilineal cousins are prescribed. Society is thus divided into two groups (i.e. compartible marriage frameworks within family circles vs semi-complex marriage structures incompartible within family circles). Marriage prohibitions in these circles are a positive fact engendering social links.

Choice of marriage partner is left open given the society/community in question. Like J.S.Mbiti (1989, pp 132-133) shows; among the Uduku, a boy meets the girl on the path, and openly declares his intention. When the girl agrees, the boy visits the girl's home when people are asleep for further commitments. Eventually, intentions are publically declared – where compartibility is also checked upon. Among the Wolof, when a boy meets the girl he wants to marry, he declares the intention to his father (for approval). The boy's parents send 'kola nuts' to the girl's parents making their marriage intentions formal (J.S. Mbiti 1989:133). Where a party is reluctant to get married or rejects a prospective partner, force or pressure is applied.

In some societies, parents choose marriage partners for their daughters and sons to make sure that there is no Incest taboo committed, but also to allow proper selection of mates. This links Incest taboo to Exogamy (marrying outside the group), which seeks diversity through marrying total strangers, hence increasing the tribe/clan/kinship. Extended kinship groups like clans – according to Emile Durkheim - at one time some person, a mythical hero, or animal is supposed to have founded a group, and all its members are descendants of the founder (common ancestral relations). Whether kinship is to be prolonged by either sisters or brothers or both, the decision/choice is left to the group itself.

As Levi further explains, the social order is born of the organization of an exchange around the Incest taboo. Incest Taboo relates to forbidding marriage between close blood relatives like brothers and sisters or of children and parents, which is a decisive intervention in the birth of social order. The prohibition of incest is a transition from a natural fact to a cultural fact of alliance, thus a meeting point between nature and culture - the indispensable arbitrary rule that man substitutes for natural order. Incest prohibition is therefore to prevent the formation of sub units of sexual partners within a family or a group. Needless to say, that these sexual bonds within groups would break down the unity of groups. Incest prohibition therefore protects the unity of the basic human unit - the family.

Levi elaborates that through marriage, one family is interlinked with other families in order to build larger groups. Women are therefore exchanged in different male groups so as to be impregnated. Within this exchange process, a kind of (marriage) agreement and the basis of transaction (bride wealth) have to be reached upon within a group that is giving away its sisters – to support the survival of other lineages/clans/social groups - through self-reproduction. Marriage thus acts as a method of circulating women from one family or group to another. Marriage as a natural phenomenon helps in reproduction and as a cultural alliance - descent is promoted. Levi (1969:111) highlights that "marriage rarely takes place inside those units that are most closely integrated in the reciprocal duties of day-to-day life, and whose solidarity is particularly affirmed in the mutual contribution, and division, of compensation paid to or received from outside groups". While incest taboo[7] is put forth as

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[7] Incest taboo is based on the hypothesis that no society has all the material goods required to survive, thus necessitating trade with people outside their communities and region. With incest rules that compel people to find mates beyond their distant relatives, lines of trade are secured and fourth coming. Cohen notes that as modern societies develop specialized political and economic institutions that establish formal trade ties, with better communication and transport system, the need for complex family alliance recedes. Cohen therefore proposes that the incest taboo will eventually disappear but does not suggest that immediate family incest would be common.

natural, marriage is the basic form of alliance[8] among human groups. To Levi, marriage seems to be the basic method through which humans organise themselves (around incest taboo). Marriage helps reproduce human societies and builds subsequent alliances. Eventually, institutions such as polygamy, bride price or gift giving, (which differs from society to society) emerge based on environmental conditions, inequalities and as a result of adaptation.

Purpose of bride price and dowry practices for instance; as G.C, Leavitt (2013:46) reveals, enhances family alliances through exchange of gifts that strengthen the web of cooperation among communities. Tonya Williams Bradford and John F Sherry Jr. (2013:140) explain that weddings/marriages comprise rituals celebrating these contractual unions that create new family units. They often encompass gift giving as one of the ritual. At the Micro level, the wedding embodies the giving of oneself to another individual, and the receiving of that individual self, thus creating a union recognized as a new social unity (Tonya Williams Bradford and John F Sherry Jr., 2013:140). Therefore, as one family loses a member (woman) to the receiving (man) family, the bride giving family has to be compensated in terms of gifts due to its loss of a valuable woman member in terms of labor (human capital). In otherwords, loss of women value from (giving) family to the other (gaining/receiving Family) is compensated in terms of bride wealth. The relations between (bride giving and receiving) families are also maintained as ties. To Leavitt (2013), such a coalition provides crucial aid during times of stress and hardship. Again, this reunion offered by the couple is a gift to the society as a whole - in the sense of reproducing and maintaining the social order (Tonya Williams Bradford and John F Sherry Jr., 2013).

In FGM prevalent communities, not undergoing FGM may imply that marriage alliances are at stake, as well as procreation and kinship. Whereas not undergoing FGM makes females not eligible for marriage, bride price in some communities is even collected back, upon finding out that the bride is not circumcised. In Kenya among the Samburu and Masaai ethnic groups, bride price bids (in terms of cattle) are twice as much for the circumcised girls, and twice less

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[8] Alliance theory developed by Edward Taylor (1888) an English anthropologist was meant to hypothesize the incest taboo. The theory has become one of the excepted explanations of the incest taboo's position in the intricate web of marriage and sex rules in human societies. The alliance theory suggests that groups of people must construct lines of cooperation to aggregates outside of their immediate kinship organization and community or risk survival. Incest taboo is common in hunter gatherer societies, and simple agricultural peoples or nomads (In G, C, Leavitt 2013:46). Cohen (1978) expands the alliance theory beyond 'savage' cultures to include the full spectrum of human societies—from the socially and technologically simplest to the most complex. He hypothesized that the extension of incest taboo to include distant relatives varied with the complexity of society, with the least complex societies having the greatest extension and coverage. As societies become more complex, the incest taboo contracts, so that a very limited taboo is found in advanced agrarian and industrial societies, covering only the immediate family (nuclear family members).

for uncircumcised girls. This makes the cultural marriage market of girls unequal, depending on the circumcision status. Yet, given the cultural and economic environment under which FGM has been adapted, less bride price possess economic threats and undermines labour compensations for bride giving families – hence making a loss. Moreover, having escaped FGM within own family does not guarantee the fact that the status will be maintained, even after the bride has been transferred to the receiving family.

If marriage is central to human organization, natural for human reproduction and favors descent in cultural terms as Levi shows: And women are scare due to incest taboos, polygamy, etc. yet valuable in labour terms in agricultural production – based communities. FGM could then be perceived as an invented tradition, meant to minimize instabilities in marriages, once marriage alliances had been arrived at or made. Therefore the sexual control of women through FGM was necessary prior to marriage or shortly after - for stability purposes in marriage and stable good relations between bride receiving and giving families. This stability would also assure fatherhood/kinship of children in terms of DNA, guarantee reproduction and procreation, reduce political instabilities likely to be caused by enmity between groups (e.g. for stealing brides), assure family unity, economic stability in terms of agricultural production and above all social order.

2.4 Social control

Every social practice is part of social control process regardless of other ends it may appear to serve. According to Pat Carlen (2003: 117-132), social control means, *"Institutionalized practices designed to set limits to individual actions in the interests of collectivity's proclaimed ideals of social and criminal justice as instanced in law and dominant ideologies."* Meanwhile, anti-social control symbolizes *"a variety of malign institutionalized practices that may either set limits to individual actions by favoring one set of citizens at the expense of another so as to subvert equal opportunities ideologies in relation to gender, race, and class…"* (p, 119). Good parenting may for example be seen as a positive form of social control when actualized in a society where all have equal opportunities and responsibilities to be good parents. However, good parenting may also be seen as an anti-social form of control in societies where poor economic circumstances prevent parents from being good or in societies where good parenting responsibilities are entirely a mother's role.

Control of women relates to political-economic institutions of family, marriage and welfare. Controls can also be through economic systems and ideological structures of patriarchy.

Likewise, ideologies of femininity also display such controls (Pat Carlen 2003:122). Anti-social control of women emanate from the desire of keeping women in their place (family and homes). Rhetoric such as good mothers make good family and good society, intends to maintain the feminine roles of women at the expense of their interests of pursuing education and employment opportunities. Meanwhile, since women assumingly do not belong to the public, less wages and prostitution can be interpreted as anti-social control practices, aiming at suppressing working class females, to eventually give up their public positions and get back to their 'normal positions' as per the social order.

Social control assumes different guises. It can be formal or informal, public or private, explicitly expressed or subtly implied (John Hagan, John, H. Simpsons, and A.R, Gillis 1976). Through various combinations of these forms, women's lives are controlled and behaviors regulated. The formal social control takes place inside custodian institutions, while informal control is mainly domesticated. John Hagan, et.al (1979) notes that women are more frequently the instruments and objects of informal social controls. Informal social controls can be coercive, although not necessarily forcefully. F.E. Lumley (1931) suggests that human societies have to rely upon symbolic devices, which are more effective than force. According to him, the means of social control are rewards, praise, flattery, education, persuasion, gossip, satire, criticism, propaganda and so on.

Ross Edward A. (2002) has also described a number of means of social control to include public opinion, law, custom, religion, morality, among others. These control measures are intertwined either consciously or unconsciously. Luther Lee Bernard (2008) distinguished between conscious and unconscious means of social control. Bernard indicates that the unconscious means are custom, tradition and convention. The conscious means are those consciously developed and employed by leaders of all types. They include law, education, public opinion and coercion.

In my opinion, every type of these social controls has been developed with a conscious purpose. Gender biases cannot be exclusive, especially when social-economic-religious-political-cultural structures are male dominated. Had there been equal gender representations (including females) towards opinion-formulations, most likely, such social orders may have been neutrally formed.

Positively indicated; given the visionary formations from historical times, some social control visions challenged traditional authority and attempted to limit arbitrary exercise of power. In

other words, *"They repudiated ideas of superiority on the basis of gender or the color of the skin, refused to accept the proposition that how a state treats its own people, is its own business, and rejected the notion that the strong do what they can and the weak do what they must"* (Paul Gordon Lauren 2011:2). In short, positive social control visions were faced with hope to change the world, because of the historical challenges. Indeed revolutions in the 18th and 19th century against slavery, rights of women and workers portrayed activism against social control systems, domination, or misuse of power.

Early figures like *"Mary Wollstonecraft (1759-1797) learned early that she would have to support not only herself, but also others through her intellect and work ethics"* (Eileen Hunt Botting, 2014:2; see also Wollstonecraft M, 1792). Wollstonecraft was largely self-educated and she financially sustained her extended family *"through work as a lady's companion, schoolmistress, governess, and finally a professional writer. She charted an unconventional path in love, marriage, and motherhood, which made her a controversial public symbol of the opportunities and pitfalls of female independence (Gordon 2005)"* (Eileen Hunt Botting, 2014:2). Wollstonecraft became an international women's rights advocates and first philosopher to write a book—"Rights of Woman"—defending women rights as human rights in the wake of the democratic debates of the French revolution.

Historical revolutions and women era awake were triggered by the unbearable negative social controls of the time. Currently, the same struggle to overcome especially women negative social controls (like FGM) that mostly domestically confine females (given the ages of performance followed by early marriage without one fully developing her life), is still ongoing in different societies.

FGM an example of women domesticated repressive social control practice in Africa tends to prevail among all aspects of human life especially in primary groups. The practice has been exercised through mechanisms of enforcement such as customs, traditions, religion, intimidations, manipulations or positive reasoning and ridicule – leading to the actual abuse (Barton Alana 2005). No one wants to suffer loss of prestige or become target of ridicule, be laughed at by people, or even get socially boycotted (not undergoing FGM among practicing communities leads to that. Both girls and mothers are ridiculed). On the contrary, people want praise, appreciation, honor and recognition by the society, which undergoing FGM achieves. Such accepted norms of behavior have become embedded into communities' social belief systems, and has become internalized to an extent that communities rarely question its assumptions but rather accept FGM as a cultural fact. Indeed, within a given constructed

social framework, many women conform to the behaviors expected of them because it is advantageous to do so.

As argued by Heidensohn (1996); quoted from Barton Alana (2005; p2-3), *"control begins with the socialization of daughters by mothers. Mothers may them-selves be dominated and restrained by domestic responsibilities but at the same time they collude with these ideologies of 'appropriate' behavior by attempting to socialize their daughters for the same roles in the future"* (Barton Alana 2005:2-3). Nothing therefore happens disconnectedly, as we all have socialization histories in life.

2.5 Socialization

Everything we are or do is part of the current coming down from the remote past, which is a historical continuity from the past ages going down through our lives (Charles Horton Cooley 1864-1929). Humans acquire a multitude of beliefs, attitudes, knowledge, skills, customs, and norms from other members of own species: culturally through social learning process such as imitation, teaching and language (Alex Mesoudi, 2011). This culturally acquired information influences our behaviors, thoughts and attitudes in different ways, and is a final product of socialization.

Socialization according to Andersen, M. L (1993) is the process through which the child becomes an adult individual respecting his or her environment's laws, norms and customs. Children through socialization receive knowledge and skills from adults (Makkonen Timo 2008) - transmitted through institutions such as; family, schools, workplaces, religious places, mass media, etc. These institutions make people conform to the norms of the groups they belong to. However, the impacts of such external forces vary dramatically from one person to the other depending on circumstances and social class status.

Bourdieu Pierre's (1994) practice theory explains the interaction between individual agents and social structures based on classes. The behavior patterns and social structures may change if practicable behavior becomes critical reflection, but different people have different opportunities to influence their habitués (Bourdieu Pierre's 1994), which explain why people recreate the social conditions that they have been taught in.

Socialization creates a system that is inherently unequal by most empirical measures of equality. There is strong indication that children from homes where both parents have higher academic-, personal-, and profession successes have significantly higher probabilities of

achieving such successes. Likewise, children from families with limited social economic success will also face difficulties in achieving these successes.

It has often been argued that fathers especially in most communities in Africa spend less time with their children compared to mothers because of their passive roles as providers and breadwinners. Gay Alden Wilentz (1992:2) notes generational continuity that includes passing on of cultural values and personal history is traditionally a woman's domain. Women/mothers are the primary and constant agents of socialization as taleteller and instructor to pass on the cultural knowledge that each community is aware of and abides with in infantry stages. As custodians of the tradition, women represent the ultimate value in African life such as the continuation of the group. To Wilentz, the term mother includes not just the biological mother, but co-mothers, grandmothers, aunts, older sisters, community women, who all are equally important in the socialization process.

History shows that a child belonged to the community. Therefore, the whole community had responsibility of disciplining children regardless of their biological connections. Mothers, aunts, community women impart most fundamental female knowledge of cultural respect (i.e. initiation rites like FGM) especially to female children getting closer to puberty stage (J.S, Mbiti 1989:119-127). Meanwhile, fathers are seen as teachers and supporters especially on the sex role development of their sons in masculinity ways (J.S.Mbitti 1989:119-138; see also Michael E.Lamb 2004—on father's role in child development).

Regarding FGM, men in their socialization roles continue to influence the practice of FGM as community elders (custodians and enforcers of traditional laws and customs), family heads (as final decision makers and consultant), spiritual leaders (as consultants and recommenders for such traditional practices), and husbands (demanding circumcised girls for marriage). Whereas; mothers especially influence daughter FGM status, circumcisers are women, and elderly women act as gatekeepers of this tradition.

2.6 Cultural component of FGM

Cultural system and social-cultural life do not operate independently of one another – since they overlap, intertwine and are mutually influential (Margaret S. Archer, 1994). Among sociologists and anthropologists, the battle has long been raged about defining culture (T.S. Eliot 1948; Raymond Williams, Keywors 1976). Given an array of definitions in social sciences, specifying cultural definitions may limit its understanding (A.L. Kroeber and C. Kluckhohn, 1963; Ann Swidler 1986). Nevertheless to Trandis (1994); one way to think

about culture is to think of unstated assumptions and ways of doing things that have been internalized to an extent that people do not argue about them. In this sense, culture encompasses elements of meaning making and meaning maintaining activity (Makkonen, Timo 2008:58).

As a manmade part of the environment (P.B Smith and M.H, Bond 1998:38), with objective aspects such as roads and tools, and subjective aspects such as norms, roles and values (H.C Triandis 1994:2, 16): - culture is more or less *""unstable, "processual" or "discursive""* under constant change and transformation (Bell S Lynda, et.al, 2001:5). As such, culture is a social product with some aspects being produced deliberately. People learn culture and in the process of using it, they eventually change it. To Clifford Geertz' (1973:89) culture provides the individual and community - with the values and interests to be pursued in life, as well as legitimate means of pursuing them.

Abdullahi Ahmed An-Na'im explains that, *"culture stipulates the norms and values that contribute to people's perception of their self-interest and the goals, and methods of individual and collective struggles for power within the society and in-between societies"* (1992:23). Power relations are the casual elements in cultural consensus building that guarantees behavioral conformity. Margaret.S.A (1996) argues that if logical consistency is low, cultural consensus may be high. The reverse is also true. Successful imposition may not necessarily require high coherence of the cultural package imposed, but may rather be successful partly because of intellectual idleness, patches of ignorance and nostalgia (p, 5). In some cases, culture may reflect coercion rather than conviction as in the case of German fascism. Therefore, to understand cultural statics and dynamics, there is a need to distinguish between logical consistencies (cultural system integration) from casual cohesion (social-cultural integration) (Margaret.S.Archer 1996).

Accounts of FGM reveal the complexities of power play and power struggles. The practices reveal men's quest for power through women subordination, in order to emphasize solidarity ties and social relations. Critically examined, FGM intentions are not far from confining women in their gender roles and maintaining them in private spheres (through marriage) as men autonomously enjoy the public sphere. Family status in community politics, as part of a power struggle, also is evidenced. A family is a subsystem of the society, which has to see to it that its members are confined in the characteristic mores of the whole system. In the sense of FGM, a family that succeeds in maintaining the social structures of the whole society by enforcing FGM upon its members – is rewarded by status and recognition. Community

despises a family that fails its roles – through placing social sanctions and stigmatizations upon family members. Males from despised families may not be allowed to speak at public functions, or contribute to important decision-makings (political life) at community levels. Families whose members fail to conform to the social norms of the community are completely isolated from community relations.

Likewise, women struggle and quest to be recognized as full adults. In cases where women undergo FGM as rites passages; without these rites, a woman of whatever age compromises her adulthood status – only to simply be recognized as a child. Such a woman cannot take on particular duties and responsibilities or even take part in community activities as an adult (see John S Mbiti 1989). Undergoing FGM thus commands status and honor. It also empowers women in their own surroundings. According to Makkonen Timo (p.79 & 200), *"the more fundamental an aspect is to a culture, the more embedded it is in various deeply held beliefs, the more functional it is in the current ecology, the deeper it is ingrained in the memory and consciousness of a group …, the more resistant to change (…). Although it is true that cultures do not necessarily dictate our understanding and values, it is important to note that culture influences and shapes them,"* (Makkonen, Timo, p.200).

In cultural uniformity, change is reinforced through external forces of developments, such as globalization. Such forces are sociologically depicted as *"diffusing inwards from the exterior, at their least, as giant mirrors of individual psychology, the traits of which were independent of their cultural context"* (Margaret. S. Archer 1996:6). Indeed, globalization and its perspectives have posed threats, insecurities and uncertainties that follow in its awake. For instance as a result of globalization, human rights are taken as foreign to local (African) cultures and a threat to the cultures' existence. These rights are perceived as western ideologies that stress individualism over collectiveness (Morten Kjoerum 2001; Kirsten Hatsrup 2001; Maurice Cranston, 1973; James Griffin 2008).

2.6.1   African sense of community

Yet, the African sense of community is expressed through such proverbs as *"Go the way that many people go; if you go alone, you will have reason to lament"* (Davidson B 1969:31). Such a proverb and many more instill and emphasize the African idea of security (both physical and ideological identity) and its values, on personal identification with the community. In the African mentality, the community as an entity remains, while individuals, as persons, come and go. Africans emphasize community life and communalism as a living

principle of which the basic ideology is community identity and solidarity. The aim is to produce and present an individual as a community-culture-bearer, with culture as a community property that has to be community protected. In that sense, an individual does not stand in contra-distinction to society but as part of it (Howard E Rhoda 1990). The individual should therefor neither be seen alienated from nor at war with his society

Makkonen has proved that most cultures organize their subjective cultures around one or more collectives like family, tribe and religious groups. That is why for Mbiti (1989:99), Africans live in clusters referred to as tribes or units, which *"are estimated to be around 3000 depending on where one draws the line in case of closely related people."* Group units make up particular cultural norm, traditional values and practices that groups identify themselves with and make them distinct from each other, in some cases closely related. Each unit places value on interdependence and group harmony.

Additionally, Olusola Ojo indicates that African assume harmony and not divergence of interests. They are more inclined to think of their obligations to other members of society rather than their claims against them (Howard E Rhoda 1990). As explained by Breen Claire, rather than survival for the fittest, *"the African worldview is tempered with the general guiding principle of the survival of the entire community and a sense of cooperation, interdependence, and collective responsibility"* (Breen Claire 2002:96). Based on two ethical principles i.e. solidarity and egalitarianism (Ki-Zerbo Joseph 1964), practices such as FGM for example make the solidarity foundation of such groups. Claire Breen (2002:94) illustrates, *"the practice has helped to maintain tribal cohesion. Initiates are commonly taught the lessons of tribal unity and their specific position in maintaining the unity of the tribe thereby ensuring the continued survival of the group."* Such belonging and membership brings with it not only social privileges which individuals can lay claim on, but also establishes strong networks of *"lifelong friendship, support and reciprocal obligations amongst the girls who were initiated together"* (Breen Claire 2002:96). Jomo Kenyatta, an anthropologist of the time used the functionalist approach to defend the kikuyu people against missionary attempt to ban FGM. Kenyatta argued that the practice was an integral and indispensable part of the Gikuyu cultural fabric (Howard E Rhoda 1990). Its eradication would antagonize the social harmony of the group. Some colonial British anthropologists also defended African traditional cultures and customs against imposition of European ways.

As far as FGM is a community culture, the 'outside' world is faced with several challenges, when it agonizes over whether it should intervene to "save" individuals from practices that are

sanctioned by the cultural group to which those individuals belong. Peter Jones (1999:92) asserts that corporate rights may compete with the claims of individuals outside the right-holding group, although there is no need to suppose that they will in every case.

3   HOLISTIC HUMAN RIGHTS APPROACH TOWARDS FGM ABANDONMENT

Although human rights can be viewed as social claims upon social power arrangements, the classic tradition of sociology is generally inhospitable towards the adoption of human rights as a sociological matter (Bryan Turner (1993). The hesitance of sociology to engage in the human rights study is due to the conflict between sociology's holistic approach and liberal individualism associated with rights discourses (R.W, Connel 1995). Critique of rights discourse was prominent in the work of Marx, Weber and Durkheim (Bryan S. Turner 1993). Marx argued that Human rights such as those in the French revolution were individual liberty rights rather than social equality rights, whose aim was to unmask economic inequality (Mathieu Deflem and Stephen Chicoine 2011). Meanwhile; Durkheim's approach of law and rights focuses on legal norms as social facts, demarcating differing tasks of philosophy and sociology (Bryan S Turner 1993; Mathieu Deflem and Stephen Chicoine 2011).

However, sociologists of human rights have argued that rights need not to be restricted to legal norms (Bryan S Turner 1993; Connell 1995). Whilst, the language of law becomes predominant and exclusive means to communicate about human rights and related violations, instead of the needs and perceptions of those to whom human rights apply (Mathieu Deflem and Stephen Chicoine 2011). Turner (1993) recognizes institutionalization of Human rights as central component of globalization, becoming more a fact to social life, where by human rights are defined as social claims for institutionalized protection.

Human rights include those moral and political claims that every individual being has upon his or her government as a matter of right and not by virtue of kindness (Howard E Rhoda 1990). The origin of human rights can be traced primarily to Europe in the 18th century, emerging from the period pertained to civil and political matters such as the right to association, freedom of opinion, conscious and religion (Rahman Anika, Toubia Nahid 2000). These developments form the basis of which discussions of human rights of particular groups (such as women and children) have occurred; more so, the expansion of human rights field to address social concerns at domestic and community levels. The approach is part of a long-term process of political mobilization and advocacy for change.

Contemporary human rights base on international treaties signed by the governments after World War II. This body of law includes the Universal Declaration of Human Rights (1948); the International Covenant on Civil and Political Rights (1966); and the International Covenant on the Economic, Social and Cultural Rights (1966). These treaties establish

universal standards by recognizing fundamental rights of people and by requiring single governments to take action in order to respect such rights. FGM is addressed in more recent treaties like Women Convention (1979); and Children Rights Convention, (1989), which have also been supplemented by regional treaties such as African Charter on Human and People's Rights (Banjul Charter, 1981); European Convention for the Protection of Human Rights and Fundamental Freedoms (1950); and the American Convention on Human Rights (1969). At national levels, laws and policies have been developed that incorporate human rights principles, thus being essential tools for interpreting international law standards.

3.1 International politicization of FGM: Towards a human rights approach

For FGM to climb on the international agenda, it came through a series of steps. FGM was first handled as a cultural issue that required noninterference of other states. Thereafter, the practice upgraded to be an international concern, but on medical grounds, as UN bodies were working and researching more into the topic. In the 1990s, FGM gained its 'fame' on the international level where it was fully recognized as a human rights issue, and as type of gender-based violence against women and girls.

3.1.1 Cultural framework

When the Economic and Social Council of the United Nations asked WHO to study FGM in 1958, WHO leadership refused with concern that the matter was a cultural concern (Heger Elizabeth Boyle 2002:65). Come the first UN world conference on women in 1975, FGM was not discussed because it was inappropriate matter for international system (Bob Clifford 2009), a matter of cultural autonomy and national sovereignty. However, the United Nations Decade for Women period between 1975-1985 (in Mexico City in 1975, Copenhagen in 1980, and in Nairobi in 1985) was instrumental for placing women both on the international intergovernmental agenda and for facilitating worldwide women's cooperation while discussing gender specific issues (Freedman Elisabeth 1995). The women decade was a watershed for issues of concern such as FGM.

3.1.2 Health framework

The UN decade for women 1975-1985 heightens international awareness on FGM that sparked activism both home and abroad. Local women activists such as the Les Femmes Voltaiques (The Women of Upper Volta), held radio broadcasts against FGM in 1975

(Mandeline Baer and Alison Brysk 2009), which opposed the practise primarily on health grounds. Activists like *"Nawal El Saadawi, an Egyptian scholar, medical doctor, and writer, published the 'Hidden Face of Eve' in 1977, which covered topics related to the lives of Arab women including marriage and sexuality, aggression against female children, and FGM"* (Mandeline Baer and Alison Brysk 2009:96). Such publications were vital in giving information on this particular cultural issue and acted as an eye opener for international concern that eventually sparked international involvement in FGM matters.

In Ghana in 1983, Efua Dorkenoo established the Foundation for Women's Health Research and Development (FORWARD), whose primary focus was to end FGM (Mandeline Baer and Alison Brysk 2009). Women who also included activists discussed their personal histories of circumcision. Their testimonies were instrumental in drawing international attention to the issues affecting African women. As a result, by the late 1970s and early 1980s The UN subcommittees through the World Health Organisation decided to study FGM and provide outlets for national governments and NGOs to discuss health issues related to FGM. WHO sponsored its first seminar on the Harmful Traditional Practices Affecting the Health of Women and Children in Sudan in 1979 (Mandeline Baer and Alison Brysk, 2009:97). The seminar thus saw practical results as Sudan became the very first country in Africa to have data collected on FGM countrywide.

FGM discussions until the point of international involvement on medical grounds was an aspiration of local activists in individual countries affected by the practice, who needed a social change in women's lives on the domestic levels. FGM discussions were thus prompted through the health approach and basically by local efforts (home based organisations or groups of individuals and social networks of activists). The Health model served as an easiest entry point to tackle such a delicate taboo associated cultural issue – at the same time, a convincing model that required immediate attention of the international community.

3.1.3 Human rights framework

Consequently, Boulware Miller-Kay (1985) notes that in mid 1990s, the International organisations like UNICEF and WHO had shifted the emphasis from the medical framework – to human rights based approach. A shift from the health to the human rights approach was sustained by debates about FGM that arose as women's rights were increasingly becoming accepted as Human rights. UN adoption of the Convention of Elimination of all Forms of Discriminations against Women (CEDAW) in 1979 was a critical step towards international

recognition of human rights abuses taking place within the private sphere. CEDAW was a stepping stone of feminists' efforts that arose both domestically and internationally to address FGM.

Western feminists working on FGM in the 1980s and 90s published on the topic and raised the issue in international conferences (Mandeline Baer and Alison Brysk 2009). For instance Robin Morgan and Gloria Steinem's article *"The International Crime of Genital Mutilation,"* published in Ms. Magazine in 1980, is also an early example of western campaigning against FGM (Mandeline Baer and Alison Brysk 2009). Also Fran Hosken's (1982) publication *"Genital and Sexual Mutilation of Females"* educated many westerns about the practice, although it sparked the debate over appropriate ways of approaching the practice.

CEDAW thus incorporated feminists' arguments about state obligation to protect women and girls from private abuse of human rights. According to the Office of the High Commission for Human Rights (OHCHR), CEDAW general recommendation No.14 expressed the committee's concern over the continued practice and urged governments to support efforts of eradicating FGM as a custom. A 1993 UN Declaration on CEDAW explicitly included FGM within the categories of violence against women. Other violence addressed included marital rape, dowry related violence and sexual abuse of female children (OHCHR.org).

Further still, The UN World Conference on Human Rights in Vienna (1993) and The International Conference on Population and Development (ICPD) held in Cairo in 1994 also specified the interconnections between women's health and Human rights regarding FGM. Result of the ICPD was the 1998 joint statement of WHO and UNICEF, and the United Nations Population Fund (UNPF). Organisations took a strong stand against FGM calling it a violation of rights of women and girls to the highest attainable standard of health (WHO 1997). The Beijing Fourth World Conference on Women 1995 and their follow-up events was also part of the milestone that included FGM in the legal framework.

3.2 Universalism vs. Relativism

Despite efforts to bring FGM to light, different philosophical traditions constitute further strands in the discourse surrounding FGM. Feminists argue that women particularly in developing countries are faced with constant challenges to maintain tradition in the face of rapidly changing social conditions due to globalization (Farnoosh Rezaee Ahan 2012). Maintenance of traditions like FGM, child marriage, breast ironing—involve inhuman treatments that are life threatening and promote women subordination/inequality – in a way

that violates human rights. Western feminists have thus capitalized on such challenges to criticize the practice of FGM on grounds that it results to the subjugation of the females. One of the important activities of feminist is to promote women empowerment and integration - while working towards altering discriminative practices.

Cultural relativists on the other hand, accept and respect variability of human practices (G Barnhart Michael 2001). They argue that behaviors of one culture should not be judged by the standards of another culture. By supporting rights of self-determination, cultural relativists claim, there is no superior, international and universal morality and ethical rules. This school lacks a boundary between methodological relativism and ethical morality. Practices such as wife beating, child battering, child marriage, FGM, breast ironing and women rape - as endorsed by some cultures cannot be seen as morally acceptable.

On the contrary, Universalists invoke justice and morality beyond laws and customs of any individual cultures or religion. This school of thought does not deny that cultures are different, but they argue (in effect) that individual sameness or similarity among human beings should prevail over cultural differences (Bell s Lynda, Nathan. J Andrew and Peleg Ilan, 2001:11).

The relativist position rejects the notion of human rights and argues them out as historical constructs by the Universalists who seem to be culturally imperialistic. Relativists claim that Universalists lack an understanding as to why some cultural values have become a preference. Relativists further claim that the Universalist position creates a moral equivalence between good and bad values.

Claire Breen quotes from Slack who criticizes the Universalists theory. Accordingly, universalism *"lacks an understanding of an "intricate and complex cultural systems and to eliminate it* (FGM)*, would be to impose outside values that might result in a disruption of this delicate cultural balance""* (Breen Claire 2002:100). This position has also been defended by Jomo Kenyatta. In his publication of 1961, Kenyatta defended FGM against western imperialism. He expressed; *""the majority of [Gikuyu] believe that it is the secret aim to those who attack the centuries-old custom to disintegrate their social order and thereby hasten their Europeanization. The abolition of irua will destroy the tribal symbol which identifies the age-groups and prevents the Gikuyu from perpetuating the spirit of collectivism and national solidarity, which they have been able to maintain since time immemorial""* (Breen Claire 2002:100). Universalists argue that such positions is nothing more than an

excuse for inaction and wrongdoing that may serve to prevent international scrutiny of domestic human rights practices.

Universalists suggest that cultural relativists maintain the structures of male dominance and control, which they (Universalists) try to break. Universalists further insist that the intention of relativists is to suppress the human rights of women, which they (Universalists) indeed defend as a tool of women empowerment. According to Oloka Onyango and Tamale (1995:694), *"to subsume gender issues within those of culture is to claim that women have no place in the creation and maintenance of that culture."* In situations where male dominated cultures define community, it makes it difficult to see how equal rights are accorded to women (Breen Claire, 2002:106). In such instances, preservation of culture may be used as a means of maintaining the status quo and impending social change.

Sidelining with Universalists, I argue that cultural practices that pose threats to human life cannot be morally justified, especially given the age factor, lack of consent, lack of choice, and no information availability in terms of counseling and guidance on risks posed by such practices. Those practices seen above are life changing and deny future economic and social opportunities to a girl child or women – who are usually the victims. Apart from being a manipulation of belief system, in no way are negative or harmful cultural practices such as FGM in best favor of the victims – for they aim at satisfying the power domination paradigm in patriarchal societies.

3.3 Human rights violated by FGM

WHO (2008) states, *"Female genital mutilation of any type has been recognized as a harmful practice and a violation of the human rights of girls and women. Human rights—civil, cultural, economic, political and social—are codified in several international and regional treaties. The legal regime is complemented by a series of political consensus documents, such as those resulting from the United Nations world conferences and summits, which reaffirm human rights and call upon governments to strive for their full respect, protection and fulfillment."* FGM violates a series of well-established human rights principles, norms and standards as follows.

Right to be free from gender discrimination: FGM is a traditional practice that reinforces cultural beliefs and stereotypes superiority or inferiority of the sexes and stereotype roles of women and men. *"It is rooted in gender inequalities and power imbalances between men and women and inhibits women's full and equal enjoyment of their human rights"* (WHO

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2008:10). The practice also *"deprives girls and women from making an independent decision about an intervention that has a lasting effect on their bodies and infringes on their autonomy and control over their lives"* (WHO 2008:10). Many girls and women have to endure FGM as a form of violence in the furtherance of culture and religious misconception. Majority conform to the practice in order to fulfill community expectations.

Girls who have not undergone the procedure face discrimination and stigmatization. Their peers and sometimes family members ostracize them, which increases their vulnerability. This is a violation of CEDAW, article.1, which prohibits all forms of discrimination against women. Article.2, which obligates states parties to condemn discrimination against women and take appropriate policy measures to eliminate it. CEDAW specifically calls on states parties to modify or abolish laws, regulations, customs and practices that discriminate against women. The obligations are also echoed in Article .2 and 5 of the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa.

Right of life and physical integrity: The Human Rights Committee (1982) – a body that monitors implementation of Civil and Political Rights – in its comment No.6, article 6 and paragraph 5 interprets the right to life and requires governments to adopt positive measures to preserve life. FGM violates the right to life in instances where the practice has resulted in death of the victim or severe injuries. FGM in itself violates a girl or woman's right to physical integrity as girls and women are forcibly restrained during the procedure to endure the pain. Besides, because of pressure to conform to social norms, girls and women 'forcefully' undergo FGM without their full and or informed consent.

Right to health: Every individual is entitled to enjoy the highest attainable standard of physical and mental health as guaranteed by Article 12 ICESCR as well as ICPD provisions. Governments are therefore obligated to devise health policies that take into account the needs of girls and women who may be vulnerable to traditional practices such as FGM. FGM often results in physical and psychological injury in the manner the procedure is done. In cases of infibulations, the scenario is complicated as the woman must be re-opened prior to her first sexual encounter and at childbirth. This is a painful experience, which the survivors have to endure. The complications associated with FGM have serious health, psychological and

social implications for girls and women subjected to it, as revealed by WHO studies in six African countries and as already observed above (WHO.int).[9]

Right to education: FGM is a precursor to marriage in communities that practice it for cultural reasons. The girls who have undergone the process are ensnared to early marriage and pregnancies. The implication here is that the girl drops out from school to take up her maternal role jeopardizing her education and exposing her to further risks.

Right to information: Majority of children and girls that undergo forced circumcision do not have sufficient capacity to access requisite information that may allow them to make reproductive health choices. Indeed the age of circumcision among communities continue to fall, since perpetrators need to take full advantage of incapacity and ignorance of children. For communities such as the Somali that practice FGM for religious reasons, there is a misconception that unless a woman is circumcised, she is impure and her prayers are regarded as invalid. In communities that practice FGM for cultural reasons (Maasai, Kissi, Ameru, etc), there is a misconception that the cut is a symbol of maturity. Women and girls in various communities have a right to accurate and timely information on dangers of FGM, packaged in a culturally and religiously appropriate manner taking into account the level of literacy in any given and targeted groups.

Right of the child: Children are incapable of making decisions about matters that affect them and hence the special protection accorded to them by the international human rights law. Thus, whatever activity done for the child, its best interest is vital. Article 3 of CRC affirms that the best interest of the child shall be a primary consideration. *"Parents who take the decision to submit their daughters to female genital mutilation perceive that the benefits to be gained from this procedure outweigh the risks involved. However, this perception cannot justify a permanent and potentially life-changing practice that constitutes a violation of girls' fundamental human rights."* (WHO 2008:9). FGM is a violation of children's rights. The practice is often performed on children who are not capable of giving informed consent.

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[9] WHO `Female Genital Mutilation and Obstetric Outcome: WHO collaborative study in six African countries` http://www.who.int/reproductive-health/fgm / (accessed on 10th April 2009)

3.4 Legal binding frame work

The practice in any way is not in the best interest of the child for all intent and purposes. Therefore, legally binding instruments are often referred to as lobbying and advocacy tools towards FGM abandonment.

International consensus documents

The *general rights framework* includes the United Nations Universal Declaration- on Human Rights (UNDHR). The document was adopted by the General Assembly of the United Nations on 10 December 1948 (UN.org). It has seven articles, which together form a basis to condemn FGM (USAID 2000). Articles 2 and 7 on discrimination, article 3 concerning the right to security of person, article 5 on cruel, inhuman and degrading treatment, article 12 on privacy, article 25 on the right to a minimum standard of living including adequate health care and protection of motherhood and childhood, and finally article 26 on education.   The UNDHR is the basis for two Covenants, a) the International Covenant on Civil and Political Rights. Most important articles in this Covenant are article 7 on cruel, inhuman and degrading treatment, article 17 on privacy.[10] b) The International Covenant on Economic, Social and Cultural Rights, article 10 on the protection of children and young persons and article 12 on a healthy development of the child (OHCHR.org).[11] These extra conventions are of particular importance to FGM.

There is also the *women rights protection frame work* - The International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), whose articles that address FGM have already been seen above (see also Meuwese S, Wolthuis 1998).

Another international binding treaty is the *Children rights protection frame* - The United Nation Convention on the Rights of the Child (UNCRC.org). This child rights convention came into force in 1989, and ratified by all states, with exception of Somalia and the USA. UNCRC addresses harmful traditional practices explicitly in the context of the child's right to the highest attainable standard of health (article 19). Article 3 of the UNCRC implies that all

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[10] International Covenant on Civil and Political Rights Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966. Entry into force 23 March 1976, in accordance with Article 49: United Nations Human Rights Office of the High Commissioner for Human Rights; http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx. Retrieved on 23/08/2013

[11] International Covenant on Economic, Social and Cultural Rights: Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry into force 3 January 1976, in accordance with article 27: United Nations Human Rights Office of the High Commissioner for Human Rights; http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx. Retrieved on 23/08/2013

actions and decisions, which affect children, should be based on the assessment of whether those actions and decisions are in the best interest of the child. Article 2 states equal opportunities to all children regardless of origin, birth, gender, religion, race. Article 6 provides the duty of the state party and all adults to ensure all resources are deployed to support optimal survival and development of children. Article 12 addresses survival and development of a child—children be given equal opportunities and freedom to express their views on all matters affecting them and that such views be given due consideration according to age and maturity of the child.

Regional frameworks

The most important *general regional framework* in Africa is the Banjul Charter on Human and Peoples' Rights, adopted in Nairobi (Kenya) in June 27, 1981 and entered into force in October 21, 1986 (achpr.org). This regional charter stems from the UNDHR, and is registered by the UN since 10. September 1991. The Banjul charter aims at promoting and protecting Human rights in general. Article 16 protects health, article 17 ensures education, article 18 protects women and children from any kind of discriminations, article 7 (1a) their cause shall be heard, article 5 prohibits torture, cruel and inhuman treatments and promotes personal dignity. Article 4 respects life and integrity. Out of 54 countries, 44 are signatories, and 53 of them have ratified and deposited the document (Africa-Union.org)

The African union also made a declaration in 2011 calling upon the adoption at the 66th session of the UN General Assembly a resolution banning FGM worldwide – in order to intensify global efforts in eliminating FGM. The U.N General Assembly made the adoption in November 2012 and the resolution was adopted by consensus (UNFPA-UNICEF 2012:4-6). In recent years, this instrument has reminded reluctant governments that FGM abandonment is still vital and worth seriously focusing on.

The Inter African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) has as well played a large role in advocating for the abandonment of FGM in Africa. IAC emerged from a seminar in Dakar in 1984 and today it has national committees in 29 African countries (UNFPA-UNICEF 2012) campaigning against harmful traditional practice. Country assessments revealed three distinct ways anti FGM activities are being carried out. These include the NGO and CBO programs, and the national level programs (WHO 1999). IAC runs majority of the national level programs. While some of the national chapters are more dynamic in for instance Burkina Faso and Ethiopia; in other countries like Egypt - they have been overshadowed by stronger agencies, or have smaller programs

(Ghana), or have never been implemented (Kenya) (WHO 1999). IAC was also instrumental in adopting an official international Zero Tolerance Day on FGM (February 6), which draws attention to the efforts required to end the harmful practice (iac-ciaf.net). On this day communication and media events, panels and conferences, and celebrations are organized around the world to act as a reminder to governments of their commitments towards accelerating actions to eliminate FGM (UNFPA-UNICEF 2012).

Under the *Women rights framework*, the African Union (AU) came up with an important regional instrument called the 'Maputo protocol' in a bid to indulge in the legal abandonment of FGM off the continent, but also other women issues of rights concerns (Africa-union.org). The Assembly in Maputo in Mozambique adopted the Protocol to the African Charter on Human and Peoples' rights, on the rights of women in Africa in 2003. Out of the 53 member countries in the African Union, 46 countries have signed the Maputo protocol. As of July 2010, 28 of 46 countries had ratified and deposited the protocol (African union.org)

Child rights framework - The African Charter on the Rights and Welfare of the Child—ACRWC (also called the African Children's Charter) was adopted by the African Union in 1990 and was entered into force in 1999 (OAU document, 1999; see also ACERWC.org). The ACRWC was ratified by 45 of the 53 countries. It recognizes the need to act appropriately to promote and protect the rights and welfare of the African Child. The instrument also notices that the child, due to the needs of his physical and mental development requires particular care with regard to health, physical, mental, moral and social development, and requires legal protection in conditions of freedom, dignity and security. ACRWC was drawn by the African Union (AU) to compliment the UNCRC.

Other consensus documents include the Beijing Declaration and Platform for Action of the Fourth World Conference on Women is one of the consensus documents against FGM. Paragraph 224 of the Beijing conference prohibits any harmful aspects of traditional, customary or modern practices that violate the rights of women (Rahman Anika and Toubia Nahid 2000). Programme of Action of the International Conference on Population and Development (ICPD)—paragraph 5.5 recommends measures to eliminate child marriage and FGM (Rahman A and Toubia N 2000). Additional documents also include General Assembly Declaration on the Elimination of Violence against Women; UNESCO Universal Declaration on Cultural Diversity; United Nations Economic and Social Council (ECOSOC), Commission on the Status of Women; Resolution on Ending Female Genital Mutilation. E/CN.6/2007/L.3/Rev.1.

At the UN General Assembly Special Session on Children in 2002, governments forged a commitment to end FGM by 2010 (UNICEF 2005). In February 2003, 30 African countries vowed to end FGM and called for the establishment of an International day of Zero Tolerance. The day was reinforced in June (6th) of that very year at the Afro-Arab expert consultation (UNICEF 2005), and is celebrated annually.

3.5 Country profiles

Since most African countries are signatories to the above-mentioned treaties as shall be seen, each instrument/convention thus requires that individual countries take action that will entrench these legal instruments in the laws of the land in national legislation and policies. Indeed, based on international, regional, and consensus documents, change of policies and criminalization of FGM on country level has been witnessed

Egypt

International treaties such as: CEDAW was signed by Egypt on 16 July 1980 and ratified in 1981 (the CEDAW optional protocol remains unsigned). There is reservation-asserting precedence of the Islamic Sharia Law (in regard with marriage and family relations) over article 2 of the convention, which prohibits discrimination of women in all forms (Rahman Anika, Nahid Toubia 2000). Further conventions that Egypt ratified include; Convention on the rights of the child—signed and ratified in the 1990, Civil and political Rights Covenant ratified in 1982, Economic, Social and Cultural Rights Covenant also ratified in 1982 (Africa-union.org).

On the *regional basis*, Egypt is a signatory to the Banjul Charter on Human and Peoples' Rights—signed in 1981 and ratified in 1984 (Africa-union.org). However, the official website of African union reveals that Egypt is not a signatory to the Maputo protocol on women rights, which causes queries about the rights standards of both women and girls in Egypt. In other words, Egypt has no official legal regional obligation to maintaining the women rights standards since it is not a signatory to the Maputo protocol. According to the African Committee of Experts on the Rights and Welfare of the Child (ACERWC), Egypt signed the African Charter on the Rights and Welfare of the Child in 1999, which she also ratified in 2001 (acerwc.org). Nevertheless, the country does not consider itself bound by Article 21 (2) regarding child marriage.

On the *country level*, several ministerial decrees against FGM have been passed. Both parliament and prominent government figures have as well indulged themselves in the

campaigns abandoning FGM. Mohammed Farid (2008), a project officer of Reproductive Health Service in the ministry of Health and Population in Egypt reports on the four decrees that have gone through a process of amendment, but all aiming at accelerating FGM abandonment. Namely; a) The 1959 Egyptian ministerial decree, b) The 1994 ministerial decree that prohibits FGM to be performed by non-medical practitioner in places other than equipped facilities in public and central hospitals, c) The 1996 decree that prohibited FGM in any health facility, except for high-indicated cases approved by the head of Obstetrics and Gynecology. This decree is believed to have been a product of the International Conference for Population and Development (ICPD) that was held in Cairo in 1994. d), finally the decree of 28/6/2007 is a correction of all the previous decrees that had justified FGM to a certain extent. The later decree prohibits any health service providers and others (paramedical or related personnel) from performing any excision, deformation or any type of surgical intervention for any natural part of the external female genitalia whether in government or non-government establishments. Anyone who goes against the law is subjected to penalties from the ministry of health and the medical syndicates.

Additionally, one can interpret several articles in Egypt's constitution, to suit the protection of females against FGM. Namely; article 8 guarantees equality of opportunity to all Egyptians. Article 40 declares the equality of citizens before the law, without discriminations based on sex. Article 10 provides protection of motherhood and childhood (Rahman Anika, Nahid Toubia 2000:141-142).

With regard to Egypt's criminal law provisions, her penal code has no specific provisions in regards with FGM. However, article 240 stipulates on inflicting harm and wounding of anybody organ. Article 241 addresses intentional or unintentional wounding resulting to illness or disability. Article 244 informs on harm resulting from negligence and breaching of laws. Article 236 covers intentional infliction of harm leading to death and stipulates punishment of imprisonment between 3-7 years, which codes can be applied against FGM (Rahman Anika. Nahid Toubia 2000).

Meanwhile, in 2007, Egypt's first Lady Suzanne Mubarak supported the acceleration of anti-FGM efforts. She launched the "Beginning of the end" campaign (Ghada Barsoum, Nadia Rifaat, et.al 2009) in order to put to an end FGM practices. In June of 2008, the Egyptian Parliament agreed to criminalize FGM in the Penal Code, establishing a minimum custodial sentence of three months and a maximum of two years, or an alternative minimum penalty of 1,000 Egyptian pounds (LE) and a maximum of 5,000 LE (UNFPA-Egypt.org; Mohammed

Farid 2008). Further still, the 'Cairo Declaration' region meeting, hosted in 2008, meant to assist on law enforcement. The Declaration was also a follow up of the 2003 meetings held in Cairo that resulted into 'The Cairo Declaration for the Elimination of Female Genital Mutilation' (UNFPA Egypt).

However, general setbacks are noted after Ex-president Hosni Mubarak had been ousted out of power (in 2011). The Mohammed Morsi government (June 2012-July 2013) that came into Mubarak's footsteps clearly supported the practice on cultural and religious grounds. This affected the political environment, which activists prior had actively used to curb down the practice. For fear of government critics, due to the political atmosphere, abandonment activities became reluctant because most activism went underground. Although the Morsi regime also lost its power in 2013, it is not yet clear which direction the acting president Asly Mansour is going to take in regards to FGM issues. In any case, the political environment has destabilized a number of abandonment activities and made a setback in the prior improvements.

Kenya

Internationally, according to the United Nations Treaty Collections Status, Kenya is not a signatory to CEDAW (treaties.un.org), although she ratifies the convention in 1984. Kenya is however a signatory to the UN convention on the Rights of the Child (UNCRC) since 1990 (treaties.un.org). Other conventions ratified by Kenya include the Civil and Political Rights Covenant, which was ratified in 1972. In the very year, ratification was also made on the Economic, Social and Cultural rights Covenant (Rahman Anika, Nahid Toubia 2000:175-177)

Regionally, the African Committee of Experts on the Rights and Welfare of the Child shows Kenya's ratification of the African charter on Rights and Welfare of the Child (AFRWC) in 2000, though not a signatory (acerwc.org/ratification). Kenya is also a signatory to the Protocol to the African Charter on Human and People's Rights on the Right of the Women in Africa (Maputo protocol) since 2003 (FIDA-Kenya 2009), but according to the ratification table of the African Commission on Human and People's Rights, the protocol remains unratified (ACHPR.org). Likewise the general regional human rights frame work- the Banjul Charter remains unsigned although ratified in 1992 (African-union.org).

On *the country level*, Kenya has laid down strategic measures to protect legally both women and girls from cultural abuses like FGM. This has been realized through the long-standing lists of amended decrees, parliamentary actions, and Kenya's major political figures

denouncing FGM. For instance, Kenya's second president Arap Moi categorically prohibited FGM operations through presidential decrees issued in 1982, 1989, 1998, and 2001 (Nairobi Times 1982). Moi also forbid health providers/workers to carry out the operations in hospitals. Moi awakened FGM abandonment activities that had been suppressed by Jomo Kenyatta - who had out rightly supported the practice on cultural grounds. Moi provided a conducive and favorable social-political environment where actors freely and legally operated. Unlike Egypt, there has not been a significant setback in the FGM abandonment efforts in Kenya ever since.

R.Anika, N. Toubia (2000) elaborates on the protection offered by the supreme law of Kenya via the constitution of 1992. Accordingly, chapter 5 contains the Bill of Rights, which offers protection for the safeguards of the individual rights and freedoms for every Kenyan. These include among others the right to life, religion and conscience. Sections 74, 250 and 251 of the current national constitution protect every individual from torture and inhuman and degrading treatment. Sections 70 and 82 part 1 and 3 rules out discriminations based on sex in application of fundamental rights. Although nondiscrimination provisions do not apply to laws related to marriage, divorce and adoption as seen in section 82 (4) (b) and (c) (Rahman Anika and Toubia Nahid 2000), nonetheless, most sections can be used to argue against FGM.

Given Kenya's penal code, in section 250, provisions are made for assaults, and punishments with one-year imprisonment stated. Section 251 provides for assaults leading to bodily harm and imprisonment of 5 years is laid out. Section 234 on grievous harm is stipulated and punishment is lifetime imprisonment. The parliament also passed a Bill prohibiting FGM practices in 2011.

According to Evelia Humphrey, et.al (2007, p.8), in 2001, Kenya adopted the Children's Act legislation that provides for the rights of children, with the aim of enhancing the welfare of children in Kenya. Section 14 of the children's act states that, *"No person shall subject a child to female circumcision, early marriage or other cultural rites, customs or traditional practices that are likely to negatively affect the child's life, health, social welfare, dignity or physical or psychological development"*. Section 18 stipulates the charges and states that, *"any convictions for FGM/C related offences carries a penalty of twelve months imprisonment and/or a fine not exceeding Kenyan shillings 50,000 (approximately US Dollars 710)"*. The Act provides for categories of children in need of care and protection. Particularly section 119 (1) (h) provides for a child who, being a female, is subjected or likely to be

subjected to female circumcision or early marriage or to customs and practices prejudicial to the child's life, education and health (Evelia Humphrey, Sheikh Maryam, et.al 2007).

However, controversies about the act have sparked. In an interview with Ochieng Christine - coordinator of UNICEF/UNFPA program at the national focal point; she noted that penalty for underage circumcision varies widely in enforcement and severity, hence defeating the purpose. One of the coordinators of field program officer of Maendeleo ya Wanawake Organization (MYWO) notes that the Act is unclear as to the kind of punishment that could be meted out to offenders. This therefore puts the sentencing at the discretion of magistrates, who have tended to issue only light sentences. The Ex-Minister of Gender and Children Affairs Esther Murugi argues that the Act is an excellent means for eradicating FGM only if local enforcement is strengthened, stronger criminal consequences are established and violations are sought out and prosecuted.

Ghana

Internationally, Ghana is a signatory to CEDAW since 17 July 1980 and ratified the Convention in 1986. She is a signatory to the optional protocol of CEDAW since 2000, and the Convention on the Rights of the Child since 1990.

Regionally, Ghana ratified the Banjul charter 1989 and became a signatory in 2004. She is also a signatory to the African Charter on the Rights and Welfare of the Child since 1997, which has been ratified since 2005. Ghana also signed the Maputo protocol in 2003 and ratified it in 2007 (achpr.org).

On a *country level*, Ghana has a legal framework protecting both women and children against FGM. That is to say, in 1989, Ghana's President Rawlings, issued a formal declaration against FGM and other harmful traditional practices (US State government 2001-2009).

Besides, several articles from Ghana's constitution (1992) offer protection frameworks against FGM. Namely, article 39 and 26(2) provides in part, that traditional practices that are injurious to a person's health and well-being be abolished. Article 17 (1-2) guarantees the equality of women and men before the law. Articles 13 and 14 protect rights of life and liberty. Article 15 (1) stipulates on the rights of dignity. Children below the age of 18 are accorded special protection under article 28 (5).

Additionally, in 1994 Parliament amended the Criminal Code of 1960 to include the offense of FGM (Criminal Code 1996). This Act inserted Section 69A, *"(1) whoever excises, infibulates or otherwise mutilates the whole or any part of the labia minora, labia majora and*

the clitoris of another person commits an offense and shall be guilty of a second degree felony and liable on conviction to imprisonment of not less than three years." Clearly, the article warns against FGM and airs out following consequences to perpetrators.

Simultaneously, the ministry of Health (1996:14) issued the National Reproductive Health Service Policy and Standards (RHSPS), which discourages FGM. The ministry puts forward strategies of ending the practice such as recruiting FGM programs into school health and education programs, enforcement of the 1994 law prohibiting the practice and cooperation among activists.

In summary, the above list of legal binding contracts signed by Kenya, Egypt and Ghana are legal enforcement mechanisms for these countries to act according to the human, women and children rights framework to protect females against FGM.

3.6 Law enforcement dissemination

However, being a signatory to a particular document or convention and translating such laws into documented-domestic policies does not necessarily guarantee law enforcement and its application. In several countries legal binding contracts have remained paper work. Nevertheless in accordance to accelerating FGM abandonment, civil organizations have worked hard to disseminate and integrate law related reforms in their projects.

For instance; *International organizations* such as *UNFPA and UNICEF (Joint programme)* have worked together to accelerate FGM abandonment in different African countries since 2008. In 2012, the Joint Programme implemented its culturally sensitive human rights-based approach in 15 African countries; Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea Bissau, Kenya, Mali, Mauritania, Senegal, Somalia, Sudan and Uganda (UNFPA-UNICEF 2012:25). The programme supports effective enactment and enforcement of the law, using national policies and legal instruments to ensure abandonment. The joint programme further promotes media campaigns and other forms of communication dissemination in a bid to publicize FGM abandonment. It also collaborates with community leaders/elders, religious groups and other organizations, and strengthens collaboration with key development partners.

In Kenya for example, the joint program constitutes a joint intervention between the Government of Kenya, UNICEF and UNFPA (UNFPA/UNICEF 2010). It focuses on 12 districts located in five provinces in Kenya. These include "the Eastern Province: Isiolo,

Meru, Moyale; North Eastern Province: Garissa; Coast Province: Tana River, Nyanza Province: Kuria, Migori; Rift Valley Province: Samburu, Naivasha, Pokot, Baringo, Mt. Elgon" (UNFPA/UNICEF 2013). The joint programme has made significant contributions to strengthening the national environment for the abandonment of FGM. In particular, it has enhanced coordination among national and international actors working on FGM abandonment in Kenya. The joint programme has also strengthened the national legal and policy framework, especially through its contribution to the passing of the FGM children's Act in 2011 (UNFPA/UNICEF 2010; see also recorded interviews - Christin Ochieng). The joint program works hand in hand with political institutions like Ministry of Gender, Children and Social Development (MGCSD); Ministry of Public Health and Sanitation; individual Members of Parliament and civil society organizations such as Action Aid and World vision in Kenya (MGCSD 2010).

In Upper Egypt, the joint Programme carries out awareness raising and advocacy work in over 20 villages (UNFPA-UNICEF 2011). In 2011, the programme used mainly the community-based approach, working directly with individual families through Egyptian government Child Protection Committees (CPC) to convince communities abandon the practice.

In Ghana, the joint programme has used a cross boarder approach to accelerate change (UNFPA-UNICEF 2011).

UNFPA further supports *local based organizations.* In Kenya for example, FIDA has been supported by the joint programme, in its activities directed towards sensitizing communities and training police officers and chiefs on Gender Based Violence (GBV), FGM inclusive (FIDA-Kenya 2009). FIDA has also revised the police-training manual to conform to new laws and gender considerations. In addition, FIDA has reviewed the Convention of the Elimination of all forms of Discrimination against Women (CEDAW) country reports highlighting key areas for improvement in laws and policies including those touching FGM (FIDA 2009). Other organizations as CRADLE Nairobi employs awareness creation and enactment of laws to protect women and girls who wish to avoid this practice (Evelia Humphrey, Maryam Sheikh 2007:15). CRADLE also trains community members on the rights of children and provide paralegals within the community to intervene in cases where children themselves run away or report being cut. The Association of Media Women in Kenya (AMWIK) seeks to reach the general public through articles, magazines, newspapers and TV program about the legal situation (Evelia Humphrey, Maryam Sheikh 2007:15). AMWIK is involved in monitoring, implementation of laws to control FGM in Kenya, Tanzania, Senegal,

Burkina Faso and other African countries. AMWIK mobilizes further the media to highlight issues that relate to FGM, and monitors the media by checking daily newspapers to assess coverage of FGM.

In Egypt, as per 2008, the National Council of Childhood and Motherhood (NCCM) in collaboration with UNDP concerted a strong media campaign against the practice through talk shows, paid advertisements on television stations and radios. Media campaigns were sparked by the death of an 11-year-old girl in 2007 in Upper Egypt, after being circumcised by a doctor (USAID 2009). NCCM further provided capacity building and networking for NGOs, community leaders and other advocates from medical, legal and religious groups.

Action Aid Ghana (AAG) calls upon law enforcement agencies particularly the Domestic Violence and Victims Support Unit (DOVVSU) of the Ghana Police Service to ensure that perpetrators are prosecuted under the law to serve as a deterrent to others (Actionaid.org). In addition, AAG encourages all victims of FGM to report to the appropriate agencies for redress since the practice is illegal under the laws of Ghana. AAG also reminds all interested parties such as the Ghana Health Service, rights-based civil society organizations and the media to deepen education on the negative effects of the practice on the health and bodily integrity of victims and advocate for its total eradication in order to ensure the rights of women.

3.7 Law enforcement application

The enforcement history in Ghana shows, in 1995 an eight-day-old girl was brought to hospital having undergone through the procedure. Serving as an alert, police arrested and charged the practitioner as well as the parents (Rahman Anika, Nahid Toubia 2000:166). Although this is a step towards legal enforcement, it may push the practice underground and may hinder seeking medical support due to fear of arrests. However the question put forward here; - is arresting parents considering the state of the victims in the best interest of a child? This question is not discussed anywhere, but remains "food for thought".

In Ghana still, in mid-1998, a practitioner was sentenced to 3 years imprisonment for having performed FGM on three girls (Patricia Akweongo fourthcoming; US Department of State Archive 2009). Despite a few cases being brought to justice in comparison to the FGM situation at hand, Ghana NGO coalition on the Rights of the Child (2005; p,14) has confirmed that laws against FGM exists but have been hardly enforced due to the lack of political will. This explains why most FGM cases go unrecognized or unpunished.

In Kenya, in 1982, President Daniel Arap Moi ordered that practitioners who perform FGM that result to death (Rahman Anika, Nahid Toubia 2000:177) face murder charges. However, no case of the kind has ever appeared to court. Problematic with Arap Moi's statement is that it somehow legitimizes FGM cases performed carefully without directly leading to death. On the other hand, one can argue that FGM acts done without leading to death directly - may be punished in other ways. This statement is thus open to several interpretations.

Looking beyond that, Kenya's Children Act of 2001 did result in a major court decision in June 2010, after a 12-year-old girl bled to death because of circumcision (UNFPA 2010). Activists against FGM reported this case to police. Consequently, the judge sentenced the girl's father and the circumciser each to ten years imprisonment.

In Egypt, press reports in 1995 and 1996 covered prosecutions of about 13 individuals accused of performing FGM that resulted into complications or death. Similar cases came up as well in 1997 and 1998 (Anika Rahman Anika, Nahid Toubia 2000:41). In the 1997 case, a doctor was imprisoned for one year for causing a girl's death. In 1998, two doctors were charged with performing FGM illegally. Here, court decisions in regards to punishments may be regarded as less impactful compared to the damage caused. For instance a court ruling of a mere one year imprisonment following death of a victim is not just. In this case, perhaps a lifetime imprisonment could have served right to the innocent victim?

Laws have been complemented with cultural sensitive education and public awareness against FGM. Declines have been generated, although at a low pace (WHO 2008). Despite some success, social norms that hold communities together make it difficult for individual families to defy tradition without feeling ostracized (UNFPA 2013). Experiences over the past two-three decades show that there are no quick or easy solutions towards FGM abandonment (WHO 2008). Thus, activists require broad based approaches and long-term commitment.

3.8 Benefits of the Human rights approach

The Human rights approach seeks to enact adequate laws and policies that outlaw FGM; at the same time streaming inherent contradictions in law. It also explores how to improve enforcement of existing legislations (FIDA 2009). The advantage of such an approach is that it provides legal platform from which projects can be organized. It offers legal protection for girls and discourages practitioners and families through fear for prosecution.

Human rights allow, but also set limits to group rights for both majority and minority. Minority rights make explicit the limits on the power of the majority or dominant groups. However, those rights must never be construed in the way that neglects the principles of equality (Asbjorn Eide 2006). FGM being a minority practice, which may be looked at as a legitimized freedom of cultural autonomy, dominant groups, justify the practice in a way that neglects equality principles and excludes equal treatment of sexes. Hence a violation to the rights of the subordinate groups (women and girl children). These subordinate groups are points of emphasis, which human rights tend to protect legally. However, the task faced by human rights law is to indicate ways in which equality could be reconciled with the maintenance of separate identities within the framework of integrity and stability. The kind of measures to be adopted depends on the nature and dynamics of communities, which differ from place to place or time to time.

There is thus crucial need for human rights education in both literate and illiterate forms - wide spread through whatever possible means, across macro and micro levels of society. When human rights become wide-spread and embedded into community cultures, discrimination habits as FGM will no longer be tolerable. The existence, preservation and teaching of human rights are not things that can be taken for granted (Diakité 2006) - for they are vital for ensuring that the rights will be maintained and passed on from one generation to the other in a way that celebrates human value, dignity and equality. Human rights education hence makes significant contributions to the progress of democratic principles (M. Arthur Diakité 2006:25).

Nevertheless if not instilled in a community's way of life, then challenges of human rights law enforcement are evidenced. For instance, legislative actions against FGM is compromised because arguments embedded within the legal approach may seem relevant from a Western angle, yet present a concept far too abstract for many of the people involved (African communities) - if not translated to fit their local realities.

Women from countries that practice FGM are born into societies where culture, traditions and social norms dictates and controls their behaviors. They have limited means, options or mechanisms for asserting individual rights – because social customs and traditions supersede such rights. This calls for urgent need of human rights education across all ages in communities. Educating on the human rights principles thus empower communities to decide on their own and make informative decisions, such as abandoning FGM. Using such rights principles instills autonomy and avoids perceptions; namely, communities are being coerced

to stop FGM (UNFPA 2013). Besides, fostering dialogues involving everyone in the communities avoids condemnations and paves way to debate FGM in light of traditional values and human rights principles. Further still, cooperation with traditional and religious leaders can facilitate the change; whereas empowering education helps people to examine their own behaviors and belief systems - especially when such education aims at exchanging experiences instead of imparting knowledge (UNFPA 2013).

A lot needs to be done to bring the human rights dialogue all the way to the community levels in an appropriate sensitive manner that will be able to bring about the desired changes.

3.9 Limitations and challenges

"We have come a long way, but there is still a long way to go" (Fernando Falcón y Tella, 2007:1) given the challenges associated with the human rights campaign to eradicate FGM. For instance; while campaigns attempt to promote individual rights for women and children, they do not address on diminishing the importance of the culture and traditions that the practice is bound into. There is thus need to double-combine the approach - without compromising human rights and at the same time not jeopardizing community relationships that might put an individual's wellbeing at stake.

On the other hand, laws might insight rebellious acts or lead to deviant behaviors because they are seen as antagonizing cultures and social norms. In Kenya for instance, colonial authorities and missionaries in 1920s and 1930s attempted to stop the practice by promulgating criminal regulations and using religious propaganda (Thomas L 1992; Chege Jane 1993). However their activities particularly in Meru and Gikuyu land did not succeed; but instead provoked cultural and nationalistic resistance (Thomas L 1998; Jomo Kenyatta 1962) namely, *'Ngaitana' (*many girls circumcised themselves in protest) as indicated by community elders of Meru and Kuria.

In Ghana, the president of GAWW informed that protests broke out after police arresting two circumcisers in 1995 and 1998. This shows that laws against FGM are protested at community levels, which may cause a challenge towards implementation.

The senior program officer—civic action—Kenya Human rights Commission, noted in the interviews that laws can only be enforced, if they are popular and when people assume them to be just. Christine Ochieng of UNFPA-UNICEF joint programmme observed that most

people in Kenya do not think that FGM is a crime, so people are even shocked if some members within their communities face arrests.

In Kenya and Egypt, the laws criminalize the practice of FGM and infractions are punishable by either imprisonment, or fine or both. The Ghanaian law equates the offense to a second-degree felony. However, none of these laws have taken into consideration the human rights issue surrounding FGM in definition, scope of culpability, or even punishment of the practice (UNFPA 2009:15).

Similarly, their implementation is not guided by the human rights principles, because several of these laws confine the definition of FGM to the context of existing criminal law regimes. This has presented various challenges in implementation - given the socio-cultural determinant of the practice - which often exempts certain relations from criminal liability, thereby defeating the application of the law (UNFPA 2009).

Concerns have been raised regarding the lack of clarity between a non-functional law and weaknesses in the institutions entrusted to apply this law (FIDA-Kenya 2009:3). According to FIDA, as long as enforcement agencies face inadequacies in the implementation of the laws, it is also very clear that the same institutions were inadequately prepared to implement such laws.

Criminal laws also face challenges of pushing FGM underground or being done on minors, while also exposing victim's life in health dangers, due to fear of prosecution or criminalization. Indeed, cases of FGM risks per day compared to the handful of prosecutions done per year indicate criminal law implementation problems.

Furthermore, the Human Rights discourse has been alienated in some countries. In Egypt, for instance many people do not see themselves as active participants in the international scene and thus do not respond to or are alienated by arguments based on international conventions (Berliner Zeitung 22.12.2000).

Conclusively; finding the right balance between law enforcement, human rights education, law sensitizations and dialogue – is difficult. Therefore the risk of alienating communities by turning to the law to protect girls and women is a real one. Enactment of laws against FGM has to go hand in hand with community education or sensitization, because beliefs and behavior changes come about through education and dialogue. In exploring the discussion, it becomes clear that human rights approach is very promising. However, careful deliberation is

required to develop action strategies that offer both protection and respect for the cultures and autonomy of those women and families concerned

3.10 Further ways of addressing FGM

In '*Female Genital Mutilation Programmes to Date: What Works and What Doesn't,*' WHO and PATH have identified a core set of overarching elements critical to ending the practice. These include strong institutions, government support, institutionalization of FGM issues into national health and development programs, properly trained health care providers, coordination among government and nongovernmental organizations, and appropriate advocacy efforts (WHO 2006; UNICEF 2010). Activists have used a combination of methods to campaign vigorously against the practice, since no single approach is sufficient enough to lead to abandonment of FGM. A multifaceted approach is thus used - based on the fact that practicing FGM depend on the complex interplay of actors and beliefs. Below I discuss more concrete approaches towards eradicating FGM.

Religious oriented approach: This approach seeks to provide information that delinks FGM from any religion (Lethome Ibrahim, Maryam Sheikh Abdi, 2008). In communities like Somali and Barana in Kenya, and among Egyptians - FGM is associated with religion - erroneously taken as complying with the Islamic requirement of chastity, morality and cleanliness. A belief that there is a *Sunnah* type of FGM endorsed by the Quran is widely held among most Muslims (Maryam Sheikh Abdi, Ian Askew 2009). In FGM context, *Sunnah* means following the way of Prophet Mohammed. Proponents of FGM believe that the practice is one of Quran tradition that is optional, but observing it confers virtue (see-recorded interviews with Lethome Ibrahim).

According to Lethome and Maryam (2008), further specific Islamic contexts that perpetuate FGM include *Mandoob*, which means permissible but doing the act is better than not doing it. *Mubaah,* which refers to any permitted act in Islam but it, has no virtue or sin for commission or omission respectively. *Mashru'u*, derived from the *Shariah* means that the practice has an Islamic legal basis. Arabic speakers refer to a circumcised woman as *mutoharat* (cleansed or purified) and to uncircumcised women as *ghulfa'a* (unclean or impure). This is followed by misconceptions that uncut women cannot be in a state of cleanliness because of the assumptions that the clitoris grows long and forms folds of skins that harbor dirt that cannot be easily removed (p.3). Therefore *Tohara*, an Arabic word for FGM, ensures ritual cleanliness because no act of worship is accepted among the Muslims if a person is not in the

state of cleanliness. *Khitaan* also appears in several religious texts to refer to both male and female circumcision. In Quran 16:123, all Muslims are ordered to follow the way of life of prophet Ibrahim, who was circumcised at the age of 80, thus being incumbent upon all Muslims to be circumcised (Lethome Ibrahim, Maryam Sheikh Abdi 2008). The need to correct such religious misconceptions by particularly religious scholars is vital, because they command respect and are influential in communities.

Historically, missionaries attempted 'to save the followers' from bad traditions like FGM and polygamy in Kenya (GTZ 2001) byborrowing from contradictory religious scripts or laws that discourage such practices. Even today religious scholars like Lethome, use teachings from the Quran (holy book of Islam), Sunna (practices of the prophet i.e. what he did, said and approved), Consensus of scholars (who interpret religious texts), analogy (comparison between similar things) to show Islamic followers that FGM is totally delinked from Islam (refer to Kenyan recordings under Lethome).

In his book, "Delinking FGM/C from Islam", Lethome (2008:23) says, *"not every act done in the name of Islam is Islamic. Many actions are done for purely cultural reasons but over time, they may acquire an Islamic justification, especially among communities that are predominantly Muslims…"* Therefore Islamic leaders de-campaigning FGM base on several teachings to intensify the abandonment message. Namely; a) an evil or harm must be removed or stopped (Quran 3: 10) through any possible means, b) Islam and harmful practices, c) Islam and human rights, d) Islam and cultures, e) Islam and women's sexuality, f) Islam and chastity/morality, g) not changing God's creation (Ibrahim Lethome 2008). In this regard, *"In 2008, a group of 15 Islamic scholars resolved to work towards abandonment of FGM and to de-link FGM from Islam"* (Ministry of Gender, Children, and Social Development 2008:9; National Plan of Action for Eliminating FGM in Kenya 2008-2012).

Lethome, a lawyer, an Imam, and a chairperson on the supreme council of Imams in Nairobi, propagates messages against FGM through sponsored forums based in practicing communities like Eastleigh, Garissa, isiolo (Interviews). Together with other Imams, Lethome also moves from mosque to mosque teaching the Quran and training other Imams and community locals (e.g. chiefs and community elders) to further promulgate the teachings to their subjects (Interviews).

The Population Council with support from UNICEF has also initiated a project through which several small group discussions have been held for religious scholars from Wanjir and other

districts in North Eastern and Upper Eastern provinces of Kenya, whose populations are predominantly Muslims (Evelia Humphrey, Sheikh Maryam Abdi 2007).

In Sohag, *"the Upper Egypt Association gathered 35 official imams from Tama, Tahta, and Maragha Markaz and presented them with various arguments against the practice (particularly from the medical perspective) and sought to convince them to preach against it"* (Ghada Barsoum, Nadia Rifaat, et.al 2011:16). A Muslim religious leader from Sohang also preaches that married couples should enjoy a healthy sex life and that FGM hinders that possibility (Ghada Barsoum, Nadia Rifaat, et.al 2011).

In the Upper region of Ghana, local Imams are asked to speak out against the practice with collaborative efforts from an NGO called Muslim Family and Counseling Services (MFCS) (U.S Department of State Archive 2009). MFCS makes these efforts more effective because Islam and its leaders are highly respected in the communities where FGM is practiced. The Director of MFCS is himself a learned Quran scholar, an Imam and a village chief.

In Christianity, messages encouraging FGM abandonment include sermons such as 'God made people complete and people have no right to destroy or change a God-given body', 'the body is the temple of God', 'thy shall not tamper with God's creation' (Ministry of Gender, Sports, Culture and Social Services 2007; GTZ 2001). In Kenya, the Catholic Diocese of Nakuru (CDN) with support from UNICEF and UNFPA joint programmes uses the religious oriented approach and works with the Ilchamus community in Baringo to strengthen FGM abandonment efforts (Interviews with Christine Ochieng). CBOs such as CIWIT, KK Weru and Mwiwi Evangelical Fellowship in Meru North use arguments that FGM has no place in the Bible to educate the community (Evelia Humphrey, Sheikh Maryam, et.al 2007:14).

Religious based propagated messages have achieved positive results. In a study carried out by GTZ (2000), religious leaders' influence was quoted second (35%) after education (38%) in factors contributing to the recent positive change of the practice amongst the Massai in Transmara District, even before health workers (16%). In Egypt in the city of Benban, daily church meetings tackle the issue separately for different groups. These meetings have been instrumental in disseminating the message that delinks FGM from Christianity.

Challenges: Many religious leaders know that FGM contradicts with religious teachings, but the scholars have not been able to come out in public to condemn the practice due to community pressure and fear of losing respect (Interviews with Lethome Ibrahim). Islamic guidance requires that one should not succumb to community pressure at the expense of

disobeying Allah and that where there is a conflict between divine teachings of Allah and community interests, the former must take precedence as seen in Quran 33:36 (Lethome Ibrahim and Sheikh Maryam Abdi 2008:23). The approach has also generated controversy among Muslims because FGM is still supported by some Muslim communities as an Islamic practice. In fact, some independent churches or mosques are still teaching and encouraging their followers to retain their cultural values and traditions including FGM. This is especially evidenced in Egypt. Religious scholars that have out rightly spoken against FGM are believed to be religiously biased. Their campaigns face criticism for being financially motivated - rather than morally oriented, and being western influenced towards destroying own cultures rather than protecting them. Despite criticism, it should be noted that FGM compromises human rights values and has no place in society.

Alternative Rites approach (ARP): Typical in Kenya (Jane Njeri Chege, Ian Askew, and Jennifer Liku 2001) unlike Egypt and Ghana, the approach is among the very few successful approaches in achieving FGM abandonment in the whole of Africa (UNFPA-UNICEF 2011). Some ethnic groups in Kenya for instance the Meru, Maasai and Kuria have had circumcision as an integral component of the traditional rites of passage initiating girls (and usually boys too) from childhood to adulthood. Such societies value coming-of-age ceremonies. To them abandoning FGM can be associated to abandonment of the rites of passage, which may create considerable social conflicts (World Vision 2008; see also interviews with the national gender coordinator of World vision-Kenya). Consequently, it is much more productive to develop new activities to take the place of damaging customs than to prohibit outright what has been done traditionally. Alternative rites approach hence seeks to adopt non-harmful rites of passage, specific to communities that value womanhood ceremonies - by providing locally appropriate alternative rites of passage for girls to substitute for mutilation while preserving the positive idea of such passages.

ARP comprises of traditional education on the role the adolescent girl is expected to play, including aspects of sexuality and motherhood, FGM and its effects, child rights (Jane Njeri Chege, Ian Askew, and Jennifer Liku 2001). Girls are secluded from the rest of the community for a week and receive their education in sacred places and other specially designated places (refer to world vision interviews). Older boys who also join the group of girls later, are sensitized on FGM and its effects. They are encouraged as future husbands of the trained girls, to marry them without circumcision. Parents join the ARP at last, to take part in FGM sensitization issues. Such rites are usually the occasion for joyful festivities lasting

for days and involving the community as a whole (Jane Njeri Chege, Ian Askew, and Jennifer Liku 2001). The information imparted in girls through this approach empowers them to make informed choices regarding whether to participate in FGM or abandon it. The knowledge acquired through the ARP model broadens participants' minds and assists them to make appropriate decisions concerning their future lives. The approach promotes advocacy for the girls' right to education, health and integrity. It further brings about a new culture that phases out the old practice of FGM and paves way for ARP adoption as an acceptable rite of passage that transforms the girls from childhood to adulthood (World Vision 2008), which has had a positive effect on attitudes and behaviors.

The first Alternative rite of passage (ARP) was first celebrated in 1996 in Tharaka Nithi District, where 29 girls were initiated into adulthood (Jane Njeri Chege, Ian Askew, and Jennifer Liku 2001). Having seen the success, PATH and MYWO developed a program, which refined this approach and promoted it among communities in Narok and Gucha districts (Evelia Humphrey, Maryam Sheikh 2007:13). By December 1998, 12 ARP ceremonies had been conducted in four districts and 1,124 girls graduated (Evelia Humphrey, Maryam Sheikh 2007:13). Today there is an ARP manual in place, which several communities work with that was developed from community contribution from Pokot, IIchamus, Tungen, Sabaot and Marakwet (World Vision 2008 and interviews). The Manual's content covers information on culture and traditions, effects of FGM, Children's rights, drug abuse and self-esteem among other topics.

Participants of the ARP trainings are girls aged 9-18 years and 19 years and above, grouped as follows. Group 1 consists of girls between ages 9 to 13. Group 2 focuses on girls between 14-18 years and Group 3 is for girls that are 19 years and above (World Vision 2008). The training lasts normally 3-5 days. Thereafter a graduation ceremony takes place, which proves that girls are now mature/adults. After the graduation ceremony, certificates are issued out to girls that have undergone ARPs.

To measure the success of the model; the numbers of turn-ups for participants is usually higher as expected, hence implying that communities have endorsed the ARPs. Additionally, community members are depended upon as facilitators throughout the sessions. Moreover, communities themselves have contributed to the sustainability of graduation ceremonies and sessions by contributing foods, work force, etc. (refer to World vision interviews in Kenya). As much as the approach has proven successful; more sensitizations and trainings, combined with public discussions and dialogues - ought to be now and again promoted.

Given the challenges; some husbands were disgruntled because they witnessed their wives attending meetings, receiving trainings and making decisions, which sometimes resulted into domestic violence. As a response, the project increased the components - involving men to ensure their approval and to protect the women (Evelia Humphrey, Maryam Sheikh 2007). According to World vision interviews; despite the training - some girls are still subjected to FGM by their parents to become fully mature adults, as a result of disbeliefs that the ARP training is not enough for the girls. Besides, sometimes stigmatization of uncircumcised girls even after the ARP threatens the wellbeing and harmonious living of girls in the communities, hence finally succumbing to the practice. The model also faces financial hardships in its sustainability until girls graduate. This is due to the fact that attendance may exceed the actual estimated number of participants.

Rescue homes : Also typical in Kenya in Narok and West Pokot, safe haven/rescue homes such as Tasaru Ntomok Center (UNFPA.org) are put in place where young girls running away from FGM and early marriages can be accommodated until the danger is over. Rescue homes serve as temporary accommodating places for the girls and provide the opportunity for them to further their education (UNFPA 2007). Tasaru center is noted among the very few rescue centers in Africa, built in 2002 by help of UNFPA funding, being a home of Maasai girls rescued from FGM mainly (UNFPA.org). By the time of my field research, the center was hosting a total number of 18 children who had run away from their families. The homes also work towards the reconciliation of children and their parents. Sensitization of parents about the dangers of FGM, children's rights, and the advantages of further education rather than early marriages – is also focused upon. Some parents after a while take back their children and regret their actions. However in some cases, reconciliation is extremely hard given the following reasons.

Challenges: Such community institutions are looked upon by some community members as spoilers of traditions who mislead their children and encourage them to turn against their parents in the name of 'children rights'. Sometimes reconciliation between the parents and the children is never possible, which leads to female children being totally abandoned by their parents. As a result, the centers have to take care (socially and financially) for the totally abandoned children until they can be independent. Some parents even after having been reconciled with their children go ahead and circumcise their daughters. In addition, the maintenance of rescue homes gets expensive as the number of children increase who seek refuge. In cases where such centers/homes lack funding, the maintenances is not at all

possible and conditions (hygiene, feeding and accommodation) may worsens. Bad conditions sometimes lead girls to opt going back to their families, get circumcised and eventually live a 'normal better life' than that provided by the center. Despite the rescue purpose, some girls simply run away from home (by help of their parents) without really being threatened by FGM and come to these centers to seek companionship and to enjoy the benefits that the centers have to offer. Such behaviors deny a chance to real victims of FGM, since the limited resources are equally shared with those not really at risk.

Way forward: Appropriate and intensive background research needs to be carried out on the girls just after they get to the center - to avoid duplications and miss-utilization of the limited resources. Follow ups ought to be also done on girls who are reconciled with their parents to see to it that they do not afterwards become real victims of FGM. If they succumb to family pressure after reconciliation, parents should be finally prosecuted in order to set an example for others.

Alternative sources of income for circumcisers: Circumcisers' skills are indispensable to the community and they enjoy social status. Their services are paid both in kind and cash (Berhane Ras-Work 1997:137). The campaigns against FGM have thus targeted changing attitudes of circumcisers by offering them alternative sources of income, while on the other hand using them as change agents. Community education initiatives have been carried out in different parts of Africa, in which circumcisers are sensitized about the risks associated with the practice. Many circumcisers have abandoned their trade after being enlightened. This is followed by providing them with alternative means of livelihood to motivate them not to undertake the practice any more. Councils of Imams and Preachers of Kenya (CIPK) in Tana River for example give grants to circumcisers to encourage them to stop FGM (Evelia Humphrey and Maryam Sheikh Abdi 2007;12). In Ghana, circumcisers were trained to become traditional Birth attendants (Armstrong 1991) through which they could earn a living. In countries like Burkina Faso, Ethiopia, Kenya, Ghana, Mali, Senegal and Uganda (Diop,T; Diallo, et.al 1998; WHO 1999), assessments show that such conversions usually include several components. Namely; a) identifying the circumcisers and sensitizing them against FGM, b) training circumcisers to become change agents and motivating them to educate their communities, specifically families that request for FGM, c) orienting them towards and training them in generating other alternative sources of income to replace circumcision.

I happened to be an eyewitness of four circumcisers who publically declared FGM abandonment and laid down their circumcision tools. This took place during an anti FGM

declaration ceremony in Marigat, in the Ilchamus community.[12] The ceremony took place on the 24. June. 2011. One of the aged circumciser said she was paid off for each circumcised girl - a) 20 liters of local brew, b) 200 Kenyan shillings, c) followed by a congratulations ceremony whenever she could perform FGM. She added that she had dropped the practice after being identified as a traditional Circumciser and receiving sensitization on FGM's harms. She publically denounced the act and encouraged other circumcisers to give up FGM completely. She was one of the representatives in signing off an anti FGM declaration agreement with the government.

Challenges: Even though circumcisers are given alternative means of income; not all will abandon the practice – given high demand for their services. CARE Kenya in their project in the refugee camps implemented an alternative income project for circumcisers, but had to stop because circumcisers did more cutting for free (Evelia Humphrey and Maryam Sheikh Abdi 2007;12). Humphrey notes that in the year CARE disbursed the funds, they recorded the highest number of girls being cut. Apparently, awareness raising, alternative skills and income are not sufficient to persuade circumcisers to stop the practice. Such efforts may encourage a few individual practitioners to stop but they have no virtual effect on demand for the practice.

Way forward: It is thus worth appropriately taking care of the demand side before putting emphasis on circumcisers. Sensitizing circumcisers and offering alternative incomes is an additional gain not to be underscored, which will be more effective only if there is less demand towards their services.

Medical approach: The approach addresses the health complications of FGM to not only health providers, but also the community as a whole. It is believed to be an easiest entry point in addressing such taboo practices. The model also seeks to deal with or get solutions to medicalized FGM. Communities are sensitized about the health risks of FGM. The approach also orients health workers to better understand the socio-cultural and religious reasons perpetuating the practice. It further equips health workers particularly with messages to

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[12] Illchamus anti declaration ceremony celebrated on the 26th June.2011, led by the chiefs and elders of the community, circumcisers, together with the 'morans' (Morans are youths and mostly made up of warriors. They play a bigger role in maintaining FGM as a practice) signed an anti FGM declaration with the government. The declaration followed one that had just taken place in Kapenguria on the 15th June 2011 in West Pokot and several others. "Meru was the first community to declare itself free from FGM and to also allow to officially supporting FGM abandonment activities. The first declaration was signed in the 1950s with community elders and chiefs…and was then renewed in 2009 by government, followed by a Kuria community in 2010," noted a 73 year old Elder of/from Meru—Rev. Stephen A. Mugambi Mwithimbu, present at the IIllchamus ceremony.

communicate to their clients in a bid to compliment on projects towards FGM abandonment. It also teaches health professionals on how to handle patients with FGM.

Population council with support from USAID has developed and implemented a training program with the Ministry of Health in the North Eastern Province in Kenya to sensitize and train health care providers not to infibulate women after delivery but rather de-infibulate them (among the groups practicing type III). The health personnel are also taught how to treat and counsel women who are suffering FGM complications during pregnancy and delivery. The training has been introduced into clinics serving Somali populations in Nairobi and is now sustained by GTZ and UNHCR support (Population council.org).

Challenges: Most complications are evidenced in infibulations. Communities that practice type II and I, complications may not necessarily exist. It is therefore hard to convince persons to stop cutting based on health complications yet in their generations, they may not have experienced at all any health complications. Medical personnel continue performing FGM for financial gains.

Promote girl-child education: FGM is associated with early marriage, which means stopping school, becoming pregnant and having children. Children that have undergone the practice feel 'psychologically mature' and big enough not to be in classes hence they drop school and get married. In Kuria for instance where FGM is normally done in December holidays, there is a reduction in the number of girl children in schools by January (see MGCSD recorded interviews under Kenya folder). Based on the World vision interviews from the national gender coordinator in Kenya, Interventions promoting and strengthening girl education (and boys) in school is one among the many FGM abandonment approaches proven to be important. This is so, because it enhances empowerment skills and can change such cultural ideologies. The intention is to encourage children to question the practice and actively oppose it within their families and communities. The model also encourages parents to keep their children in school instead of marrying them off young. Education emphasizes future benefits such as poverty reduction through employment opportunities, which are minimized given the education level.

World Vision Kenya (2008) is using this approach and giving out sponsorships to children, especially 'girl child' in Maasai and Narok. The Child Protection officer of World Vision in Namanga notes that families that have been given this opportunity by the World vision - are made to sign agreements that denounce FGM in exchange of scholarships. The Child

protection officer noted positive results from the approach especially in Namanga region, where World vision offices are located. In Ghana, the Government committed to continue its efforts to enhance girls' access to education in primary, secondary and tertiary levels - in order to lower the drop-out rates (Kwame Akyeampong, Jerome Djangmah, Abena Oduro, Alhassan Seidu, Frances Hunt 2007; UNICEF 2007). An NGO called Ghana Education Project Foundation also aims at combating especially girls drop out from school, and achieving education for all through its sponsorship scheme (See Ghana education project.org.uk/projects). In Egypt, several projects have also been run to get girls into schools at all levels (UNICEF 2008). This is followed by the fact that school enrollment remains lower. The gender gap disparities in primary net are seen to be high especially in Upper Egypt - ranging from 15.7% in Beni Suef, 14.2% in Assuit, and 12.6% in Fayoum (Malak Zaalouk- UNICEF, Cairo). The chief of Education Programme at UNICEF in Cairo - Malak Zaalouk identifies poverty as the main reason for families' failure to send their daughters to school. Therefore; in partnership with the Ministry of Education, UNICEF and local communities, community school initiatives was established in 1992 in the governorates of upper Egypt, where gender disparities were high – say in Assuit, Qena and Sohag.

Positive deviance approach: Identifies women and men who oppose the practice despite prevailing norms and capitalizes on their support to raise awareness on FGM and advocate for change. The approach targets influential people who could serve as advocates such as religious leaders, teachers, community chiefs and elders, ex-circumcisers, girls who have escaped and now successful in their communities etc., (recorded interviews -the Illchamus declarations against FGM in Kenya).

In conclusion, as stated by the head of gynecology department at the University of Nairobi, a researcher and FGM activist called Dr. Jaldesa says different communities have different ways of approaching FGM. There is no universal way. One needs to understand every community and motivation dynamics behind the practice before doing any kind of intervention or implementation. *"Let communities give socially acceptable methods of intervention",* instead of activists telling communities what to do. However, in order for communities to freely express themselves on issues addressing FGM, sometimes there is need to separate communities into groups (say, women, men, youths, etc.). The medical informant recommends need for community diagnostic studies and more people to do more FGM studies in different perspectives, to address FGM in specific cultural contexts. In order to achieve that, in 2011 Dr. Jaldesa had a visual concept of creating a Center for FGM abandonment

leadership and research for Africa, with the aim of training and using African scholars in doing research and providing leadership in advocacy against the practice (Interviews).

Dr. Jaldesa is a practicing obstetrician/gynecologist and a senior lecturer at the University of Nairobi, College of Health Sciences based at Kenyatta National Hospital in Nairobi. He has been studying FGM since 1995, focusing on its development and complications during pregnancy, childbirth, and the postpartum period among the Somali populations in Kenya. Dr. Jaldesa also studied and published on psychosexual health consequences of FGM among the infibulated women in Kenya. He also served as principal investigator on the WHO FGM/C and obstetric squeal study, published in The Lancet in 2006.[13]

Meanwhile, as a general challenge for all FGM projects, Denison E. et.al (2009:22) have demonstrated that the Population Reference Bureau (PRB) carried out extensive research on intervention projects in Africa by applying the 'best practice' criteria as defined by the United Nations. Out of the 92 projects that were identified being in use, only 27 had been evaluated mainly by observation methods, from which only 4 gave positive result, through a controlled before and after design (Denison E. et.al 2009). These included the Alternative rites approach in Kenya, the health intervention education in the Shao community in Nigeria, Tostan in Senegal. Most projects, which did not qualify for the study, had evaluation and monitoring loopholes. However, implementers should ensure sound formative research of program design, implementation, monitoring and evaluation - with key audiences and stakeholders. They should also make process outcome and impact-evaluation a high priority.

For Izzet and Toubia (1999), *"Monitoring and evaluation of programs are among the most important items on the FC/FGM agenda (…). Before further investment is made in expanding existing approaches or experimenting with new ones, it is crucial to determine whether activities are achieving their objectives and whether there are measurable outcomes in terms of changing attitudes or a reduction in circumcision."* This will support measuring success and failures in project activities, as well as tracing loopholes that require adequate redress. Besides a broad approach that has been implemented to modify knowledge, attitudes and behaviors about the practice; numerous studies (like Denison E. et.al 2009) have also provided understanding about promising-methodologies, designing effective interventions and enabling factors – that support success, control and drawbacks. Thanks to the different types of organizations that are spearheading abandonment activities and propagating abandonment

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[13] Africa Coordinating Centre for the Abandonment of FGM/C, University of Nairobi, http://accaf.uonbi.ac.ke/node/307. Accessed on 20/01/2014

messages in different packages. It is known that the longest tradition of activism against FGM is within the NGO sectors/civil society. More details follow in the chapter below.

4 NGOS AND FGM

The definition of NGOs is an essentially contested concept in social sciences because it appears to be abstract, yet remote from daily life. The term is laden with theoretical assumptions, unsolved problems and value judgment (Ottoway M 2008:167). However, depending on who uses the term and in what context (M.A Ölz 1997), NGOs can be understood in different ways. As Willet describes, *"the world of NGOs goes beyond standard operation and advocacy activities, to include many other, less well-known activities, such as harmonization of technical standards, maintenance of communication systems, provision of information, (...) sustaining shared values or a common identity, protecting collective interests, empowerment of the disadvantaged..." (Peter Willets 2011:8).*

NGOs are widely believed to be none profit groups that combine resource mobilization, information provision and activism to advocate for change in certain issues (Deborah L. Spar and Lane T. La Mure 2003). In there more current incarnations, NGOs run the gamut from small-scale grass groups, to large and professionally managed institutions. They may thus *"be categorized in operational groups that run their own projects or advocacy groups that seek to influence policy" (*Peter Willets 2011*).*

Majority international organizations fall under the advocacy groups and are active in the field of economic and social assistance, while few UN associations are involved in social structuring *(*Jürgen Schramm 1995:1*).* Social structuring organizations are more involved in human rights and democracy and tend to organize primarily around ideas and collective commitment to some shared beliefs or principles (e.g. Human rights), operating independently of any government. However, as Schramm (1995:3) notes, social structuring organizations are seen today as purveyors of a particular ideology, a fact certain governments have seized on in order to reduce both the degree of cooperation and financial support.

NGOs operate on several levels including initially standard setting (international norms of measuring conduct) and fact-finding - by serving as a kind of Ombudsmen intervening diplomatically on behalf of the oppressed (William Korey 1998:5). Civil societies were basically formed on arguments that they give preferential treatment to individual's daily freedom from violence, enable groups to define and express their social identities, give freedoms of communications in networks of sized non-state communication medias, (John Keane 1998) and paves way to democracy amidst politically regulated and socially constrained markets through power regulation.

Until the adoption of the UN Charter in 1945, the term NGO did not exist. *"In 1910, a group of 132 organizations, which are now known as International Organizations, came together to form the Union of International Associations (...) The representatives of "international associations" at the league committees were called "assessors" (...) When the UN charter was finalized (...), under Article 57, a new term, "specialized agencies," was defined to cover international organizations such as WHO (...). Under Article 71, a second new term, "non-governmental organizations" was invented, but was left undefined (...). After 1945, private international organizations started calling themselves NGOs, but the term did not move outside the world of diplomacy until the 1970s" (*Peter Willets 2011; 6-7*)*.

Back then NGOs formed around distinct well-defined problems and societal issues that were either being ignored or sponsored by formal authorities. For instance *"In 1775, Quaker activists founded the Pennsylvania Society for Promoting the Abolition of Slavery, dedicated to liberating enslaved blacks and crusading against slavery more generally. They were followed a decade later by the British Society for Effecting the Abolition of the Slave Trade, which sought an end to the transatlantic slave trade"* (Deborah L. Spar and Lane T. La Mure 2003:79*).* Here protestors targeted the obvious source of power such as governments. Eventually, other groups with similar principles such as foot binding in China, working conditions for immigrants and child labor increasingly came up and took their protests on streets for purposes of combating the laws.

Today the notion of NGOs has expanded beyond national boarders to international levels along with its continuum from civil to uncivil aspects. Non-state actors such as multinational corporations are more and more a direct target of activism. None state actors' reactions are aimed at - in order to force single governments to act by strengthening laws, improving Human rights standards and strengthening their democratization process. The growth of NGOs has given them an increasingly important role, hence forming a distinctive sector within civil society. NGOs are engaged in all sectors of social life such as relief, rehabilitation, health, education, development programs, peace, human rights and environmental issues.

Open borders and space has allowed the co-existence of the two types of organizations (domestic and international). The successful existence of the two organizations and positive results in their fields of operations depends on their genuine cooperation and complimentary roles towards each other. Posner states for instance that DNGOs have access to information on ground through a variety of contacts that INGOs could possibly not get access to - on their

own (M.H Posner, C. Whittcome 1994:269; M.H Posner 1997). DNGOs may also have access to political and legal strategies within national jurisdictions, which knowledge, INGOs may not have access. Besides DNGOs persuade or socialize states to accept their legal interpretations, which INGOs take over in order to mobilize international government support? This support is later used to enforce international laws and influence policies at national levels. Efua Dorkenoo for example, through FORWARD (DNGO) – plus many more activists (including international feminists) – made strategic moves that made FGM a global issue (Helen Rappaport 2001), hence its recognition today as international human rights challenges.

4.1 NGOs advocating against FGM

NGOs tirelessly stress the disadvantages embedded in the practice of FGM, while working out ways for abandonment. With community efforts and alignment, most NGOs have come up with socially and culturally acceptable solutions towards behavioral changes. Casual mechanism is drawn by using threats posed by FGM, public pressure and victims. NGOs employ different intervention strategies such as top-down or bottoms up models. As Panda B (2007:261) explains, the bottom up strategy emphasizes community participation, local decision making and grass root movements, while the top-down approach focuses on lobbying and advocacy activities such as winning government support, bargaining with decision making authorities, funding and putting pressure on various campaign methods.

Grassroots NGOs mostly follow the bottom up approach, while international NGOs and big domestic NGOs mostly follow the Top-down intervention model. While INGOs mainly influence government policies through lobby activities, DNGOs mostly implement government laws and policies.

INGOs: Development partners like UNICEF, UNFPA, UNIFEM, USAID, have played an important role in FGM abandonment through supporting anti FGM activities. They have promoted institutionalized structural dialogues with stakeholders, strengthened advocacy and policy dialogue, heightened the role of networks and coalitions, and promoted women in leadership (Beatriz Sanz Corella, An Van Goey 2012). UNFPA and UNICEF for example have supported the strengthening of existing institutional frameworks, increased the potential for social dialogue, supported possibilities offered by social media, given technical assistance, assisted in funding mechanisms, and peer support (Beatriz Sanz Corella, An Van Goey 2012) in the fight against FGM. Through their support, there was a realization of the development of

the National Plan of Action in Kenya and the creation of the National Committee for the Abandonment of FGM in Egypt.

Other organizations such as GTZ, Action Aid, World Vision, Care International, etc. have been instrumental on national levels to curb down the practice through advocating measures, supporting and collaborating with CBOs and government. World vision for instance works at grassroots levels with support of the indigenous populations/communities - to improve the human rights and gender concept (see World vision interview recordings).

In Kenya, GTZ collaborated with the Ministry of Health and conducted operations research. Results were then utilized to design, monitor and evaluate FGM projects in Kuria district, Kajiado and Transmara district, Greater Meru, and Garissa (Humphres Evelia, Maryam Sheikh Abdi, Ian Askew 2008). In Ghana, Action Aid calls for strict enforcement of the laws against FGM (actionaid.org). In Egypt, UNFPA has worked with circumcisers, influencing them towards behavioral changes (see interview recordings with population council).

Similarly, **DNGOs** involving a number of local based organizations have also played a very important role towards FGM abandonment. Among other examples in this category are the Faith Based Organizations that address FGM especially on a religious perspective. Examples in Egypt include; the Coptic Evangelical Organization for Social Services (CEOSS), the Coptic Organization for Services and Training (COST) and the Jesuit and Frere Association (Nahla Abdel-Tawab, Sahar Hegazi, 2000). These FBOs integrate FGM abandonment faith based messages into community development activities, including awareness raising seminars. Seminars tend to be more participatory and include men and women. UNFPA and UNICEF joint programmes sponsor the above-mentioned FBOs, to implement their activities.

In Kenya FBOs like the Anglican Church of Kenya (ACK), St Martin's, Christian Community Services (CCS), Full Gospel Church of Kenya, Julie K, Lutheran Outreach, Catholic Secretariat, Supreme Council of Kenya Muslims (SUPKEM), Maranatha, Nakuru Diocese, Kenyan Arab Friendship Society (Evalia Humphrey, Sheik Maryam, et.al 2007), have also actively been involved in FGM abandonment activities.

Community based organizations (CBOs) like Tasaru Girls Rescue Centre (TGRC), Tigania Cultural Development Association (TCDA), SDA Rural Project, Pastoralists Girls Initiatives (PGI), Ogiek Welfare Community, Daraja Community Based Organization, Kuria Child and Development Program, MAIKOO ATE (Maasai people's program) (Evalia Humphrey, Sheik

Maryam, et.al 2007:9) and several others in Kenya influence behavioral changes against FGM using different kinds of approaches.

Other DNGOs like - the Egyptian Society for Prevention of Harmful Traditional Practices against Women and Children (ESPHTP) is known for its FGM awareness-raising campaigns in Egypt (Nahla Abdel-Tawab, Sahar Hegazi 2000). The Center for Egyptian Women's Legal Assistance (CEWLA) is another organization that maintains informal relations with trainees in relation with FGM abandonment. *"The trainees inform the Center staff about any problems they encounter in taking legal action and also seek technical advice on appropriate procedures to follow"* (Nahla Abdel-Tawab, Sahar Hegazi 2000). In Kenya, organizations like FIDA, Population Council, AMEWOPA and MWYO, also engage in several FGM campaigns. In Ghana - Ghana Association of Women Welfare and Muslim Family and Counseling Services (MFCS) have worked together on seeking solutions to ending the practice (US Department of State Archive, 2001-2009).

Since most DNGOs are 'community insiders' or work hand in hand with the affected communities, they can easily deal with grassroots people or communities without facing much rejections. They also rarely have language barriers and communication problems, as compared to organizations that come from outside targeted communities. Most importantly, because most examples of NGOs mentioned above are community based – with workforce usually coming from within communities themselves, they have opportunities of addressing FGM problems more sufficiently. This is so, because of their ground knowledge (e.g., who does what, when and where, what is the best time for targeting communities or implementing abandonment projects, etc.) in their respective communities. They can also reach out with ease stakeholders (elders, circumcisers and chiefs) in areas of target or locations, seeking their cooperation towards FGM abandonment activities. The aim is to turn such groups into positive deviances agitating for change (Evalia Humphrey, Sheik Maryam, et.al 2007).

4.2 Examples of NGO Successful intervention models

In Kenya MWYO initiated its successful community led FGM abandonment program - the alternative rites to passage approach (ARP). This approach has now been replicated in different regions of the country, where ethnic groups such as Maasai, Ameru and Kiisi circumcise girls as a rite of passage into adulthood. ARP prepares girls for adulthood without the cut. Gachanga says the ARP has been in use since 1980s, but the model is now proving

more successful because of the involvement of the entire community (UNFPA-UNICEF 2013).

The success of this program necessitates wide participation of men, women, and youths of all social settings. MWYO organizes forums that engage community members in discussions on their life, hopes for the future, ways to improve their well-being and human rights. The whole abandonment process through the ARP model ends with a public pledge.

In Meru, the council of elders has been an entry point of the ARP model into the community. The Meru council of elders had banned FGM in 1956; however in 2008 they renewed their commitment to ban FGM and in 2009, a public declaration abandoning FGM was made under UNFPA-UNICEF support (see UNFPA-UNICEF 2013, and interviews with MGCSD Kenya). Results from the ARP show that *"from 2010 to 2012 during the traditional cutting season in December, 435 Meru girls participated in alternative rites of passage"* (UNFPA-UNICEF 2013:11). No reports have been given of any girls falling back into the practice.

A Christian community - Deir El Barrsha - in Egypt also made statements denouncing FGM, signed by the priest Safwat Ghabriel. Community leaders, religious clerics, local women groups and traditional circumcisers – without intervention of policy makers or politicians (Amal Abdel Hadi 2006), led this Egyptian community into the abandonment statement. Declared behavioral changes were a result of fundamental change in gender relations in the local society. These fundamental changes comprised of women participation in religious dialogues and in markets, education and literacy programs. These development efforts promoted women participation and autonomy, which eventually led to women empowerment. Through empowerment, the Deir El Barrsha community eventually criticized FGM from within.

TOSTAN (meaning 'breakthrough' in Wolof) in Senegal is also another community project that has seen success in its abandonment projects (N.J.Diop and Ian Askew 2009; 2006). The organization was established in 1991, with the major aim of helping people acquire knowledge and skills to sustain their own development. The methodology of Tostan project relied on Senegal's oral traditions such as songs, dance, poetry, etc. When Tostan included the sessions of human rights and democracy, women came to rethink about FGM. According to UNFPA/UNICEF, Molly Melching the founder and director of TOSTAN in Senegal explains, *"Our goal has been to empower people at community level to improve their lives. We found that the key—instigating factor and a huge catalyst for change—have come from human*

rights education. Without that, women would never have felt the confidence to take the brave stand for positive change or even reach out to their own and to other villages" (UNFPA/UNICEF 2013:6-7).

As part of the program, communities with Tostan projects engage nearby communities and villages, which are inter-linked by marriage and trade - in discussing about the practice of FGM. This sharing of information within social networks especially in intermarrying communities - facilitated by community elders, religious leaders and women groups - is very important and has seen tremendous success that has led to several public declarations of FGM abandonment in Senegal. For instance in *"July 1997, more than three dozen women in the village of Malicounda Bambara announced in the presence of 20 journalists, that they, their husbands, the village chief and religious leaders had all agreed to end FGM/C"* (UNFPA-UNICEF 2013:5). Eventually further public statements against FGM were held in the village of Diabougou, followed by further 13 more communities. This has accounted for reductions in prevalence levels and change of attitudes countrywide.

Examples of successful approaches have demonstrated the value of community engagement and participatory approach for implementations of its interventions towards behavioral change. Due to the social nature of FGM, both government and communities are pivotal in making commitments that will ensure the end of the practice. It is thus essential to have cross sectional programs, while providing an environment that is conducive to raising awareness and promoting behavior change in a cultural context, while putting into notice individual preferences and lifestyles. This implies that the intervention methods chosen must be context specific. If interventions are not applicable to a specific culture, success is due to be limited. Therefore well researched community based studies are recommended before any interventions can be done.

4.3 Achievements

FGM abandonment campaigns such as community awareness campaigns address various stakeholders such as church leaders, traditional circumcisers, community elders and chiefs, women groups, children, men and youths about the health effects of FGM and advocate for abandonment because of its harm to women and girls. Campaigns against FGM take place in community meetings and gatherings, through organized seminars, or holiday's activities organized to target school going children (World Vision 2009, Nafissatou J. Diop and Ian Askew 2006). This has achieved community understanding about impacts of FGM, which has

led some community members to be advocators against the practice and others to change their attitudes completely (World Vision 2009) hence abandonment.

Community led approaches have shown prospects towards achieving FGM abandonment (M Mohammed, S.Radney, K. Ringheim 2006; UNICEF 2010; G.Mackie 2000) by creating sustainable change (GTZ 2001) through empowerment of the whole community at large. Empowerment especially of women, has led women to participate actively in decisions affecting their lives (Nafissour J.Diop and Ian Askew 2006), which has made communities examine their own behaviors and come up with ways of abandoning harmful social norms on their own (Jane N Chege, Ian Askew, J Liku 2001).

4.4 Challenges

The slow declines in prevalence levels of FGM given decades of intervention projects raise questions of effectiveness (UNICEF 2010:10-12; 2009; Toubia and Izzet 1999), due to inadequate evidences shown to prove sustainability in change of behaviors. Below are some of the challenges towards project effectiveness experienced in FGM abandonment techniques/methodologies.

Identical interventions may give different results in different settings. For instance, Amal A Hadi (2006) notes that success of one community led project in Deir El Barsha (Egypt) was not parallel in the neighboring villages because of variations in social and religious factors. Also, TOSTAN community intervention models of abandoning FGM are more successful in Senegal, compared to those in Burkina Faso and Mali (Nafissatou J.Diop and Edmond Badge 2003; Nafissatou J. Diop and Ian Askew 2006; 2009).

Project replications can also spark community rage or hostility, which may lead to boycotting FGM intervention projects. An example can be drawn from the FGM abandonment project that was replicated on the Ethiopian Christian site and among the Somali Muslim refugees in Kenya. It is reported that intervention organizers experienced great hostility from Somali Muslims, yet the project had been successful on the Ethiopian site (Population Council 2002). Organizers did not research enough about Sunna Muslim Somali communities in Kenya like they had done in Ethiopia before FGM project implementation, yet it was a Christian based organization leading these interventions in a purely Muslim community, with little inclusion of Somali community stake holders to influence decisions and attitudes. The emphasis of prior community researches to identify unique points is necessary for project interventions

and implementations or an introduction of more supportive abandonment interventions based on community context is critical.

Inadequate funding, has also limited NGOs operations and scope of activities. A 1999 review of more than 85 agencies with FGM abandonment projects in Africa indicate that more than 85% identified a lack of funding as a major challenge (Muteshi J, Sass J 2005). Although, financial support may have increased since the review, funding arrangements have largely remained small scale, piece meals and fragmented. World Vision (2009) reports that most of its funding comes from small grants that last a short period, which limits meaningful change, especially within communities where the practice is universal. According to World Vision (2009), the current resources allocated for project implementation are only adequate to create community awareness and initiate discussions on issues surrounding FGM. Muteschi J, Sass J (2005) argues that the unpredictability of aid disbursement has undermined effective and efficient budget management and has led to discontinued or delayed projects and small scale initiatives with limited reach.

Financial support from donors is instrumental to get intervention projects done, funding materials and advocacy to create enabling environment (Muteschi J, Sass J 2005). Incentives provided such as education sponsorships, compensation for participating in meetings and trainings, may ensure community participation and engagement (R.E B Johannsen et.al 2013). World Vision applies these types of incentives in implementing its FGM abandonment projects, despite the fact that sustainability may be a challenge given the limited resources. Financial constraints should provide an impetus of NGOs to look back on a long period of successful activity, in order to engage themselves more forcefully and in particular to secure themselves greater financial dependency (Schramm Jürgen 1995). NGOs that emerge from this dependency phase ought to adapt to face such challenges.

On the other hand, there is a risk of non-genuine actual intentions to change attitudes towards FGM, as people may support the cause in order to get the incentives (R.E B Johannsen et.al 2013). Community members that have led or supported anti FGM movements are often times accused of being bought by donors, hence expressing mistrust towards the messages delivered. Such challenges have rarely been documented yet they affect project effectivity. Long time project frame works can partly help to deal with mistrust, because during the course of operations, people may genuinely decide to change their personal selfish aims and motives. The longer the project periods, the deeper abandonment messages sink, and the more possibility towards behavioral change and sustainability.

Limited time frameworks do not encourage proper abandonment. World Vision (2009) admits its operations in communities where FGM prevalence levels are high. However, its area development plan does not have FGM featuring as a main component to be addressed (World Vision 2009). FGM has been allocated as a one to three year short-term projects hence making it hard to achieve FGM-reduction set goals, especially among the most conservative community members who may require support for a longer-term period to facilitate behavioral change. Limited interventions based on short periods may be applicable to those already questioning the practice, but seek to get social acceptance for their change (B. Shell-Duncan et, al 2010) or gives a push towards change to the ambivalent and those ready for abandonment (R.E B Johannsen et.al 2013).

There is also scant empirical evidence about the impact of various models of programmatic interventions, thus making it impossible for organizations to identify between interventions that work, and those that do not. Interventions have been implemented with little attempt to document how they work or to evaluate their influence on knowledge, beliefs, attitudes and behaviors (Nafissatou J.Diop and Ian Askew 2006). Yet, NGOs also seldom document the process they follow in implementing interventions, difficulties faced in implementation, or ways of overcoming given difficulties. For those few that attempt to make evaluations (Hanne Lotte Moen, et al 2012; John Masas 2009), the systematic appraisal of the evidence is lacking. More so, evaluation may not entirely be separate from the design of the intervention as intervention to some extent can be controlled or influenced by those undertaking the study (Nafissatou J.Diop and Ian Askew 2006).

In the process of monitoring and evaluation of FGM projects, feasible or valid impact indicators are vital (Population Council 2002). These indicators will be used to assess, which approaches and what characteristics of implementation are important for success. While impact indicators aim at comparing the success of different approaches, they need to be adapted to specific contexts, because abandonment of FGM is so context specific (Population council 2002). However a number of problems lie ahead, while trying to identify primary indicators. In Egypt for example, there are high levels of agreements between self-reported FGM statuses and clinical based studies (Huntington. D et al 1996). In contrast, the study taken in Navrongo (northern Ghana) shows high levels of contradictions in self-reporting of FGM status amongst women. After getting informed about the law against FGM, over 60% of women in Northern Ghana denied having been circumcised after previously reporting that they had been circumcised (Reshma Naik, Elizabeth.F Jackson, Patricia Akweongo 2004, and

Population Council 2002). Such variations in reports may corrupt evaluation of projects with information that can be hardly proven, especially when dealing with self-reported results. Although ethically disapproved, considerations of clinical based examination of genital would be an appropriate measure.

Theoretically, some NGOs are lured by the market economy and transformed into profit making bodies. They may thus behave as rational, profit maximizing agents, whose first and overriding concern is to create and maintain their own value through offering competitive services and employing expensive expertise labor in order to remain in 'business'. This is so especially with NGOs that contract services depending on fund availability. Such organizations may move from project to the other because that is where finances are directed and usually do not care if set objectives or targets are met or not, which makes project half way done. The prior target to address the social problems of the population is somehow compromised at the expense of maintaining the NGO in 'businesses'. Unless firm legal measures that prohibit this kind of transformation are put in place, NGOs will lose track of their real objectives of say addressing social problems.

Additionally, NGOs that serve wider interests such as minority rights, women and children rights, etc., find it more difficult to gain access to political channels unlike those with specific interests (like trade unions) (Hundewadt Erik 1995). Relations between the state and the NGOs are sometimes a battleground. Although NGOs at one point associate closely with the state, but once government activities are criticized, the cooperation between the two institutions may cease, and the operating political ground is likely to be damaged. In Egypt for instance, NGOs associated with women rights or human rights in general have somewhat lost their ability to operate amidst strong Islamic law enforcement. Given my field research experiences in 2013, organizations such as the Population Council came out bravely to criticize the Morsi government for working against FGM abandonment projects activities. Meanwhile, the National Council of Childhood and Motherhood (NCCM) failed to give its opinions about the practice in general, despite its past well known countrywide activities against FGM during the reign of Hosni Mubarak.

Non-democratic government may decide to control country implication damages by incorporating NGOs into state machinery - in order to neutralize NGO power and limit on their maneuver or operating grounds (Hundewadt Erik 1995). This in turn fails the actual objectives of NGO operations and effectiveness as civil, social, political, economic and basic rights of the people may fail to be defined because of limitations imposed by the

governments, constituting operational barriers. To overcome such challenges, governments should promote an environment in which NGOs have clear and constructive roles for lobbying their activities. NGOs should be empowered to participate in constitutional and law drafting processes. Besides, constructive dialogues between the two institutions should exist.

Additionally, the role of the media in creating a positive environment has to be emphasized. Mass media coverage of FGM in Egypt for instance is limited. According to the press file compiled by the National FGM Task Force, coverage of the issue of FGM did not exceed 25 stories in 1998 (Nahla Abdel Tawab 2000). Moreover, coverage of FGM on television (the leading source of health information for the majority of the Egyptian public) is rare or almost non-existent, especially on the national channels (Nahla Abdel Tawab 2000). This calls for more organized media and policy activities to influence public opinion.

NGOs must thus ask themselves some serious questions. For instance, when the people stop FGM, does it weaken or strengthen the work of excisors and major players in FGM decision making? After projects are implemented, does FGM diminish or gets worse? Can the implemented strategies make a sustainable difference that leads to permanent behavioral changes? If not, why is the change not sustainable? (For successful intervention projects, the change must severe to advance the NGO project goals.) Why do communities respond differently in a way that some accept abandoning the practice, and others not? Arguably, NGOs have not yet fully grappled with these questions. However, such questions weigh project effectiveness.

4.5 Supporting elements: Lessons learned

The organization introducing an intervention must understand as fully as possible *the context* in which it is operating. Community values, practices, and stakeholders (etc.) should primarily be researched upon through descriptive or formative researches. According to Nafissatou J.Diop and Ian Askew (2006:137) "*without systematic research, the cause- and- effect relationships between intervention activities and desired outcomes are seldom clear…*" WHO (2011) puts forth that interventions to end FGM should be community-led, as this ensures both participation and intervention becomes context relevant.

Population Council (2002) suggests the use of Participatory Learning Approach (PLA) to generate behavioral change models drawn on community perspectives. Through the participatory approach, communities are fully engaged in the problem solving process, which avoids generalization and assertions involved during project implementations across

practicing communities (Population Council 2002). Interventions designed based on the PLA model are in most cases fully acceptable and compatible to the communities, whose behaviors are intended to be changed, because such interventions suit the context or cultural modes of life. In Northern Ghana for instance, the use of the PLA model led to the development of two interventions, which included a series of health education activities and activities to develop the autonomy of girls and women (Population council 2002).

Nevertheless, Nafissatour J.Diop and Ian Askew (2006:137) warn that *"Interventions effectiveness cannot be assumed simply because it is feasible and acceptable to the community (…) and that its effectiveness cannot be measured …without a quasi-experimental study design",* thus suggesting the need for pilot testing and outcome evaluations before final implementations.

There is also need for identifying feasible indicators. These can be identified through consideration of communities that have publically declared FGM abandonment and the need for evaluating FGM interventions for a long-term period. Preference for long term periods depend on the fact that, *"circumcision can be performed over a wide age-range and a short-term evaluation might only be detecting a delay in age at circumcision rather than a circumcision averted" (Population Council 2002:16).* Feasibility can also be applied by linking indicators to stages of behavioral change models.

More so, age-specific rates for being cut should be used when evaluating interventions, because most project evaluations consider the age groups that have already been circumcised, yet these age groups can no longer be affected by interventions aiming at eliminating the practice. Younger ages should be targeted to determine the changing rate. There are examples of studies that have applied such solutions. Chege et.al for instance controlled for age when comparing the reported cutting of daughters by parents exposed to sensitization activities in Kenya (Chege, J., I. Askew and J. Liku 2001:38). El-Gibaly et al did the same while comparing self-reported cutting among girls of different ages - whose parents had been exposed to media publicity about FGM in Egypt (Abdel-Tawab, N. and S. Hegazi. 2000). The study in Navrongo, Ghana, recruited a cohort of girls who were aged 12 - 19 years during the baseline survey in 1999, 12 years being the age that they are first at risk of being cut. This is an open cohort in that each year of surveillance other girls aged 12 were added.

Besides, it is necessary to document the implementation process as it happens, including the challenges encountered at each stage of intervention and the lessons learnt. This helps to

explain partly why and how changes have occurred or vice versa. Through understanding the intervention process, monitoring roles are fulfilled. These roles include analyzing expectations of FGM projects, routine documentation and reporting of program activities (which ensures: - that program activities are implemented as planned, problems identified and addressed, and good use of resources within the budget estimates). Most community-level interventions are never implemented as planned, and descriptions of how activities were actually undertaken in real-life situations are crucial if a successful intervention is to be replicated elsewhere (Population council 2002).

Being able to understand how individuals and families reach decisions about changing their beliefs and behaviors, and especially which messages most influenced them, can be difficult to do solely through baseline and end line surveys. Collecting this kind of information is important in especially unique situations such as refugee camps, because responses are often unpredictable.

Long project durations should be targeted to measure effectiveness, because evaluating short-term projects does not give reliable results towards change in behaviors. Projects tended towards FGM must also demonstrate sustainability instead of mere abandonment. This is followed by the fact that no matter the decreasing FGM prevalent rates, sustaining abandonment is still questionable.

Additionally, there is a need to realize that FGM projects are competing with daily social-economic individual problems at community level, in addition to domestic chores. This does not only divide community attention and attendance, but also limits the degree of seriousness - FGM abandonment projects ought to be given. Activists ought to address underlying causes that are likely to affect participation. In Ghana for example, when the Navrongo experiment (Charlotte Feldman-Jacobs and Sarah Ryniak 2006) was introduced to some communities in the upper east, income-generating avenues were side by side introduced besides targeting FGM abandonment. The turn up levels increased, income was partly generated and abandonment was achieved. In Kenya, according to field experience, attendance of FGM forums were high, because communities expected incentives such as bread, sugar, soap, lunch packages from World vision, hence attracting high turn up numbers. Although both models do not necessarily guarantee abandonment; The Ghana model stands higher chances of winning genuine abandonment behavior given a period of time, than the Kenya model. The Ghana model empowers community, while for Kenya's case; the lack of supply of incentives may

affect turn-ups in the coming meetings. Actually, the Kenya model (example) is expensive to be maintained and therefore not a reliable means.

Measurements that compel FGM abandonment in a comfortable way ought to be designed. Such measures should not only ensure communities to meet their everyday needs through socio-economic empowerments, but also take into consideration community/village schedules. For example, think of possibilities of delivering messages to the people in their respective homes, doing different home chores and dealing with different situations, rather than making them gather somewhere to get informed. Such messages can be passed on radios, routine house or compound visits, Rent cars on the move that deliver audio messages within communities at different times. Communities will love the projects because they make their lives easier, reduce on transport costs and is time saving. Such abandonment mechanisms have a feel good factor to the consumers (communities) besides aiming at FGM eradication because they assure safety, considering frightening conditions that may affect individual participation in group seminars, etc.

Personality should be added, by thinking about the language and imagery that helps to tell an engaging story rather than just being a matter of fact. This will capture a variety of audience, to include the illiterates, children and old. The use of language and imagery will also help express different feelings that will embrace active community engagement.

Abandonment messages/ approaches should aim at giving the communities reasons not to be ashamed of expressing themselves, as well as creating the desired change without any particular slight discrimination that may not be intended. With this, the message will highly be grabbed at heart with desire.

All in all, FGM abandonment messages should be kept as simple as possible. Activists ought not to compromise the legibility by giving complicated messages. Strike a message that will stay stuck at heart (less is definitely more), numerous messages may arise to insignificant impacts.

4.6 Involvement of stake holders and reasons for their involvement

WHO (2008) states that, the perpetuation of FGM is partially due to local structures of power and authority. Religious leaders for example are authoritative in their respective communities. Certain segments of the community believe that religion prescribes FGM and others simply

follow the teachings of religious heads. It is thus relevant to include religious leaders in the fight against FGM, because they often function as norm authorities.

Medical professionals also are important community caretakers in terms of health risk problems. Their involvement in abandonment projects is worth. Nafissatou J.Diop and Ian Askew (2006) recognized that trainings of health professionals about the risks of FGM and their need for immediate involvement in campaigns for abandonment have failed to improve the knowledge and beliefs of FGM significantly, particularly regarding the complications of FGM. Even their constant involvements in carrying out the procedures have become increasingly frustrating. Hence, constant sensitization of medics and introducing a medical curricular about FGM trainings is advisable. Once medics have changed their conformity attitudes, they will help their patients as well to change attitudes, through counseling sessions or outreach education projects (see Kenyan recorded interviews with Dr. Jaldesa).

Community leaders and elders (Muteshi J, Sass J 2005), who are the gatekeepers of social norms can influence change. Once their attitudes are changed, their influence to the rest of the community towards abandoning the practice will be dramatic.

Similarly, educating traditional circumcisers is of influence. This is because circumcisers produce and train generations of circumcisers who enforce this long-standing tradition. If their activities are checked upon, communities will be equally safe from the procedure. While traditional circumcisers are engaged towards FGM abandonment, also equal efforts should be given to the community as a whole, especially the decision makers in the FGM status of the girls. This will help cut back on both the demand and supply side.

Again, more emphasis needs to be put on education staff, to transmit abandonment messages further to their pupils or students. Education staffs are capable of influencing parents (through parents-teachers meetings) to value the education of children, and also integrate FGM studies in school curricular (see interviews with World vision-Kenya).

Meanwhile, legislators ought to be trained about how to handle FGM perpetuation cases brought up. This should go hand in hand with implementing government policies against FGM and making follow ups, so that perpetuators serve the punishments that they deserve. Legislators should further indulge in sensitizing and training local communities about government laws and policies, in that communities fully grasp the dangers of being caught in 'red-lines'. In population council recordings in Egypt, police has been noted for failing to

cooperate on making follow-ups on reported FGM cases, because their families are also practicing it (see population council recordings).

Further still, politicians and government officials ought to be practically engaged in abandonment campaigns. Politicians have used their power and vote seeking, to encourage FGM practices. For example in Egypt in the governorate of Menya, government made 'FGM-sales' when it put female circumcision at 7 Egyptian pounds, and male circumcision at 10 pounds (see population council recordings). Under the auspices of protecting social norms and cultural institutions, politicians have used cultural practices to raise their votes (see KHRC, World Vision, Lethome Ibrahim, MGCSD recorded interviews in Kenya). The same group of people also highly contributes towards determining the security of environment within which FGM campaigns take place by either making it conducive (Ghana and Kenya), or hostile (Egypt).

Youths and children, being the future generations and the same time the victims of the practice (females subjected to FGM and males demanding circumcised women for marriage) should be highly targeted for sustainable behavior changes.

Besides, men should be reached extensively to address FGM issues, because FGM is not just a 'woman affair' as most men see it. History shows male passive resistance in eradication campaigns in Kenya, Sudan, and Egypt. Men taking the leading position resisted early eradication campaigns (Ahlberg B.M 1991; E, and Elsworthy. S 1994; Lane, S.D & Rubinstein, R.A 1996; Natsoulas, T 1998). In the 17th century for instance, the catholic priests in Egypt banned FGM. Egyptian male converts as a result, declined to marry uncut women, which forced the College of Cardinals in Rome to change its decision (Lane, S.D & Rubinstein, R.A 1996). Similarly, the male dominated nationalist movement in Kenya used the colonial ban on FGM to mobilize people to resist colonial rule, also forcing missionaries to compromise (Murray J. M. 1974; Ahlberg B.M 1991). The reality in which FGM takes place must therefore be understood. To focus on women as victims and perpetuators is to miss the complex and socially constructed meanings, power relationships and social norms that define a normal or proper woman.

Other groups such as Women/women organizations ought to be induced in abandonment campaigns - as they are the major decision makers in the FGM status of their children (being the mothers). Once the message is put across them, information dissemination through women groups that are willing to abandon, and across families can be highly relied upon for change.

Likewise, the aged, disabled, blind, and dumb are vital for inclusion as well. These categories of people are usually forgotten. Even the materials used (during abandonment programs) to help them cope up with their various situations is usually insufficient or unplanned for. Whereas these groups could be influential especially when the positive deviance approach towards eliminating FGM is used, various means should be devised to engage them in abandonment activities.

Last but not least, journalists should also be indulged in projects aimed at intervention, because at the end, they play a big role in creating, and shaping society through media.

5 FACTORS CONTRIBUTING TOWARDS FGM PERSISTANCE

Despite of the wonderful efforts NGOs have displayed against FGM, some discouraging findings have accompanied characteristics messages of good hope. Various other factors contribute to FGM persistence as discussed below.

5.1 Cultural elements

Constraints imposed by culture in a bid to eliminate FGM and transform society are enormous and embroil. The continued influence of traditional institutions and values, which exist side by side with modern institutions and the norms they represent make any approach to development that side steps the issue of culture a nonstarter. Chieftaincy institutions that defend cultures and social norms are more influential especially in rural areas. These rival with modern political institutions that may foster conventional human rights. In Uganda for instance, when government considered outlawing FGM among the Sabin ethnic, the male elders passed a law requiring all women to undergo circumcision (Eliah E. 1999). While the traditional institutions of chieftaincy aim at strengthening cultural values (such as FGM), modern ones (through which transformations would occur) are often at critics for trying to destroy cultures and traditional social norms.

Marriage retains much of its cultural importance (John. S, Mbiti 1969, 1989, 1997, 1999). Parents express worry when their children especially daughters remain unmarried when they are expected to. According to field observations, the great concern about marriage is an attitude found among both the formally educated and the uneducated. Even today, most women find fulfillment in marriage and childbirth. As long as FGM remains an important pre-requisite of finding a husband in prevalent communities, women will still trade their bodies for circumcision in order to be eligible for both marriage and childbirth.

Beliefs associated with the practice hamper its elimination. For example, a former circumciser in Ivory Coast expressed concerns about banning FGM and stated that; *"the mystical and spiritual elements associated with circumcision ceremonies, such as masks and masquerades accompanying the practice, represent spirits that are believed to protect both the practitioner and the circumcised girl. Banning the practice may therefore generate a kind of spiritual vulnerability"* (Rogaia Mustafa Abusharaf 2006:9). Strong believers in both myths and spirits may not easily come to terms with FGM abandonment messages - once the belief system is not dealt with and hence the persistence of FGM.

5.2 Imperialistic underpinnings and language use

"The resistance from Africans is not necessarily against the termination of the practice; rather it is against the strategies and methods (particularly their imperialistic underpinnings) used to bring about the desirable goal..." that dehumanizes African women (Obioma Nnaemeka 2001).

Korier (2005) as quoted by Rebekka Rust (2007:23) indicates that *"in their fight to 'eradicate' female circumcision, Western feminists and development agencies have over sensationalized the issue by making it seem as if they are dealing with a plague instead of peoples, societies, cultures, and values"*. Within the public intellectuals, FGM has portrayed family and social life in Africa as dark, brutal, primitive, and barbaric. Most politician and feminist theorists have argued that the practice deserves a place on the list of the absolute evils along with human sacrifice, holocaust, etc. In effect, *"African women are doubly victimized: first from within (their culture) and second from without (their 'saviors')"* (Obioma Nnaemeka p.174), which has partly accounted for the practice's persistence out of defiance, even though outlawed. Toubia (1995) warns that *"both the message and the facts about FGM will be lost if advocates use the language of superiority—the language of the colonizer or slave holder"*. The language (See also Abusharaf 2006; Rust Rebekka 2007) used has undermined the objective aim of abandonment strategies (Shweder Richard, A. et al 2002:16), hence calling for normative judgment with particular care once dealing with members of non-conforming cultures (Sager G, Lawrence 2002:170). Winning the hearts and minds of people is relevant - about the ways and manners of communicating with the various tribes involved. Choice of words and critical reflection on own cultures therefore becomes a crucial asset in addressing FGM issues.

5.3 The role of media and the politics of poverty

Obioma Nnaemeka (2001) states that the role money plays in the politics of poverty, in the campaigns and interventions require extensive research. She (p.176) states, *"In the so called Third World, poverty makes people more vulnerable and exploitable."* She bases her argument on the fact that some western media organizations have offered money to circumcisers to have girls circumcised, as they film and picture the proceedings for their magazines, books and documentaries – instead of rescuing and protecting the girls. Nnaemeka criticizes a book; *"The day kadi lost Part of her Life- by Rioja and Manresa 1998"* that depicts African women in an undignified ways (p.174). She also mentions about a New York

Crew, for whom arrangements had been made to film the circumcision process, having paid off the circumciser to do that (pp. 175,176). Arguments are that these shots are eventually used to raise money from sponsors in the West in 'disguise' of helping African women and children achieve their human rights and dignity. Despite the show, grants collected usually eventually "swell private accounts". Nnaemeka writes about a Germany based NGO - INTACT that used billboard announcements in 1999 for its campaigns against FGM *"with pictures of an object: an old, rusty, crooked, bloodstained knife; a long thread needle; a rusty, bloodstained pair of scissors; and a rusty, bloodstained razor."* This move as interpreted by Nnaemeka; was for purposes of making the NGO known and to stimulate donation, achieved by manipulations of African social-economic situations. The author warns that the aggressive use of the practice for various ambitions (through media representation) has undermined African women respect and also abandonment possibilities.

5.4 Persuasion methods

On the other hand persuasion methods like laws have further led to FGM persistence and reluctance in law enforcement and abiding especially in Africa. According to E.H. Boyle; in 1994 when Egypt was forced to take a position on FGM after CNN broadcast of a circumcision of a 10 year old in Cairo, one of the most prominent Islamic clerics in the country Sheikh Gad el-Haqq issued a religious decree. This decree recommended local clerics to encourage families to circumcise their daughters just as they encouraged individuals to pray (Elizabeth Heger Boyle 2002, pp 3-6). The recommendation from the Islamic cleric was electrified, because of foreign pressure on Egypt towards enforcing FGM laws that led to arrests of the circumciser in question. The cleric's message was a kind of public protest against persuasion methods used against indigenous cultures.

Marie Héléne et.al (2011:10) notes, *"It is not so much the relevance of the legal prohibition of the practice that should be questioned, but the manner in which it is decided, from the 'top' with emphasis on the criminal sanction that is difficult to enforce, and is easily avoided by 'traditionalists'..."* When forming or drawing FGM laws and policies, most times grass root communities are alienated from active participation. Yet, local communities are expected to abide by laws that they do not take part in forming. Such processes express political principles that are not very participatory (Marie-Héléne, Mottin Sylla and Joélle Palmieri 2011:17). As a result, FGM practices continue in unsafe conditions, which prevent parents from seeking medical help when complications occur (Olekina 2005b).

Reluctance towards FGM-law enforcement was also evidenced in a 2008 case in Ghana. A father took his 13-year-old daughter in a neighboring community for circumcision, under the pretense of attending a grandfather's funeral. The case was followed and eventually GAWW helped tracking down the father – but no government intervention took place. Experience has shown that passing legislation against FGM is most successful when educational campaigns that include discussion of the role of law have informed the development of the law and accompanied its implementation. More so, a participatory legal process paves way to easier implementation since parties are likely to feel more obliged to act according to the laws.

Besides, threats of cutting foreign aid, as a persuasion measure towards FGM abandonment, has achieved little success. As seen from Boyle, *"Under Senator Reid's bill, cosponsored by senator Patricia Schroeder (Democrat Colorado), states in countries where FGC occurred would have to develop policies to eliminate the practice or face reductions in foreign aid from International Monetary Fund and the World Bank"* (Elizabeth Heger Boyle 2002:5). As part of persuasion method of FGM abandonment, donors' conditions of the kind often spark resistances at local levels. String - attachment to aid donations demonstrates partly that aid given to developing countries serve the interests of donor countries (Peter J. Schraeder 1998; Nicholas Eberstadt 1988; Lloyd D. Black 1968) as developmental needs remain acute.

Highlighting Kenya's colonial example and resistances against pressure to eliminate FGM, FGM is one of the factors that led to Kenya's independence. Kenya's history thus shows that western influence in African cultures has long been resisted (Jomo Kenyatta 1962). Ahlberg et al. (2003:35) argue that the persistence of FGM rituals is actually more a reflection of resistance to *"preventative approaches used since the early Christian missionary campaigns"* than anything else. Absharaf (2001:115) has also noted that FGM practices have become a focus of African resistance to foreign encroachment and interference (See also Abusharaf R.M, 2006; (et.al) 2007). Many Africans have clung on such unhealthy practices for sources of identity, repelling imperialism and intrusion (Hope Lewis (1995:1, 31). Nahid Toubia expresses, *"The fear of losing the psychological, moral, and material benefits of 'belonging' is one of the greatest motivations to conformity. Africans who love and cherish the positive aspects of their cultures and have been wounded by colonialism, fear that the action against FGM will be used as another excuse to invade and humiliate them"* (Nahid Toubia 1995:232).

No wonder in some instances; in order to impress donor countries, evaluation reports have constantly shown a decrease in the practice and success of intervention models – even though at local levels, different communities have reacted differently (e.g. hostile and resentful)

towards FGM abandonment messages – especially those that employ persuasion intervention methodologies. Negative reactions from communities and unsuccessful intervention models are seldom documented. Besides, no further steps are taken to find out why some models are successful in some communities and others not. Consequently FGM practices performed underground are rarely documented and researched upon, yet such characteristics show community reactions against interventions that persuade abandonment.

Very few studies have taken trouble to document FGM denials and causes for denials. For instance, the one in Northern Ghana (Patricia Akwaengo 2004; Charlotte Feldman-Jacobs and Sarah Ryniak 2006; Elizabeth F. Jackson, Patricia Akweongo, et al 2003). As long as most studies depend on self-reporting to evaluate intervention models, there is a needed degree of cautious about certain developments in behavioral changes. Challenges of self-reporting can be covered by clinical based studies due to their clarity and dependability. However, very few studies apply clinical based methods. Successful examples here are studies taken in Mali, Burkina Faso (Jones H, Diop N, Askew I, Kabore I 1999) and Gambia (Linda Morison, Caroline Sheri, et.al 2001), which practically examined the status of women vagina instead of relying on self-reports to prove whether FGM is decreasing or not. Even though clinical based studies suffer limitations,[14] they are the most reliable of all studies.

There is therefore a high possibility that reported FGM declines at local levels are not genuine. To some extent, declines reported upon intend to escape criminalization, entice foreign donations and aim at attracting community help through incentives offered when FGM projects are implemented. Depending on the issue at hand and the context, foreign policies have to be sensitive in the way they are applied especially at local levels.

Top- down methods of FGM abandonment bares less fruits. Opportunity must be given to the locals to solve problems that affect their own lives, through empowerment projects. When addressing FGM, considerations ought to be given to the social dynamics and context under which FGM takes place. Implementing FGM abandonment methods helps communities get informed and empowered. The decision to either end or continue practicing FGM lies completely in the hands of communities at question. Therefore comprehensive community based models of intervention, given the social dynamics of the practice, are highly

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[14] (e.g. (a) they are very few in number, b) their scope of intervention/reporting is limited given the vastness of geographical areas or communities, c)such studies are resource demanding (very expensive); e) require much time to evaluate behavioral changes because they encompass individual clinical reviews).

recommendable. Mackie Gerry's (1999) model of the social convention theory of abandonment is practical in this case (See also Gerry Mackie and John LeJeune 2009).

5.5 Social-economic powerlessness of women

FGM has also proven persistent because the practice is part of persistent global problems (also evidenced in the West) in which women remain powerless because they lack access to resources, jobs, and education (Barbara Bagihole 2000; 1993). Like foot binding in China (C.Fred Blake 1994), sex tourism and children prostitution in Thailand (Brian M Willis, Barry.S Levy 2002; R.Bishop 1998), women dressing, veiling, and other customs in the Middle East (Judith E.Tucker 1983), etc. FGM also indicates the social-economic powerlessness of females in especially African communities. Social inequalities of such kinds are historical problem evidenced even in the slave trade- and colonial eras amongst subjects where by Women's lives especially were regulated (Mimi Abramovitz 1996; Stanlie M. James & Abena, P. A.Busia 1993; Molara Ogundipe Leslie 1993).

According to the colonial family ethics, women were left out on education and formal employment as their roles were particularly domesticated (Mimi Abramovitz 1996). Men on the other hand, were promoted in various ways and their influence in society politics became more and more established. Unequal power relations of that kind generated dependency of women on males for social and economic survival, as their roles were increasingly subordinated. Women in different geographical locations have coped up with such problems in different ways, in which adhering to practices such as FGM for women survival is one of them. Poor socio-economic conditions of women make it difficult for many women to appreciate most of the human rights provisions that protect them, because such provisions do not match with women realities at local levels.

Many governments have also failed to address the gender gap through their policies because of poor budgeting, corruption, and resource misallocations. FGM persistence is thus highly a product of poor social-economic-political living conditions that people, mostly women and children suffer. As long as women empowerment in those areas is not maximally addressed, there are still risks of resistance to change behaviors and sustainability.

5.6 Education

Many women worldwide are less competitive in the formal education and employment sector. In Africa in particular, parental attitudes and the traditional undervaluation of girls have

continued to act as hindrances to girl education. The most affected FGM region of the Northern Ghana was for instance denied the education opportunity right from the colonial era. *"Schools were more concentrated in the southern industrial Ghana, leaving Northern Ghana virtually untouched"* (Eyango Mahadevan Vijitha 2001: 107). I argue that lack of education is the main cause of ignorance and the main root cause of resisting changes that could affect positively one's own life through critical decision-making. Ignorance only acts as a blockade to critical thinking. Education thus, is the most important tool to individual empowerment. However, its denial in preference to early marriages, children indulgence in economic 'labor' and help in domestic work, has contributed to the vicious cycle of perpetuating FGM (for marriage-ability) and the prolonged poor social-economic conditions (i.e. poverty leading to women subordinations, gender violence, and looking at marriage as the opportunity to escape poverty).

As Birgit Brock-Utne (2000:5) explains; education programs for girls and women designed by 'the Jomtien conference on education for all by the year 2000', was aimed to eliminate the social and cultural barriers that discouraged or excluded women and girls from benefiting from education opportunities and promote equal opportunities in all aspects of their lives. The Jomtien conference that took place in Thailand on the 5-9 march 1990 sponsored by World bank, UNICEF, UNESCO, and UNDP, aimed at solving falling completion rates, falling enrollments, and poor learning outcomes within primary education in developing countries, targeted to be reached by 2000 (Birgit Brock-Utne 2000). Results of the conference among others included gender equity in education sector, as proposals in changing Draft C of the World Declaration of Education for All (WDEFA) and the framework for action.

Although education is currently accessible in Africa due to several educational reforms that have taken place in recent years (World Bank 2009; UNESCO 2008; Birgit Brock-Utne 2000), it remains unequally distributed across region, class, gender, or race. In Ghana, education reform reinforced by President JJ Rawlings and institutionalized in 1987, offered fresh and promising approach to education (World Vision 2009; Eyango Mahadevan Vijitha 2001; Ghana Statistical Services 1992; UNESCO 1998b).[15] However, unequal representation of females in Ghanaian education continues at all levels of formal schooling across all age groups. Primary enrollment ratios for girls are 70% while for boys is 83%, secondary

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[15] Reforms included a reduction in number of years spent in school, broadening of the curriculum, 'Ghanaianizing' education to meet the local demand and national needs

enrollment is 29% to 45%, tertiary enrollment is 0.6% to 2.2%, and polytechnic levels 23% to 77% respectively (Eyango Mahadevan Vijitha 2001).

Likewise Kenya's early childhood enrollment education despite rapid growth (World Bank 2009:5) in arid and semiarid areas and slums has remained low. About 2.8 million children (68 percent) are not accessing early childhood education, and many of these children are girls (Ministry of Education 2007; CREAW-Kenya.org). In January 2003, the government introduced free primary education and participation in primary education has since achieved near gender parity (World Bank 2009). Nevertheless, in certain regions, gender disparities that favor boys still exist. According to the ministry of education-Kenya, in 2006, out of the national average of 86.5%, only 20.8 percent of children in the Northeastern province of Kenya (where infibulations at lower ages are almost universally practiced) had been enrolled in school. From the enrolled percentage, 24.3% were boys and 16.5% girls (Ministry of Education 2007). According to the millennium, development-goals status report (2007) of Kenya, university attendance of women was rated very low (Republic of Kenya 2008). Further gender disparities have also been observed in Egypt's education system (Ronald G. Sultan (2005).

These gender gaps in education levels reflect the cumulative effect of factors (FGM inclusive) hindering the progression of girls and women in education from the time of entry (at the preprimary level), way through institutional levels. NGO Strategies should therefore seek to rectify this imbalance by pushing for reform strategies right from family level to national level - to encourage girl participation in Education. Strategies should run from theorization—to initiation of action—to implementation. To address this issue, we have to move from the issue of education access, and address the quality and relevance of the educational program itself especially in Africa. The lack of relevance of education for viable employment opportunities, coupled with the existence of a thriving informal sector, in addition to the social-economic problems faced by families like poverty, lures girls out of school thus opting for marriage as a means of socio-economic survival. Since FGM is a marriage requirement, girls see no problem of undertaking the risk, having weighed the benefits thereafter.

Van der Kwaak (1992) explains the development and modernization theory in terms of FGM and notes that as societies experience dramatic social change in the process of development, traditional values will erode and adherence to the practice of FGM will decline. Equal opportunities and improvements in education schemes and availability of employment opportunities, health care, etc. gauge the level of development in a given society. These

factors should therefore be explicitly addressed and gender inequality gaps bridged, in order to promote women development and encourage social change and sustainability. If such problems are not given the particular attention that they deserve, families that embrace change (especially women); stand risks of coping with real life challenges.

FGM is a pre requisite for marriage, of which marriage and children are vital aspects of women's role and economic survival. Therefore, as development needs remain acute especially at local levels, there is a force of resistance and reluctance towards abandonment of FGM amongst practicing communities. This is so because of limited alternatives of achieving social and economic life securities.

Chapter 6 explores methodology of the study: A comparison of FGM practices and abandonment strategies in Kenya, Ghana and Egypt. Chapters 7-9 deal with single-country discussions including empirical findings. Chapter 10 compares the three countries basing on field results. Chapter 11 offers discussions and conclusions.

6 METHODOLOGY

The purpose of this study is to explore perceptions of participants about a) FGM practices, b) strategies addressing abandonment, c) find out the gaps that limit change in behaviors and sustainability in abandonment attitudes and d) using findings/results to address identified loopholes or challenges. Field study took place in Kenya (May - July 2011), Ghana (March - April 2012) and Egypt (March to May 2013).

A both quantitative and qualitative questionnaire was mainly used to gather data from participants across the three countries. This was supplemented by interviews and group discussions that took place in participants homes, workplaces, public space, schools, hospitals, among other places. Because the questionnaire was in English and not prior translated to fit community local language reality, interpreters were used for one on one questionnaire clarifications and interpretations. In such instances; my role as a researcher was to carefully fill in the questionnaires on behalf of the respondent/participant upon interpretations. Although it was time consuming and resource restraining; this method accommodated all types of participants (including illiterates), leading to qualitative information gathering.

Methodology as defined by Iryn and Rose (2005) constitute a systematic and theoretical analysis of methods used in a particular study. It involves the choice made by a researcher on how to study a particular topic, which may include ways of gathering data and the methods used to analyze data in research (Silverman 2005). Several methods exist such as exploring attitudes, behaviors and experiences of a studied group (Miller and Crabtree 1992), which this study fully explored through questionnaires, observations, interviews and narratives as both quantitative and qualitative methodologies.

Although interviews and narratives are critiqued for being expensive, time consuming, unable to discern data validity and reliability, being subjective and a form of exploitation (Seidman 2006, Patai 1988; Katherine Miller 2001) – these methods nevertheless provide space of

respondents to share their feelings. This equips the researcher to better understand the world of others. Interviews and narratives also enable the deconstruction of the realities that are often otherwise taken for granted (Schultz 1967, Rubin and Rubin 1995, Seidman 2006, Gonza Lez 2009).

This chapter addresses research designs/research instruments of data collection, scope of study, researcher's role, data collection procedures, personal limitations and solutions, and eventually a summary of the methodology.

6.1 Combining Qualitative and Quantitative Research Methods

The research undertook exploratory and descriptive case study research design, employing both qualitative and quantitative research methods of data collection and analysis. Both methods were combined, in order to overcome shortcomings of mono-methods. As Anthony J. Onwuegbuzie & Nancy L. Leech (2005) point out, mono-method research is the biggest threat to the advancement of social sciences and thus advocate for the combination of both methods for pragmatic research, so as findings can be taken seriously. A combination of both methodologies produces reliable data. Golafshani (2003) defines reliability as the degree of consistence with which results of a study can be reproduced again using the same methodology.

A debate upon quantitative and qualitative research is based upon the differences in the assumption of reality, and whether reality is measurable or not, and how we can better understand what we know (through objective or subjective methods). Shaker (1990) however represents these arguments as a metaphorical journey moving from quantitative ideologies in the past, to more recent naturalistic qualitative perspectives (Isadore Newman, Carolyn R.Benz 1998). Both paradigms co-exist in the world of inquiry and together, they form an interactive continuum (Isadore Newman, Carolyn R.Benz 1998). Modern day scientific method is inductive and deductive, subjective, as well as objective. Validity is thus more likely to be built in studies, when researchers are open to the dichotomy, rather than precluding one over the other (Isadore Newman, Carolyn R.Benz 1998).

6.2 Qualitative Research Methods

Qualitative methods were compatible to the research problem, thus chosen. In order to gain insight, explore the depth and complexity inherent of FGM – this interactive and subjective research approach was included because of its unique element. The method involves shared

interpretations, individual interpretations, communication and observations, word analysis, theory development, etc. Applied survey research therefore meant to acquire first hand in-depth knowledge, detailed analysis and contextual issues that encompass the subject. As Elliot Eisner (2008) states; the many fusions of art and qualitative inquiry are changing the face of social science research, opening possibilities for alternative perspectives, modes, media and genres - through which to understand and represent human condition.

Instruments used to collect data included questionnaires (involving both restricted-'yes or no' and unrestricted form), group discussions, interview guides (structured and unstructured) and observations. These methods allowed investigating the problems in its realistic setting, rather than in a screening room under artificial conditions (Katherine Miller 2001). The selection of these tools was guided by the nature of data to be collected, the time available, as well as the objectives of the study. Qualitative narrative data was for instance collected from review of relevant responses from individual participants and group observations. Meanwhile, interviews were commonly done with institutions pertaining FGM projects. Participants were also recruited at FGM sensitization forums and FGM abandonment ceremonies – upon identifying their capability and relevance of information given during open discussions.

Interview: Face to face interviews and phone interviews (structured and unstructured) were used as basic instruments of data collection. Despite the fact, that people's experience can be understood by examining personal and institutional documents, interviewing goes a step further by facilitating the understanding of the meaning people make of their experience (Seidman 2006). Interviews thus explore, discover, understand, reveal and act on social problems (Rubin and Rubin 1995). Because events and objects are understood and interpreted differently by different people, this instrument accommodates the diversity of realities in the social world (Rubin and Rubin 1995).

Interviews also attempt to obtain reliable and valid measures in form of verbal responses, while watching expressions, mimics, and behaviors of the participant (Fowler, F.J. and Mangione, T.W 1990). This mode of data collection allows question clarifications, can apply to both children and illiterates, it reduces anxiety, so that potentially threatening topics can be studied. It is a means of obtaining personal information, attitudes, perception and belief (Perry, Alison Rosalind 2009; See also Jessica Clark Newman, et al 2002), which develops an empathetic understanding of the world of the others (Geertz 1986).

Contrasted from face to face interviews, telephone interviews that this study also undertook - are cost efficient and logistically simpler - especially if the participant resides in a geographically distant location (Wells K.B, Burnam M.A, Leake B, Robins L.N 1988). Telephone interviews are also advantageous if an individual is personally unavailable for a face-to-face interview, feels threatened by the presence of the interviewee or perhaps shy – despite relevance of information he/she may wish to share. Telephone interviews may therefore offer solutions to limitations met during face to face interviews. Besides, general limitations met in questionnaire (e.g. closed ended, language barrier, expressions) may be overcome by use of interviews. Therefore use of both methods offers complementary roles to each other.

Disadvantage of the instruments is that unstructured interviews yield data too difficult to summarize and evaluate, data is incomparable and cannot be generalized. While structured interviews, yield uniform data that introduces rigidity into the investigative procedures. Generally, interviewing suffers the inability to discern the validity and reliability of the data gathered. For example, it is hard to know if the participant is telling the truth or not, and suffers difficulties in generalizing the results (see Seidman 2006:23). Given the instrument's inherent efforts of finding solutions to people's problems, interviewing is critiqued as blurring with advocacy (Thomas 1993) and faces challenges of separating the researcher and the researcher roles (Adler et.al 1986). It is also seen as expensive, time consuming, subjective and a form of exploitation (Seidman 2006, Katherine Miller 2001).

Focus Group Discussions (FGDs): Group discussions are particularly an interactive instrument that tends to explore peoples knowledge and experience (Bruce L.Berg 2004), in order to generate ideas about what and how people think, and why they think the way they do. It encourages participation from people who are reluctant to be individually interviewed, or who feel they have nothing to say (Jenny Kitzinger 1995; 1994). FGD facilitates group interactions through asking questions, exchanging anecdotes and commenting on each other's experiences or points of view (Bruce L.Berg 2004). Focus groups provide an opportunity to encourage triangulation in research by approaching the problem through multiple methods (David L.Morgan, Margaret T.Spanish 1984). Nigel King (2004) refers to triangulation as the processes through which interview findings are compared with findings obtained through other methods such as documentary analysis or quantitative survey data. Many studies triangulate these techniques to gain a more complete and complex explanation of phenomena (Katherine Miller 2001).

Multi-site FGDs were carried out in Kenya and Ghana in order to capture in-depth views, opinions and perceptions, which may not have been fully explored by questionnaires. Such discussions in Egypt were too difficult to achieve, due to community hostility and the diffusion of politics in such sensitive issues (see Interviews by population council).

FGM sensitization forums and FGM abandonment declaration ceremonies: Perspectives from anti-FGM forums in Kenya, also address the study. Various views, from different actors (government, NGOs, CBOs, FBOs, community elders, circumcisers, youth groups, etc.), inform the study. Closely working with the Ministry of Gender, children and Social Development, enabled my participation in two FGM abandonment ceremonies in Marigat and West Pokot. World Vision Namanga Branch also facilitated my presence at a number of FGM sensitization forums organized in Namanga, Mailwa, and Ibisil. These forums and ceremonies were very informative and enhanced in depth discussions about FGM from people of all lifestyles.

Document analysis: This involves using pre-existing data for a purpose different from that for which they were originally collected (Piet Daas, Judith Arends-Tóth 2012). Document analysis involves three different secondary research strategies. These include; content analysis, secondary analysis and systematic review (Piet Daas, Judith Arends-Tóth 2012; 't Hart et al. 2005). Content analysis sources in my study included reviews of scholarly materials such as books, journals, position papers, credible scholarly websites, Newspapers, and reports by local, national and international agencies. Secondary analysis involves using previously collected quantitative data like DHS and MICs sources, WHO and UNICEF statistical studies, among others. Systematic reviews combining and investigating the output of other researches with similar phenomenon (previously researched topics on FGM), have been employed to fulfill the study aims. The technique has multidisciplinary appeal, with extremely diverse academic fields drawing on the information included in secondary sources (Daas and Beukenhorst 2008). All methods used under this category belong to the academic discipline of secondary research (Golden 1976).

6.3 Quantitative Research Methods

The goal of an experiment study is to maximize the ability of the researcher to draw conclusions about the casual relationship between the independent variable and dependent variable (Katherine Miller 2001). Data gathered from experimental study are typically analyzed with statistical techniques that allow the comparison of groups on the dependent

variables of interest (Katherine Miller 2001). For survey and interview techniques, individual perceptions have important theoretical and pragmatic implications. Self-reports of research participants are used to measure attitudes or relationships to measure predisposition of particular behaviors. Structured measurements have been applied for the quantitative analysis. Phillips (1990) states that socially constructed realities of actors can be objectively investigated, by the use of appropriate quantitative research methods (Katherine Miller 2001:142). From a phenomenological perspective, multiple realities exist and multiple interpretations are available from different individuals that are all equally valid (Gouglas 1976, Geertz 1973).

Quantitative positions assume a common objective reality across individuals. Some basic methods that the study used involve correlation and regression techniques – aimed at exploring the different relationships concerning the practice, attitude, and opinion. This objective method used in the study aims at testing relationships, besides examining cause and effect relations. Univariate, bivariate, multivariate and cross tabulations are examples of analytical ways used to unleash the study analysis and findings. Advantages are; it is easy to extend the findings of this research to wider populations with the same degree and allows the easy determination of the statistical significance of the data collected. The following steps inform the quantitative analytical procedures of field results

Questionnaires: A pre-coded structured self-administered questionnaire was used to collect quantitative data. This enabled access to representative populations in Kenya, Ghana and Egypt. Research was mainly concerned with demographic data of respondents, practices surrounding FGM, FGM abandonment strategies, area prevalence, progresses and challenges. The target population was a mixture of illiterate and literates, employed and unemployed, women and men, of all lifestyle based especially in areas where FGM is common. The education variable did not at last, directly inform the study in Kenya and Ghana, with exception of Egypt – since many people felt confronted about being asked their education backgrounds – hence thought it was an exclusion tool.

Several participants (especially those with English language barrier) in the pre-tests interviews often reacted *"what does my education status have to do with the study? Are you interested in my education, or do you want information concerning your topic?"* Others just remained silence about the question, while very few answered it directly. Because this attitude was persistent, yet the load of work ahead of me was realistically a lot, I was forced to ignore the question. This decision was taken in order to save time, avoid offending participants and

to generate progresses. However, during the course of interviewing, eventually some participants indirectly confirmed education variable.

For analytical purposes in the following quantitative analyses of Kenya and Ghana (with exception of Egypt), the education variable has been simply left out for systematic results and to avoid insignificant percentages. However, the occupation variable (either informal or formal, with space to indicate particular profession) could as well determine or help interpret education levels of participants, though not as systematic as when directly captured.

Questionnaires were made up of sections consisting of socio-demographic data, FGM practices, prevalence levels, FGM strategies, and challenges and progress. The questionnaire was both open- and closed ended. Open-ended questions are unstructured questions in which the respondent answers by using his or her own words (Seidman 1998). The practice was measured with statements that elicited "yes" or "no" responses, while objective practices were listed and participants chose the responses relevant to them. Some few questions required open statements. This was done in order to capture views of participants that had not been mentioned in the close-ended questions, yet could be relevant for the study.

To explore the strategy, statements describing institutional involvements/their activities against FGM and methods used towards abandonment in target communities were used. The prevalence of FGM was self-reported, using percentages of women that had undergone FGM on one side, and statements that sought to know if the practice was still highly observed in communities. The strength of questionnaire lies in the fact that due to the uniformity of questions, yielded data is more easily comparable, than data obtained through interviews (Michael Wilson, Roger Sapsford). Disadvantages include difficulties in accessing respondent's motivation, which affects the validity of the response - leading to biased samples. Also, misinterpretation of some questions may as well bias some of the results - yet it is not possible to vary independent variables, as it is the case in laboratory experiments (Dominick R. Joseph, 1999). However, watching on the length of the questionnaire and breaking down the complexity of questions, thereby caring about the quality and design of the questionnaire can minimize disadvantages.

Data entry and coding: For qualitative data, a detailed literal description of data that identified themes of answering the research questions was presented. These themes were organized into categories that summarized the data and revealed the content of the study. On the other hand, quantitative data from the study areas was manually entered into a well-

designed Microsoft excel sheet using double entry validity. A database adapted from the excel sheet was created according to the way the pre-coded questionnaire appeared on hard copy. Codes that were assigned to each response to the question and the corresponding number were used to develop a coding sheet. The coding sheet was then referred to at a later stage when feeding data in the database. As K.Miller identifies, working with behavior coding and archive is distinguished by its attempt to view the interactions in an objective and reliable manner and by its search for systematic explanations of phenomena. Two routes of developing coding systems can be used which include, a) the application of rules of formal logic, or b) the development of categories based on theoretical concerns (Katherine Miller 2001).

Through reviews of relevant coded responses from questionnaires, the research was able to quantify FGM practices, FGM prevalence levels, strategy reviews of abandonment and progress achieved towards abandonment.

Practices were subcategorized into a) participants' experiences, b) the extent at which FGM is performed, c) type of FGM practiced, d) period when circumcision takes place, e) age of FGM, f) justifications of performance, g) the main decision maker/actor in the process of FGM, h) place where FGM is carried out, i) implications of FGM. The prevalent rates of FGM were self-reported in addition to observing how wide the practice was being done.

Strategies were subcategorized into a) the existence of FGM organizations/institutions in communities spreading awareness messages and applying other strategies towards eliminating FGM, b) organization categories (whether NGOs or government bodies), c) examples of such bodies, d) the methods such bodies use to eliminate FGM, e) challenges met, and f) commenting on individuals or groups supporting the practice.

Progress was analyzed using a) individual attitudes towards FGM (maintenance or abandonment), c) opinions towards circumcising daughters in future and d) by gauging the general rate of progress (good, fair or poor).

Data analysis: Using the clean data files produced from the database, final analysis of data was done using STATA software. The quantitative data collected was analyzed through descriptive and inferential techniques. Thereafter, the information was represented in tables and figures. This information has been descriptively interpreted and represented in the following chapters (7-10). In this study, both the independent and dependent variables were categorical. Categorical variables were expressed in percentages, absolute numbers and

themes. For comparative analysis, cross tabulation was used to compare the differences between the categorical variables. Qualitative data was analyzed using narrative analysis, where by information from participants' responses was sorted into labeled data. Labeled data was organized into categories. The patterns within and between categories were identified, from which themes were derived. The themes highlighted were used to draw conclusions that shed light on the research questions pertaining attitude and perception towards FGM practices and abandonment strategies.

6.4 Scope of study

Study communities in Egypt included; Fayoum (Salakhana and Gharb Tarawuniyet communities, Beni suef (Bush community), Cairo (Marg Jadida community), and Assuit central. In Ghana, research was undertaken in the upper east region among communities of Sirigu, Kandiga and Manyoro, located in the Kassena- Nankana district. In Kenya field study embraced Nairobi, Namanga, kajiado, maisikisha, Ibisil, Mailwa, Longoswa, Narok, the Illchamus in Marigat, and Garisa. Most of these mentioned communities are rural set up and all of them indulge actively in FGM practices of different kinds.

Study participants included men and women, youths, victims, perpetuators, NGO- and government persons, urban, rural and semi-rural populations of ages 15 years and above. The aim was to make the study as much representative, accommodative and inclusive as possible. Participants who took part in the Kenya studies were 100 in totals, involving mainly the Maasai and to a smaller extent that Somali. In Ghana, 50 respondents came from the Nankana and Kassenes speaking people. In Egypt, 115 people addressed the study. Focus group discussions were four in total, two from Kenya, and another two from Ghana. A questionnaire that targeted organizations' views, were 3 in Ghana, 3 in Egypt, and 10 in Kenya.

In answering the questionnaire, random selection mostly took place in participant's homes, workplaces, public space, schools, and hospitals, etc. Time and resources limited the number of study participants. In Kenya unlike Ghana or Egypt, several organizations were involved in the study, because in the year of field research (2011), FGM abandonment had been exclusively made a priority by the Kenyan government. Therefore targeting organizations with FGM projects, worked like a chain. In other words, a visit paid to one organization systematically led to the other through individual recommendations.

In contrast, the struggle of tracing organizations to participate in the study was real in both Ghana and Egypt. In Egypt for instance, several approached organizations denied having

FGM projects and some were not willing to share the information (e.g. NCCM) – most likely because of the political threats. Ghana on the other hand, seemed to have a limited number of ongoing FGM activities on ground, thereby making it hard to trace organizations with sufficient knowledge.

Information in Kenya was achieved from several organizations. These included UNICEF and UNFPA joint programmes, World vision, Minister of Gender, Children, and Social Development (MGCSD), Ministry of Public Health and Sanitation (MPHS), Kenya Human Rights Commission (KHRC), Kenya National Secretariat for FGM Abandonment, Population Council, Federation of Women Lawyers (FIDA), Maendeleo Ya Wanawake Organization (MWYO), Pokot Outreach Ministries, Council of Imams, Tasaru Girls Rescue Center and individual activists. Contacted schools involved Illchamus primary school in Marigat, Longoswa primary school in Ibisil, Mailwa primary school found in Maisikisha, Namanga Primary School near the Tanzanian boarder and Masaai girls` high school, Ole tipis secondary school, both located in Narok. These schools gave a clear picture of the impact of FGM in schools/ on education. In the health sector, Kenyatta National Hospital and the Ministry of Public Health and Sanitation—(MPHS) were engaged as well. Additionally, authors like Lethome Ibrahim and Sheikh Myriam Abdi and Dr. Jaldesa gave their views concerning FGM practices in Kenya. I must say that the strong networking in Kenya allowed cooperation within various institutions and FGM activists without retaliation.

In Ghana, organizations of contact obtained, Navrongo Health Research Center (NHRC), Ghana Health Service (GHS) and Ghana Association of Women Welfare (GAWW). One primary school in Kandiga and a health center in Sirigu also participated in research. One country known FGM author -Patricia Akwaengo (once a project coordinator at NHRC FGM projects) further took part in the research.

In Egypt, apart from community participation, organizations such as EBESCO Care, National Population Council and CEWLA gave their views about FGM. Involved were also a national hospital and private clinic in Cairo.

6.5 Researcher's role

My role as a researcher involved being an independent interviewer. I personally administered the questionnaires and conducted interviews. I ensured that participants were recruited knowingly, willingly and without coercion. I explained technical terms where necessary, to enable understanding and active participation. Where I faced language challenges, I used an

interpreter (as a third party) to clarify and translate the questions for study participants to fully grasp the subject. This also enabled me to fully understand the discussions or answers given accordingly. In the translation process, I took side notes, once information was given in abundance. This I used later to inform the study.

I also filled in participants' questionnaires on their behalf (where necessary), particularly for the audience that could neither read nor write English. Although this was time consuming, it accommodated a wide range of views, shared by a disadvantaged group, because of their language disabilities. Language barrier was most experienced especially among the Ghanaian communities, which led to less involvement of participants (only 50), compared to those of Kenya (100) or Egypt (115). Participation in Ghana was low because the process of one on one questionnaire interpretation and fill in consumed much time, yet the study was limited to only two months. Meanwhile, a three-month study was undertaken in both Kenya and Egypt.

Although I was a foreigner, working with a sensitive topic, the advantage of being an African researcher amongst African communities (particularly those in Ghana and Kenya) gave me benefits to access the information easier. Study participants built trust in me, because the time I spent in these communities researching, I stayed within and not outside the communities. I ate with them, dressed like them, cracked jokes with them, respected their behaviors and customs, put myself down to their levels, etc. This won me community trust and good relations. In Kenya for instance, I was given a Maasai name - 'Naserian', which means 'blessing' – as a sign of trust. In Egypt, despite of my Christian background, I dressed up like a Muslim woman, which won me sympathy and trust.

Information access was also enabled by choice of interpreters. I chose interpreters from within the community members. These were well known at local levels, some of them were strategically important figures, respected within their own communities. This also made information access easier than expected, as community cooperation was easily won given the trust communities had in interpreters, who accompanied me out on several field trips.

However, not all went smoothly. Egypt gave me some troubles in some areas, because of a) the political threats and instabilities, b) my religion, b) skin color challenges, c) some hostility to the extent of body harm and d) insults. However given the fact that research was a random selection that included door-to-door activities, parts of the communities where violent attitudes were detected, were simply avoided.

6.6 Data collection procedures

For qualitative interviews and FGDs, data collection involved making appointments. This procedure helped to prepare field time schedules. Before the beginning of every interview, there were brief introductions and informal chatting that helped participants to relax before interviews could take course. Likewise, my-self-introduction was vital to those who were randomly selected, to take part in answering the questionnaire. Focus group discussions also generated some times individual participants, who answered the questionnaire.

6.7 Challenges and solutions

Some of the challenges met included vast distances within homesteads, particularly in rural areas, yet there was no any public means of transport available, connecting villages or homesteads. In other words, each individual homestead was dispersed, which sometimes involved long distance walking. Such communities were worth the choice, because of their typical engagements in FGM practices, thereby guarantying firsthand information. Arrangements of private transport means dealt well with the problem, though this was also quite expensive, depending on the number of field trips made, or hours spent within a particular village/community searching for information. Results were however fruitful and worth the pain.

Despite my Ugandan background (home country); I was still criticized within certain communities for having a western background/influence, upon finding out that I study and stay in Germany. My motives seemed then unclear; i.e. if I have been sent to question the very African cultures – I grew up from, hence the suspicious and mistrust attitudes. This was the case particularly in Egypt. Nonetheless with polite explanations of study purposes, good handling/relations and respect of study participants, I eventually overcame this challenge. Good handling in this case entails respecting community persons, treating them as equals and knowledgeable with none judgmental views, while trying to understand their own positions. Meanwhile, the more time I spent within the targeted communities, the more I gained trust from the locals or community members. Also; employing interpreters from within the communities, helped drain out such doubtful thoughts – thus being seen as partly belonging.

In Egypt, some areas posed dangers to female researchers. Not being accompanied by a male person, would easily lead to sexual assaults. In my case, I employed a male interpreter, who was always in my company.

Additionally, having a sensitive topic to deal with made some Participants curious about my FGM status, before they revealed further information. Upon confirmation of my negative status (as cutting is not practiced in my tribal group - Buganda), some participants immediately denied information. In some cases, I was insulted. This was a problem experienced mainly in Egypt, because FGM is universal there, therefore each female expected to undertake FGM. One who does not is an impostor and disrespectful to Islamic traditions. Kenya and Ghana's reactions were not so dramatic because not all ethnic groups practice FGM, hence coming across someone who has not undertaken FGM is usual. However, since the study was a random selection of individuals and homesteads, I did not expect each confronted community member to corporate on the same level. Where information was withheld, I did not waste too much time. I simply moved on to identifying the next informant, which saved time, given the load of work at hand and the vastness of study communities.

The above were the most experienced challenges in data collection, which however, did not hinder in any way the gathering of data. I tried to get a solution for each challenge, thereby paving way to field success, while achieving my study objectives.

In summary, chapter six has discussed the triangulation methodology used in the study. In the coming chapters, studied communities and participants have shared their experiences and thoughts in order to deconstruct the taken for granted realities about them. Country case studies that follow highlight on the country background information, practices and strategies towards abandonment. Quantitative and qualitative data has been analyzed to address the themes of the following chapters.

7   FGM IN KENYA

Kenya is located across the equator in east-central Africa. It borders Somalia to the east, Ethiopia to the north, and Tanzania to the south, Uganda to the west and finally Sudan to the northwest. The country was a British protectorate since 1890 and achieved its independence in 1963 (J.Ainsworth 1900; Peter Rigers 1979; C.H.Ambler 1988), with Mzee Jomo Kenyata as the first president (1964-1978). Since 2013, President Uhuru Kenyatta, the son of Jomo Kenyatta (Tagesschau), governs the county. By 2012, Kenya's population estimates was 43, 18 million (World Bank) with population growth of about 1.5 percent per annum (Republic of Kenya 2012; Government of Kenya 2012). Christians account for 82.5% and Muslims 11.1% (CIA-World Fact Book).

Kenya's cultural environment is diverse. It is composed of sixty-two different languages, though Swahili and English are widely spoken by about 40 different ethnic groups. Some cultural practices associated with population dynamics include low age at marriage, high levels of polygamy, low social status of women, large desired family sizes, widow inheritance and circumcision for both males and females (National Council for Population and Development 2013).

Economically, Kenya is classified as a low-income society - 58.3% of the population make less than 2$ per day and 46% of the population are unable to meet the essential food requirements necessary to live on (World Bank 2013). Nevertheless, the Kenya Demographics profile of 2013 indicates literacy rates for males at 90.6% and females at 84.2% aged 15 years and above. The country has a free primary education and tuition free secondary education since 2003 and 2008 respectively. However, the country suffers from high levels of primary dropout-rates and low transition-rate to secondary and higher levels of education - traced especially amongst females (National Council for Population and Development 2013). Such developments in the education sectors underscore the emerging challenges of FGM – accompanied by early marriages, which could be a possible shortfall for increasing school drop outs amongst other factors.

Most communities that practice FGM in Kenya nearly justify it as puberty rites passage to adulthood (Van Gennep.p, Kegan Paul 1960), when the female is ready for the responsibility of adulthood - signifying the end of her education (Murray-Brown, Jeremy 1973:134) or rather marriage preparations. However, reasons- and age of FGM may differ from community to community. In the Northeastern Kenya for instance, girls as young as four years are

circumcised for cleanliness, purity, chastity and to emphasize virginity before marriage (Population Council 2007). UNICEF groups the country as second, where FGM prevalence is intermediate with only certain ethnic groups practicing FGM at varying rates (UNICEF 2005). Significant regional variations of FGM range from 0.8% in the west to over 97% in the northeast of Kenya (Population council 2007).

Like many other cultures in question, FGM's history in Kenya is uncertain, though believed to be a common practice that dates back beyond anyone's memories. Early history suggests that FGM precedes both Christianity and Islam. It is found among Muslims, Christians, Animists and Judaism so that the distribution of the practice does not follow the distribution patterns of these religions (Olenja M.Joyce 2002:9).

7.1 FGM and resistance against British imperialism

Colonial authorities and missionaries in 1920s and 30s forbade their subjects to practice Clitoridectomy (FIDA 2009). They attempted to stop the practice by promulgating criminal regulations and using religious propaganda (Thomas L 1992 and 1998; Jane Chege 1993). Africans who embraced Christianity at that time had to give up FGM and polygamy in order to be fully endorsed by the new religion (Thomas L 1992). Men especially felt coerced/ attacked by the new religion – which was called the 'white man's religion'. They interpreted it as cultural imperialism over African cultures. As a result, *"Most Africans abandoned the white man's religion and formed their own independent churches, which emphasized the cultural way of life"* (Republic of Kenya 2008:20). Cultural and nationalistic resistances overpowered activities that aimed at eradicating polygamy and FGM (Thomas, L 1998).

In Meru for instance, the 'white men'/colonialists collaborated with the Njuri Ncheke - an officially sanctioned male council of leaders- to ban Clitoridectomy in 1956. However, in the three years of the ban - 2,400 girls, women and men were charged in African courts for defying the orders (Thomas Lynn 2000:129). Indeed, the more pressure was exerted to abandon FGM, the more people took on defiant dimensions such as - 'Ngaitana' - meaning I will circumcise myself (see Thomas Lynn pp 129 ff: In Bettina Shell-Duncan & Ylva Hernlund (Eds) 2000).

The practice became an instrument of war among various affected Kenya ethnic groups, leading to the 1950 insurgencies - the Mau-Mau rebellion. The rebellion was led by mainly Kikuyu militants, reacting against what they perceived as cultural imperialistic attacks by the Europeans. These developments led to Kenya's independence in 1963. Jomo Kenyatta –

Kenya's first president (1964-1978), an ethnic Kikuyu and a strong proponent of the practice - used FGM as a mobilizing agent around cultural rights to come to power. In his book, "Facing Mount Kenya," Kenyatta wrote that no proper Gikuyu would dream of marrying a girl who has not been circumcised (Jomo Kenyatta 1965). In his opinion, those who attacked FGM lacked *"the understanding of a very important fact in the tribal psychology of the Gikuyu –, namely that this operation is still regarded as the very essence of an institution, which has enormous educational, social, moral and religious implications, quite apart from the operation itself"* (Jomo Kenyatta 1961:133). Elites of the time concluded that colonialists and missionaries preached against polygamy to reduce the number of blacks for political reasons and were against FGM in order to disrupt the social norms of Africans (Lynn Thomas 2000).

FGM practices that foreigners sought to extinguish at the time - firmly held together indigenous cultures and played a big role in bringing down the British rule through the Mau-Mau rebellion. It should be observed that Kenya is the only country in Africa, where FGM interventions played a bigger role towards ending the British political rule.

Lessons learned

- ✓ Sensitivity while dealing with cultural norms and traditions
- ✓ Prior investigations on communities and their customs may offer a better entry point and solutions to overcome unexpected challenges
- ✓ Coercive measures are likely to instigate resistant-attitudes
- ✓ Sensitization should be highly prioritized
- ✓ Inspirations towards cultural behavioral changes should come from within community

7.2 FGM prevalence in Kenya

Looking back at the earlier years when the FGM controversy began, time seems to have validated earlier criticisms of FGM being inhuman and unhealthy. Of current, FGM is practiced in more than three quarters of the country, although the prevalence varies widely from one ethnic group to another. The practice is nearly universal among the Somali, Abagusii and Maasai, highly prevalent among the Taita taveta, Kalenjin, and Meru, and practiced at a lesser extent among the Kikuyu and Akamba (UNFPA-UNICEF 2010). Out of the 40 ethnic groups, the Luhya and Luo are the only two groups said not to have female circumcisions (Population council 2007). The type of Cutting varies by ethnic groups. For instance Abagusii and Kikuyu practice Clitoridectomy, Meru and Maasai - Excision and Somali, Boran, Rendille and Samburu - Infibulations.

Countrywide, the 1998 KDHS estimates 38% prevalence rates of Kenyan women aged between 15 and 49 years having been circumcised. Declines of up to 32% in 2003 (KDHS 2003) and 27% in 2008-2009 (UNFPA 2011) have been observed. KDHS (2003) indicate 30.6% circumcisions common among rural women than urban women - 16.5%; with the North Eastern Region having FGM rates of up to 97.5%. Population council indicates that the proportion of women cut decreases steeply with age, from nearly one-half of women aged 35 years and above to 26% of those aged 15-19 years (Njue Carolyne, Ian Askew 2004:2. For further comparisons in generation trends see 2008/2009 KDHS & UNFPA 2011). Such declines are particularly pronounced within particular ethnic groups like the Kalenjin (from 62% to 49%), Kikuyu (43% to 33%) and Kamba (33% to 27%). (Njue Carolyne, Ian Askew 2004).

FGM prevalence among the Maasai and Somali communities is 93.3% and 98% respectively (Republic of Kenya 2010:5). UNICEF-UNFPA states that the proportion of Muslim women who undergo FGM is twice that of Christian women (2013:6), which is true at a certain extent. However among the Somali (Muslims) and Maasai (Christians), the practice is almost universal regardless of religious affiliations. Differences though are noticeable in affected ages, reasons and the type performed. Infibulations for instance common amongst infancy stages in the Somali communities are associated with religion, purity, cleanliness, virginity and at a later age to secure marriages and uphold fidelity. Meanwhile Clitoridectomy and Excisions usually undertaken at puberty stages – as rites of passage to adulthood and to secure a husband are highly prevalent among the Maasai groups.

7.3 Ethnic descriptions of studied communities - Maasai and Somali

The Maasai are a semi-nomadic, pastoralists (mostly cattle herders), and a Nilotic peoples. Many of them live especially in southern Kenya and a few in northern Tanzania along the rift valley on semi-arid and arid lands (Maasai-association.org). They live under a communal land management system. Maasai are nomadic-pastoralists and therefore do not have permanent settlements but rather often move from one place to the other in search for pasture and water for their animals. They rely on their animals for food, which includes meat, milk and blood. While men go out for cattle herding with spears and pangas/big knives to protect their herd from wild animals (lions), women are responsible for housework and building homes. The Maasai traditional wear is a special red dress called Shuka, with self-made traditional jewelries.

The Maasai people have a variety of ceremonies and rituals, which both sexes must undergo. These include *"Enkipaata (senior boy ceremony), Emuratta (circumcision), Enkiama (marriage), Eunoto (warrior-shaving ceremony), Eokoto e-kule (milk-drinking ceremony), Enkang oo-nkiri (meat-eating ceremony), Orngesherr (junior elder ceremony), etc. Also, there are ceremonies for boys and girls minor including, Eudoto/Enkigerunoto oo-inkiyiaa (earlobe) and Ilkipirat (leg fire marks)"* (Maasai-association.org). While women's initiations focus mainly on circumcision and marriage, many other rituals concern mainly men. Every ceremony identifies a new life, which marks rites of passage and every child is eager to go through these stages of life.

Female circumcision among the Maasai is arranged once in a year for ages 12-14 to celebrate rites of passage to adulthood and to mark marriage readiness. Once a woman is circumcised, she is recognized as a female head of her new household, she is allocated livestock and she can bear children, hence stressing the importance of the rite of passage to womanhood (Bettina Shell-Duncan 2000). The ceremony commands community respect and chastity for victims. The rate of FGM among the Maasai accounts for 93.3% of type II (Republic of Kenya 2010). According to '28 too many' (2003), there exists a legend about FGM among the Maasai. Supposedly, a girl called Napei had sexual intercourse with her enemy. She was subjected to FGM as a punishment in order to suppress her sexual desires.

The Somali communities in Kenya belong to a Cushitic tribe, along with the Borana, Rendille and Gabbra. The origin of the Somali communities can be traced in Somalia, a country bordering Kenya in the east. They live in the Northeastern province of Kenya and are mostly Muslim herdsmen. They mainly practice a nomadic pastoralist way of life keeping herds of camels, sheep, indigenous cattle, and some goats. Camels are highly recognized animals within this group, because they provide transportation, milk, meat, income, and status to a majority of Somalis. Women are expected to submit to men and to fulfill their duties as daughters, wives, and mothers. Somali women generally do not socialize with men in public places.

Marriage: Somali marriages have traditionally been considered a bond between man and woman, and clans and families. Girls usually get married at the age of fourteen and fifteen (Esther K Hicks 2011:95). Marriages are accompanied by bride price which is paid to the girl's family. Earlier, most Somali marriages were arranged, usually between an older man with some wealth and the father of a young woman he wished to wed. These customs still hold true in many rural areas. Until very recently however, many urban Somalis choose a

mate based on love and common interests rather than accepting an arranged marriage. According to Levi (1962a:8 & 16), Somalis are strongly patrilineal and Islamic, whereas their marriages are mostly polygamous. The Islamic law permits a man to have up to four wives if he can provide for them and their children with equal support.

Amongst the upheld rituals and traditional ceremonies is FGM mainly type III (infibulation). This accounts for 98%. According to the 2008-09 DHS, girls are cut between the ages of 3-7 years, mainly for purifications and to emphasize virginity before marriage.

Pokot, Kikuyu, and Samburu were also among the studied communities, but in less numbers.

The sections below describe research findings accordingly: a) The social demographic characteristics of study participants, b) the findings about the practice, c) the strategies against FGM abandonment and d) the progress.

7.3.1   Demographic characteristics of participants

Out of a random selection of the total number of 100 study participants, 54% were married, 27% single and the rest fell under other categories (divorced, widowed and none-response). Given their ages, 33 years and above composed of 49% and 35% were below 32 years. The rest did not respond. Females comprised of 73% and males 25% (2 respondents did not indicate their sex). Although the study tried as much as possible to be gender representative, men did not feel comfortable with getting directly involved in the study. Employment status indicated 59% having a formal occupation and 39% informal. Meanwhile, 43% leaved in study areas for all their life and 26% for over 10 years, with the rest falling into other categories. Maasai and Somali communities made up the biggest number of study participants.

7.3.2   Practice: The distribution patterns of FGM

All respondents

FGM is still widely practiced as indicated by 49% in contrast with 34% arguing against the practice. Clitoridectomy has been pinpointed by 42%, mainly from the Maasai community, while 15% claim infibulation procedures rampant among the Somali community. Meanwhile, excision has been shown by only 7%. FGM procedures take place mainly in the fourth quarter of the year (October, November and December) as indicated by 60%. December is mostly

favorable and circumcisions are at a highest peak because the season is usually holidays for school going children. Therefore it provides ample healing time, specifically for girls resuming school (e.g. Somalis because FGM takes place usually at very low ages) and marriage arrangements (e.g Maasai because puberty stage marks marriage readiness) - (K - World vision: No.13).

UNFPA-UNICEF (2013:7) also confirms school holidays being favorite seasons for FGM. Njue Carolyne and Ian Askew (2004) indicate that some health providers take leave during December holidays to open temporary FGM-clinics, seeing as many as 50 girls per day.

Despite the above challenges, fast 44% female participants were uncircumcised (because of changes in behavioral attitudes and education values), while almost 37% were victims already (as a result of community pressure) and 19% did not indicate their status. 30% indicated usual age of FGM to be 4-17 years, of which 23% observed the most affected age as 11-14 years. Traditional practitioners account for 47% of the procedures and 36% are accounted to medical personnel. Although FGM performed by traditional circumcisers is still rampant, medicalization is on the rise as it allows the use of antibiotics and anti-tetanus injections and also provides a hygienic surrounding (K- community: No 7). None of the victims undertake FGM decisions by themselves, but rather their families (including parents and senior relatives) – as observed by 77%.

Female respondents

Out of 73 female participants, 32 were uncircumcised, 27circumcised and 14 did not indicate. Out of the 32 non-circumcised study participants, 15 were single and only 9 married (the rest had other statuses e.g. divorced). Of the 27 circumcised females, 18 were married and only 5 single. Since most non-circumcised females were mainly single while those circumcised were mostly married, it is thus likely that FGM affects marital status.

A possibility that FGM influences occupation-achievement or occupation status highly transforms FGM decision making, is as well recognized. In the study, the formally employed women were fewer victims to FGM than those occupying informal employments. Those who were not circumcised (32 in total) but formally employed were 28. Not-circumcised females with informal occupation were just 4. Meanwhile 21 females out of the total (27) cut females were informally employed and only 6 had a formal employment status.

Bettina Shell-Duncan, et.al (2000:111) note that the improvement in social-economic status and education of women has far reaching social effects that include declines in demands of FGM.

Females in both categories highly disagree that FGM is still widely practiced (18 non-circumcised and 17 circumcised females). Meanwhile, those who agree (upon wide performance) are 14- and 10 women respectively. All the 27 females that underwent FGM were affected at ages 11-17 years. Not undergoing FGM amongst typical practicing communities may instigate poor family-community/social relation as observed by 37 women. Meanwhile 41 females (both victims and non-victims) agree that culture mainly justifies FGM. Existence of medical complications (like bleeding, pain, urine retentions and depressions) and social consequences (school drop outs, early marriages) of FGM is admitted by 46 females.

According to Toubia (1993), women may hide health complications for fear of legal repercussions, or may report such complications only if they are severe or prolonged (see also El.Dareer 1982). Toubia and Izzet (1998) point out that fistula in Africa partly results from pregnancy in young girls whose pelvises are not well developed. Infibulations can be very painful during sexual intercourse and birth. Lethome Ibrahim (2001) emphasize that the removal of the clitoris and infibulations results in less sexual pleasure, which may cause divorces.

33 females (from 46 of the total respondents) applauded NGOs (e.g. World vision, Tasaru Centre) for playing a leading role towards intervention in contrast to government involvement (e.g. Ministry of Gender, Children and Social Development). Common and best intervention models are community-based approaches – as recognized by 36 females (or 53 of the total respondents) - unlike human rights or health-models. Especially economic (financial) challenges hinder NGO intervention - as noted by 32 females (or 45 of the total respondents); though also social challenges (recognised by 10 participants) like lack of community cooperation – cannot be ruled out. Nevertheless projects towards abandonment are highly welcomed, thus leading to remarkable progress – with almost all participants supporting FGM abandonment.

7.3.3 FGM and Education: A qualitative situation description

Effects of the practice upon education[16] cannot be under looked, especially within communities that justify FGM as a rite of passage to adulthood (K – World Vision – recording No 14; see also K - MGCSD – recording No. 9). In Kuria for instance, one school had no girls in form 6, all had been circumcised and married off - below 15 years (K – MGCSD – recording No.9). Also, school registers in Longoswa and Mailwa villages (Maasai areas) show very few girls attending primary schools, as seen in the two pictures below.

The 2011 enrollment structures of both girls and boys in Longoswa primary school from pre-primary to class eight. Photo taken by Idah Nabateregga on 15.06.2011

From the photo above, gender disparities are displayed accordingly. Namely the ratios of girls to that of boys who joined pre-school (kindergarten) are 56 to 54 respectively. Class 1 is rated with the highest participants of pupils (58 girls and 54 boys). Generally observable is; the higher the level of education, the lower the attendance. This applies for both sexes. However, the school dropout prevalent rates for girls clearly surpass that of boys (e.g class 8 with 4 girls and 14 boys).

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[16] According to the education system in Kenya, there is pre-primary, then primary (from class 1 to 8), and then to high school (senior 1-4), then to higher institutions of learning (as the highest level. All levels require 1 year of study until one gets to the higher institutions of learning and specializes in a particular course with different periods of study limits as per courses/study taken

SCHOOL INFORMATION

Name of School: Mailwa Primary School
Address: Po Box 12 Namanga
Code No: 87-21-07-010
Sponsor: Catholic
Type: Day Mixed

PUPILS' ENROLMENT — No. OF TEACHERS

Class	Girls	Boys	Total	Yrs	F	M
1	28	25	53			
2	23	16	39			
3	34	28	62			
4	40	37	77			
5	19	28	46			
6	20	23	47			
7	17	3				
8	8	20				
Total	184	230	411			

Even in Mailwa, class 1 (beginner's level) has 28 girls compared to the ratio of 25 boys, making a total of 53 primary school attendees. In the eighth grade (highest class) however, there is a remarkable decline of the number of girls - only 8 - as compared to that of boys (26).

Both schools are located in Maasai-land in villages nearing the Tanzanian boarder; however, each village is far apart from each other. Similarities traced in both pictures are; low primary school attendance, the high rates of school dropout especially for girls and particularly in higher levels. Both communities are rural-based and characterized by high rates of FGM practices, accompanied by early marriages thereby affecting mainly girls' education.

Qualitative interviews taken on both school premises confirm this relationship and show justifications as well as FGM-associated consequences. Accordingly, one teacher noted, *"Because of poverty, girls are subjected to early marriages and dowry is collected. A circumcised girl fetches more dowry than an uncircumcised. Parents do not therefore want to risk economic prospects by leaving their girls uncircumcised, later on leading to early marriages. As a result, education is affected. Leaving girls in school however, delays the circumcision process and sometimes may rescue girls from getting circumcised, once their age mates have already been cut. This again may affect the amount of bride price to be collected, should the girl get married within the community"* (K - Narrative interview No.1).

To a 9 years old girl: *"Ceremonies attributed to FGM are very attractive and seeing a particular age group celebrating in excitement also makes other girls anxious about the practice"* (K - Narrative interview No.2).

One of the headmaster's views indicates: *"Functions of any kind are very rare in most villages or do not exist at all. Therefore celebrating new ages after circumcision is very common and usually looked forward to. It does not only bring girls who have undertaken FGM together, but also joins together relatives and well-wishers to congratulate the 'new adults' in society. This ceremony gives girls and their families, respect and honor. The ceremony makes young girls of all ages wait excitedly for their turns. Likely results are, out of both excitement and ignorance, girls submit willingly to circumcision at the expense of education. There are very few families in this village, whose family members including girls have become prosperous because of education, even without circumcision. Though in the past, such families have faced too much stigmatization, today they are pointed out as community role models"* (K – Narrative interview No.3).

It should be noted that Maasai region generally suffers from low education and economic levels. The trend is likely to continue if behavioral attitudes towards harmful practices are not changed. World vision intends to rectify such problems, through its girl-child education sponsorship schemes, rescue centers and sensitization on consequences of FGM to various communities.

A World Vision, Kenya study (2003) amongst the Maasai reports that uneducated women (58%) possess highest rates of FGM prevalence than those with at least some secondary education (21%). Moreover, a 1998 UNICEF/PATH study found out that the Kikuyu and Kalenjin families with higher levels of formal education and higher economic status are more likely to favour abandoning FGM. Meanwhile, Mbugua Isabel (2000) argues that girls increasingly perform worse in school after FGM, which is attributed to loss of concentration and lack of study motivations. As discussed by Gruenbaum (1982), effective change can occur when efforts are directed towards improving the social inequality of women such as, economic dependency, education disadvantages and limited employment opportunities.

Such records show how FGM negatively affects education and how education can positively affect FGM prevalence through fostering reductions. Moreover, a direct or indirect correlation between FGM and economic prosperity can be drawn.

7.3.4 Strategies implemented against FGM: Field experiences from Organisations

This section exploits findings about ways of eliminating FGM. It gives highlights on FGM projects undertaken by organizations that participated in the study. These included World vision, Ministry of gender, children and social development, Maendeleo Ya Wanawake Organization (MYWO) and Tasaru girls rescue center (Tasaru Ntomonok Initiatives)

A. World Vision (WV)

World Vision is a Christian relief, development and advocacy organization dedicated to working with children, families and communities to overcome poverty and injustice. Focusing on the most vulnerable of society - especially the most poorest and oppressed - WV began its operations in Kenya in 1974. Currently widespread in 35 Kenyan counties – WV provides hope and assistance to children and communities (www.wvi.org/kenya) through mainly four child well-being aspirations. According to the World Vision's National Coordinator of Gender and Development,

"We are a child focused organization, so we go into communities through the children. We have an integrated focus… We are child based, Christians and community based… In the child that we focus, we do whatever we do at the community level. We work with the community to be able to bring about the wellbeing of children and as an organization, when we are working in any area; we have what we call child well-being aspirations… Children are educated for life, as one of the aspirations. Aspiration number two: boys and girls enjoy good health. Number three: boys and girls experience the love of God and the love of their neighbors, because we are Christians. Aspiration number four, the children are cared for and protected at all levels - family, community and national levels" (see K - World vision National Coordinator of Gender and Development, recording No. 14).

With 15 years of experience working with FGM and the rights of girls in African communities, WV recognizes interventions to be community led to enable and initiate the process of change from within. Its projects to combat FGM basically involve community`s full participation through partnership with local and home-grown advocacy groups, families, community leaders and local law enforcement agencies to guarantee especially girls' rights.

World Vision (2011:2) believes that "a girl child`s right to reproductive and overall physical health and protection should not be compromised in the face of ongoing harmful traditional

practices (HTPs)". Based on assumptions that abandonment is rarely a community priority and is always seen as a foreign ideology (World Vision 2011), WV intertwines its FGM abandonment programs with both community social and cultural developments.

"What we are championing in the communities is that there is equitable distribution of resources, so that there is no discrimination based on gender…" (K - World vision National Coordinator of Gender and Development, recording No. 14). According to the same source, WV further applies the following strategies against FGM

a) The education strategy

"…Together with the community, we are coming up with interventions to ensure that boys and girls are educated for life without discrimination, given the fact that the priority in most communities go to the boy child (…). FGM is an issue in Kenya and has a health implication on the girl child. To ensure that children are educated for life and protected (children enjoy their rights) (…) awareness is done. Teachers, administrators of schools, opinion leaders and other partners are targeted. When the teachers are educated, they will transfer the knowledge to the children at school. At the same time, teachers have meetings together with parents, so they tell parents the side effects of FGM. In schools, they have a section of guidance and counseling, so we want to ensure that teachers talk to children about FGM issues. We are pressing that in the school curricula, there is an inclusion of FGM through ARP models, throughout all learning institutions. We have a Christian Commitment Unit, which is working into the communities through the churches. Churches are also helping take home this message (…)."

Why the strategy?

"In most Kenyan communities, once a girl is circumcised, the next step is marriage. In areas where FGM is prevalent, you realize that the enrollment rates for girls and their completion of primary schools are issues because of FGM (…). A circumcised girl fetches more dowries. Education reduces dowry. Educated and not circumcised girls receive five cows as dowry. Circumcised and not educated may fetch 30 cows because a girl is complete. For an educated and circumcised girl, it will take a boy who is also educated to marry her because she knows the value. However, in most cases, communities determine the dowry. Like in Pokot communities, relatives contribute the dowry. If they learn that the girl is not circumcised, her value diminishes, because she is not a complete woman…"

Schools have been targeted for sensitization and awareness, from where the majority of boys and girls get reached out – for empowerment— to be able to stand up against all odds and say NO to FGM.[17]

The education project officer of World Vision in Namanga village, responsible for implementing the girl education-scholarship scheme informed - *"Promoting girl education through scholarship awards, is one of the ways the organization intends to accelerate abandonment by creating empowerment measures on single family levels. Agreement is made with the parents that the sponsored child never undergoes FGM at whatever cost. Doing otherwise may lead to withdrawal of the support, reimbursement of the funds, and serving legal punishments of jail or fine as per government regulations. The intention of the sponsorship project is to influence parents to abandon FGM and embrace the rewards of education in future. Field officers follow up the girls under the award until late ages, when girls are not vulnerable to the practice any more. The challenge is that the Maasai community is initially nomadic, which makes it harder to follow up the girls. Sometimes there are risks of losing contacts because of lack of registration systems in areas of settlements"* (K – Narrative interview No.4)

ii)   Rescue homes are created to nature the education strategy

This ensures access to a safe physical and learning environment that is critical to children well being. According to K - World vision National Coordinator of Gender and Development, recording No. 14:

"We are building schools and calling them rescue centers or dormitories. Because once you create awareness on FGM, many children will start running away from home. So some children are put in rescue centers. They are called dormitories, under school administration (...). Some parents even cooperate on continued sustenance of their children in schools through offering counseling and sending in resources (e.g. food, firewood) *for sustenance (...). We host reconciliation forums between parents and run away children. (...) Some children who come to these rescue centers are also running away from marriage, but they have already undertaken FGM. However, this* (Rescue centers) *is not a better alternative. We*

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[17] Ruth Kahurananga and Marina Mafani; Empowering women and girls: Challenges and stratgeies in gender equality. A briefing paper prepared by World Vision Afghanistan, Burundi, Brazil, India, Kenya, Mongolia, Nicaragua and Romania; International Policy and Advocacy Department, World Vision International.
http://childrencampaign.org/PolicyAdvocacy/paHome2.5.nsf/allreports/48DFE2BBABABCDED88256F8E001B3ECE/$file/CSW05rev.pdf. Viewed on 10/02/2013

are calling for foster homes within the communities and then through CBOs, we look for reconciliation between girls and families"

iii)   Economic benefits for circumcisers

"...Strategy 3, we are encouraging circumcisers to abandon FGM through providing them with alternative sources of income. However, the challenge is that demand is still there. Communities float circumcisers for the cut."

iv)   Alternative rites of passage

"...Formally we were taking girls for 2 weeks seclusion, but this has a financial implication on budgets, so we decreased the period to one week. In seclusion, we educate girls everything about life, minus the cut. After one week, there is a graduation ceremony. There is cooperation in communities (like bringing food and community owned persons to give anti FGM messages during the seclusion period). Boys who are also against the practice are called upon to be sensitized. We have a manual for reference about the ARP model. It also has life skills models. There are places where there has been resistance. Families come, abduct their children from the centers, and take them for FGM. Sometimes community has not contributed its part, say, providing food and firewood to sustain the ceremonies. Some community facilitators have double standards. They tell the children to do the ARP for world vision, but encourage them afterwards to give in to their cultures. Organizations pull resources together, but resistance comes from communities themselves or women (…)."

My own observations and experiences, having had a chance to personally work with World Vision – Namamga branch - to implement strategies within communities and participate in forum discussions: WV also carries out community sensitization and awareness creation on the dangers of FGM. Forums are organized in community-gathering areas in cooperation with community leaders. Areas of communion may include churches, market halls and shaded trees found in the compounds of community elders. Workers of World Vision's FGM and education units, together with an outside facilitator – who usually belong or come from the targeted communities - take charge of FGM forums. However, community representatives are also elected from such forums and trained, in order to lead the awareness forums henceforth. Once aware of the dangers posed by FGM, the community owns up the responsibility to stop circumcision (More details of the forum procedures are revealed in the next part).

World Vision has seven stand-alone projects in different communities in Kenya, noted the national project coordinator. Most of these projects are concentrated in the North rift valley,

because of high FGM prevalence rates. Communities where implementation of abandonment strategies is taking place include mainly Kalenjin, Pokot, Samburu, Illchamus and Maasai. Other projects are located in the south rift part of Kenya and in Nyanza, to include the Kuria and Kiisi communities. WV's intention is to reduce the numbers of FGM to zero. However, this seems a big challenge since resistance to anti-FGM messages remains stronger in some places

In the Kiisi community for instance, where FGM is 98%, the practice is highly and quietly medicalized that one may not know about it. Community members have employed underground tactics. This is due to the children's act against FGM that threatens criminalization. Communities do everything to ensure that FGM is further practiced without direct government knowledge. Obviously is the central government not at grassroots levels; however local chiefs and community owned resource persons are government representatives, responsible for watching the communities and reporting FGM cases to the local administrators. The practice has been formally common at 12 years. Of current however, it is declining to 5 years, due to the fact that small children are less likely to defend themselves and their choices. Hence cannot report or file FGM charge against their parents. Moreover, these ages are usually excluded once awareness is created. In contrast, a 12 year old is already socialized and therefore likely to run away from home or inform activists – who then take protective measures. The fear of such reactions from older ages has thus pushed FGM unto minors as a tactic of cases remaining unnoticed and less observable.

World Vision Kenya protects girls under the threat of circumcision through Child-line Kenya, a network organization that runs a toll free child helpline for children and any person with issues affecting children. *"People call to report abuse and to receive counseling. Girls in danger of FGM and early marriage have also sometimes used the helpline to call for assistance, which they have been rendered,"* (www.worldvision.org). World vision (2011: 4) additionally *"supports the use of legislative force, especially through community-level child protection mechanisms such as Area Advisory Councils (AACs), which ensures that gender violence cases are prosecuted. This works as a deterrent force against would-be circumcisers, at the grassroots level."*

All in all, World Vision has succeeded in putting FGM issues on public discussions. There is hope that the openness around once a taboo topic will be a platform for future change.

Procedure of World Vision's community based FGM sensitization forum in Longoswa

On the 14.06.11 World vision, Namanga branch facilitated an anti FGM forum at Longoswa village. FGM community program coordinator, the scholarship department representative and an outside facilitator from a religious community based organization, spearheaded the forum. I was also asked to actively participate on behalf of World vision for observations and experiences. On our arrival (at around 1:30 pm), with a privately hired vehicle by World vision, fully packed with incentives (bread, sugar, soap, salt, crates of sodas, etc.), we were welcomed by a crowd of over 150 community members including elders and religious leaders. Being my first time to attend an anti-FGM forum of any kind, it was fascinating to see such a big crowd anxious to be sensitized. High attendance was achieved through announcements made by village elders to individual homes, religious leaders informing their congregations during the Sunday sermons and by use of the Longoswa primary school pupils, who carried information notes and messages back to their parents. This was the very first forum to be organized within this village. Gatherings were held under shades of tree at a church owned large piece of land, although later, the facilitators decided that we use the church building for proper discussions.

Under the directions of the community elders, the forum started with an opening prayer from the pastor of Longoswa village. Recognizing the presence of all community leaders and elders, women group representatives, facilitators from World vision and I - followed this. We all shortly introduced ourselves, before our motives for gathering were clarified. Thereafter, the floor was given over to World Vision facilitators, to start up the forum. The forum, which was held in Kiswahili language, lasted about three hours.

Discussions were opened by an outside facilitator, introducing the topic of children's rights namely - the right to- education, good health, security and own voice in homes, especially in issues affecting children. In order to spark off community involvement into the discussions, participants were asked to give their views about the topic, and to generate reasons as to why children rights are issues of concern. Children education and associated advantages were emphasized, against disadvantages of not sending children, especially girls to school. FGM issues were tackled through discussions that covered the health of children. In addition, other cultures such as 'Dooro'[18] that affected children's well development were also highlighted

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[18] As explained by the World vision facilitator of the FGM forum, Dooro practices are common among the Maasai, and encourage boys to chess or go after girls at night. If they get them, boys are free to have sexual contacts with them no matter the girls' consent. The practice is meant to scare away girls from moving at night especially after 7:00pm., yet in some cases,

upon. The poor social-economic conditions like poverty, illnesses, etc., that are highly affecting the village were partly discussed in relation to FGM and early marriages. Arguments involved the denial of female children a chance to complete their education paths and pursue careers (employment opportunities) with hope of changing the dramatic poor social economic conditions in villages. Meanwhile, children being future generations were looked at as future human resources capable of economically developing the community and rendering financial assistance to their respective parents, should their education be prioritized.

After the child right topic had been intensively discussed, and having laid down the foundation platform for discussing FGM issues, the facilitators now needed to re-emphasize the topic of FGM being the initial motive of the forum. Inquiries were carefully made, if participants were ok to tackle FGM issues deeper within a mixed audience (men, women, youths, and children). Inquiries needed to be done, taking into consideration the sensitivity and taboos surrounding the topic, for female private parts are usually taboo for public discussions. Therefore discussing FGM within mixed audiences was likely to hinder participation and hence worth questioning.

One-village chief recommended that the discussions be held without separating the groups, because FGM is a community problem regardless of gender and age. He noted, *"When women are separated from men, and are sensitized about FGM and its effects, women keep the topics to themselves. They do not share results of such seminars with their children and husbands, because of fear of their husband's reactions. Women cannot also decide on their own the daughters' status, without seeking approval of their husbands. Now, we want FGM to be discussed in men's presence, so that we know how the practice affects us all. These are our wives and daughters in question. We need to support them"* (K - Narrative interview no. 5).

When asked for more views, five other male participants including a community elder, a teacher, and three other local members supported the idea of having discussions together. Despite the fact that men's support was guaranteed, women seemed shy about combined discussions. Nevertheless, agreements were reached and FGM discussions finally took place within a mixed audience.

Explicit discussions about FGM then continued. Participants were asked to justify reasons for FGM. These were said to be; the rites of passage to womanhood, strengthening of community identity and solidarity, family honor, marriage reasons, etc. Participants were also asked to

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walking at night is unavoidable for instance for girls who walk long distances to and from school (K – Narrative interview No.6(b)).

compare the difference and similarities between families that decided not to circumcise and those who circumcised their daughters. Several participants identified just one family they knew of that had not indulged in the tradition, but nevertheless its girls had all been married off, well educated, had good jobs, leave in cities, and one of the girls was also identified as owning a car (a big achievement within the village, given the standards of living). One participant identified that this family had been stigmatized in the past, to the extent that it had no any community contact for social relations.

In contrast with majority families that adhered to the practice, any such achievements were hardly mentioned, apart from marriage successes and good community relations. A male participant gave an example of his friend, who married an uncircumcised woman and lost respect - he became a laughing stock in the village. One more example, involved an educated man who refused to marry a Longoswa girl, but instead got his bride from another community without FGM culture. The narrator explains that the action of getting a bride from a foreign community without FGM culture perplexed the community for years as they lacked explanations for such a behavior. It is only during the forum, that clarifications about such actions were made, hence addressing community doubts.

Facilitators capitalized on FGM consequences to raise awareness. Consequences observed included; instant/psychological growth of girls after FGM, the unforgettable pains and bleeding, school dropouts, early marriages, early pregnancies and problematic sexual relations. The facilitators raised bible teachings that were against FGM, such as 1 Corinthians 1:12-26 *"God created us in his own image; each part of the body has a special function; people shouldn't alter body appearances"* (K - Narrative Interview No.6). People were thus encouraged to drop such norms that affected personal wellbeing.

At the end of the forum, World Vision representatives carried out evaluations by seeking community views of what participants had learnt from the forum. Generally most people were happy to have received FGM sensitization, directed towards daily challenges communities face. Some voices vowed to stop the practice. Others recognized that some cultural practices are enemy of the children's well development, because they limit future achievements. Participants also demanded that such forums be conducted frequently - to allow discussions on more perturbing questions and get more clarifications of abandonment procedures. The family example used, which did not circumcise any of its daughters and nevertheless prosperous, stands out to be currently a role model within the community.

Recommendations from community views emphasized the importance of organizations to find immediate solutions to girls running away from FGM. One participant claimed, *"If girls start defiling family decisions such as undertaking FGM, whom will they run to for help?* (K – Narrative interview No.7). Hence arguing that abandonment messages be complemented by supporting elements that sustain change such as improved infrastructure, building rescue centers, increasing the number of schools in villages to avoid long walking distances, increase the number of scholarship awards for both genders, create activities that empower women and men to improve their economic conditions, etc.

The forum ended with thanking messages and a closing prayer. Thereafter, we loaded off the vehicle with community goodies (sugar, salt, soap, drinks and bread). These were distributed to participants, on their way out of the building/church.

In my observations, general challenges facing such abandonment activities involve the lack of enough personnel/staff to sensitize the communities considering the vastness of the areas targeted. There is also lack of transport means (due to poor infrastructure) that connects facilitators easily from one village to the other. Some participants walk very long distances to reach the places where forums are organized, which may eventually lead to low turn up due to lack of motivation/desire for long walks. High expenses are also incurred involving forum arrangements. For instance hired transport means, improvising portable power supply means in case films are to be shown etc. Extra expenses are also incurred through buying incentives for participants, to motivate participation. An additional challenge is that FGM cannot be discussed as a stand-alone topic, which consumes a lot of time. However, by combining the issue with other topics like health, poverty, etc., - an entry point into discussing FGM is offered. Sometimes if the community elders or village chiefs do not approve NGO activities, such forums are deemed to fail. (Reference to: K - Longoswa FGM-sensitization forum, recording No.6).

FGM sensitization forum organized by World Vision at Longowsa. Photos taken by Idah Nabateregga.

From left are the village members, the World vision facilitators, and then examples of calendars distributed in abandonment campaigns

B. Ministry of Gender, Children, and Social Development (MGCSD)

Another actively acting body against FGM is MGCSD. The ministry was curved out of the Ministry of Gender, Sports and Social Services under the Presidential Circular No 1 of May 2008 (MGCSD 2009). It comprises of two departments, namely, gender and social services and children services. It is national machinery with the responsibility of implementing Gender mainstreaming in policy formulation, planning, budgeting, monitoring and evaluation (Republic of Kenya 2008). As highlighted by the republic of Kenya (2008), MGCSD promotes gender mainstreaming in national development processes, co-ordinate and harmonize the implementation of the National Policy on Gender and Development (2000) as stipulated in the National Plan of Action of 2008-2012. The National Plan outlines the vision of the ministry as being the leader in the provision of Gender responsive, child friendly and social services leading to a society where all enjoy equal rights, opportunities and a high quality of life (National Plan of Action 2008-2012). In summary, the Ministry is committed to promote, coordinate, monitor and evaluate gender equality, women's empowerment, social development, care and protection of children and other vulnerable groups as integral parts of national development (MGCSD 2011).

In Kenya, the concept of bringing gender issues into the mainstream of society came into establishment, as a global strategy for promoting gender equality in the Platform for Action, adopted at the United Nations Fourth World Conference on Women in Beijing in 1995. The Beijing conference highlighted the necessity to ensure that gender equality is a primary goal

in all areas of social and economic development. FGM being a hindrance to such developments, whereas the necessity to protect female children is pending, the ministry has been active in supporting FGM abandonment and has championed in coordinating projects at national level.

MGCSD (2009) study shows that the National Policy for the Abandonment of FGM, which was presented to the cabinet (Kenya parliamentarians) through the gender ministry, was eventually approved in June 2010, under the ministry's endorsement. This national policy against FGM specifies in detail what must be done to enforce laws against FGM and how to gain public and political support for these laws. It requires government to develop and improve services for access to justice, recovery, rehabilitation and integration of girls and women who have suffered from FGM and its lifelong consequences. Additionally, the policy requires government to take concrete legislation, public education, outreach programs, advocacy and media coverage, in order to empower women and improve reproductive health services.

Given the qualitative responses:

Ministry initiated projects involve comprehensive research studies to inform policy, programming and implementation. In addition, sensitization and awareness projects, back up community anti FGM declaration ceremonies. Additionally, the ministry gives several speeches against FGM. There is a setup of help lines, shelters and rescue homes, gender-based- violence and recovery stop centers, legal aid clinics, psychosocial support services, rehabilitation and resettlement services, and police gender desks. Men have also been increasingly targeted, for systematic involvement in issues that affect women. All these aim at reinforcing abandonment. (K- MGCSD recording No.9 & Illchamus FGM-abandonment ceremony/public declarations File 1, recordings 1-6).

The assistant deputy minister of MGCSD—Onyango Protus informed that: *"The ministry was influential in passing of the Children Act Bill of 2001- against FGM and is still actively involved in its implementation plans until now"* (K- Narrative interview No.8)

Christine Ochieng, coordinator of UNFPA-UNICEF joint programmes at the national focal point (K – Recording No.12) highlights: *"The National Secretariat for FGM has been established at the Ministry of Gender to coordinate and oversee the efforts of stakeholders nationwide, who are involved in fighting against the practice."*

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In my summarized opinion, active involvement of this government ministry both at national and grassroots levels signals commitment and willingness to end FGM, despite political challenges involved within the process (e.g. disagreements among politicians during parliamentary debates and lack of cooperation from some politicians – i.e., resistant to passing of FGM bills). The ministry's achievements in the field cannot be underestimated, even though much still needs to be done to achieve the goals of FGM-free generations. The ministry thus recognizes the need to build strong coalitions and partnerships among stakeholders and other actors. It also embraces the requirement to sensitize law enforcement officers at grassroots levels. Furthermore, MGCSD is also aware of the need for community-willingness to cooperate with government in order to overcome obstacles against FGM abandonment. Obstacles involve the patriarchal nature of Kenyan society, poverty, illiteracy, ignorance, stubbornness, insufficient personnel to address FGM at local levels and the strong cultural diehards who do everything possible to preserve FGM.

MGCSD's indulgency in FGM abandonment ceremony in Illchamus

Prior to the Illchamus declaration ceremony on 24.06.2011, the ministry facilitated and participated in Meru renewed declaration in 2009, Kuria's in 2010 and West Pokot's on 17.06.2011 (K- MGCSD recording No.9).

Given my experience and direct involvement, I focus on the Illchamus declaration ceremony that took place in Marigat, Baringo district (Maasai region) in Kenya (K - Illchamus FGM-abandonment ceremony/public declarations File 1, recordings 1-6). Baringo has many tribes including Tugens, Njemps, Pokots, Turkanas, Maasai, Kikuyus, Numbians and Kisiis. It is one of the 47 counties in Kenya, located in the former Rift valley province. The district is bounded by Turkana and West Pokot counties in the North, Samburu and Laipikia to the East, Nakuru and Kericho to the South and Marakwet to the West.

June 23, I was told to pack my bags and join the group that was heading for this ceremony. Meeting point was at the ministry premises in Nairobi and take off time was at 2:00pm. We set off with MGCSD's deputy director – Onyango Protus, Meru elder and two other MGCSD workers. Because of the long distance, we spent a night in a UNFPA-UNICEF reserved hotel in the nearby city after Nakuru, with the aim of making it on time (10:00am) at Baringo the following day. On our arrival at the hotel, we met other elders from Kuria and different stakeholders, who were also heading for the same function. This facilitated intensive interaction and exchange of various experiences on the topic – almost Kenya-wide.

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Come June 24, next stop was at Baringo district headquarters at 10:00 am, where we met several stakeholders from government, CSOs, schools, churches and private individuals. A short meeting for stakeholders was held at the district headquarters, opening with a word of prayer, followed by an introduction round of present activists, including myself. The meeting was about focusing on ways to completely abandon FGM and clarifications on the day's program (See K - Illchamus FGM-abandonment ceremony/public declarations File 1, recording No.1 - Activists and government meet to discuss FGM issues shortly). Thereafter we proceeded to Illchamus, where the function took place. We arrived towards 11:30am, being welcomed by a singing crowd and dance performances.

Opening ceremonies proceeded firstly with tree-planting by significant stakeholders (e.g. government officials and community elders) and a look at different displayed community artifacts (like accessories that both none-circumcised- and circumcised- girls wear to mark differences in age sets) before the actual open up of the declaration ceremony at 12:00 noon. The ceremony was thereafter opened officially with various speeches, entertainment and drama addressing FGM abandonment. Among spokespersons included community positive deviances, elders, women leaders, spiritual heads, group of circumcisers, government officials, NGO representatives, etc. (See K - Illchamus FGM-abandonment ceremony/public declarations File 1, recording No. 2 – Ceremony speeches and performances).

Meanwhile, inquisitive to know factors that led to the community declaration, I used the opportunity to interact and interview a number of stakeholders. One informant explained: After the baseline survey about the FGM situation in the area; spearheaded by Ministry of Gender, finding were implemented with community help. Communities came up with their own anti FGM committee that addressed FGM practices without being pressured or coerced. The Ministry of Gender only gave support (technical support, monitoring, evaluations and reported on results) and direction of how things should run. After thorough education and awareness on all levels; youths, girls, circumcisers and elders got enough information about the dangers of FGM – hence the declaration (See K - Illchamus FGM-abandonment ceremony/public declarations File 1, recording No. 4 - factors leading to the Illchamus declaration).

Elders and 'surgeons' made a rallying call criminalizing old age deeply rooted traditions, which force young girls among the Njemps to be circumcised. The groups pleaded for an end to the practice. '*Matung'ai muratare oo ntoiye'* was an appeal slogan in local dialect encouraging the community to dump the practice. Special appeal was made to the older men

and morans (youth groups) lined in the waiting queue to secure younger brides - to stop the acts of early marriages.

A 12-year-old girl (standard four pupils at Kokuwa Primary School) who escaped FGM narrated: *"My father nearly subjected me to the practice last year but I declined and stood firm. He wanted me to be circumcised and get me married off to a man who was younger than he was. He told me to leave home if I did not obey the instructions. It is then that I escaped to stay with strangers at Kukwa Island camp to avoid my education from being brought to a sudden end."* (K - Narrative Interview No. 9; see also K - Illchamus FGM-abandonment ceremony/public declarations File 1, recording No. 2 – Ceremony speeches and performances). A nurse and her helper who now live as a family took in the girl. The rescuers claim that the father has never bothered to make any contact to the daughter or even search for her. According to the girl, her father has had a strange appetite of giving her daughters away for marriage at young ages.

Chief Francis ole Kiprich an administrator for Salabami location observed that, *"the practice has continued because of the strong cultural values and tradition attached to circumcision. Those who observed the practice are held in high esteem by the community and are given key roles in the community. However, the practice should be discarded to give young girls chances to good health, education and a better life"* (K - Narrative Interview No. 10 & K - Illchamus FGM-abandonment ceremony/public declarations File 1, recording No. 2 – Ceremony speeches and performances).

A 20-year-old girl (second year bachelor of education student at Egerton University) from the Illchamus community, who also escaped the practice, acts as a role model and an activist. Given her experience - *"Initially I became a victim of stigmatization even by my own family members. They derided at the long held belief that I will not secure a husband in future. I am proud I can now mentor others to emulate my stand. (…) Luckily, my father supported me. I ran away from home to stay with a daughter of a pastor with whom we were buddies"* (K - Narrative Interview No. 11). In her case, it was the mother who pressured that she be circumcised, having done the same to the first-born daughter. However, teachers who are members of Illchamus lobby group and the Catholic Church encouraged her not to bow to the pressure. She further adds that a sudden death of a girl that resulted after circumcision sent a scare in the whole village, leading to the community's change of mind about the practice.

Her father confirms reasons for daughter's protection from FGM and says - *"my daughter is the first female graduate the community has produced. If she had undergone FGM, this dream would have not been realized. I did not go far in my education. It is for this reason that I supported my daughter's desire to remain in school. Again, she had been a deeply religious child as she grew up. Neither was it my wish to break her desire. Young adults are delicate; going against what they want can turn out to be tragic"* (K – Narrative Interview No. 11a).

One circumciser aged 50 resolved to destroy her tools of trade and seek for alternative means of livelihood. She confirmed that she earned Kenyan Sh.200 per girl who underwent the cut. She pledged publically to be a positive deviance and act as an example within her community. Gachanja said UNFPA is attempting to link circumcisers to other social networks where they can be engaged in worthwhile activities run by income generating women groups.

The community elder aged 64 years regretted the past and pledged to support campaigns against FGM within illchamus community. Mzee Lekaragoi declared in Kiswahili: *"Hatutaki tohara tena hapa kwetu. Tumekataa utamaduni mbaya"* meaning– *"We do not want FGM practices here at our place again. We have rejected a bad tradition"* (K – Narrative Interview No. 12).

Dr Nyikal – permanent secretary of MGCSD - welcomed the elder's position of supporting FGM campaigns, basing on the analysis that they (elders) are the biggest hindrance to the campaign. He also criticized circumcisers for firmly holding and championing the practice for economic reasons. Dr. Nyikal reveals government plan and comments that *"the program which the government is currently undertaking targets involvement of the elders and women who carry out the business, (...) because these particular groups and old aged community members are the custodian of the tradition"* (K – Narrative Interview No. 13). Dr Nyikal also noted previous attempts from the Njuri Ncheke (Meru elders) and the Pokots in stamping out FGM, hence resulting in positive impacts. Namely, indications in the last five years show that primary school dropouts for the girl child have dropped by about 35 percent. Dr Nyikal confirmed that young men and traditional morans will also be brought on board in the next phase of the campaign for the purposes of sensitization (see also K - Illchamus FGM-abandonment ceremony/public declarations File 1, recording No. 2 – Ceremony speeches and performances).

UNFPA's Florence Gachanja also added that; *"elders are custodians of cultures and have great influence over social norms and young people have influence on peers. Emphasis on*

offering education to young girls is important" (K – Narrative Interview No. 14). According to Gachanja, the practice contributes to under development in areas where it is carried out. The practice denies counties of qualified personnel, if education is not extended to each child. Gachanja further emphasized that the number of women affected by the fistula disease and delivery complications have increased because of widespread application of the cut in the region. She thus calls for abandonment of the practice to allow improved community developments and good health (K - Illchamus FGM-abandonment ceremony/public declarations File 1, recording No. 2 – Ceremony speeches and performances).

The Baringo Kenya National Union of Teachers (KNUT) executive secretary—Charles Kamuren in his speech notified, *"although there is no concrete data currently available, signs are there, that the practice is declining. The Catholic Church and NGOs involved in the anti FGM campaign are yet to make this public. Communities in West Pokot, Tugen, Marigat and Marakwet have resolved to discard the practices"* (K - Illchamus FGM-abandonment ceremony/public declarations File 1, recording No. 2 – Ceremony speeches and performances).

The declaration was honored and signed in the presence of government officials (e.g. the Permanent Secretary of Ministry of Gender, Children and Development—Dr James Nyikal; Deputy Director of Ministry of Gender, Children and Development—Mr. Protus Onyango; The District Commissioner of Baringo—Mr. Saul Muguawya); CSOs representatives (UN Women representatives—M.S. Gachanja from UNFPA, Christine Ochieng—of UNFPA-UNICEF—National focal point FGM/C joint programmes, Maenndeleo Ya Wanawake Organization (MWYO)) and community elders from Kuria and Meru (Johnson Chacha Mangiteni—Co-ordinator Kuria council of Elders and District Peace Committee Kuria East District, Matiko Mahiri—Chairman Kuria Council of Elders Kuria West, and Meru's—Rev. Stephen A Mugambi, and Isaac Mbogori) who prior successfully made the same declarations in their communities. Further advocates present included; Kenya National Union of Teachers - Baringo branch (Mr Kamerun Charles), the Catholic diocese of Nakuru and myself (See K - Illchamus FGM-abandonment ceremony/public declarations File 1, recording No.1 - Activists and government meet to discuss FGM issues shortly & recording No. 2 – Ceremony speeches and performances).

The ceremony closed with a declaration document signed by the elder's representatives, chairperson ILAFF, spiritual leader, women leader, youth leader, FBO/NGO/CBO

representative, and finally sealed by the permanent secretary of Ministry of Gender, Children and Social Development – Dr Nyikal.

Groups of elders, circumcisers and morans respectively, publically discard FGM acts in the Illchamus community in 2011. Photos taken by Idah Nabateregga

Elder, circumciser and youth moran respectively - sign the official document discarding FGM in the Illchamus community in 2011 at the end of the Community declaration ceremony. Photo taken by Idah Nabateregga

Figure 9 shows the Permanent Secretary of MGCSD sealing off the declaration document in the Illchamus community in 2011. Fotos taken by Idah Nabateregga
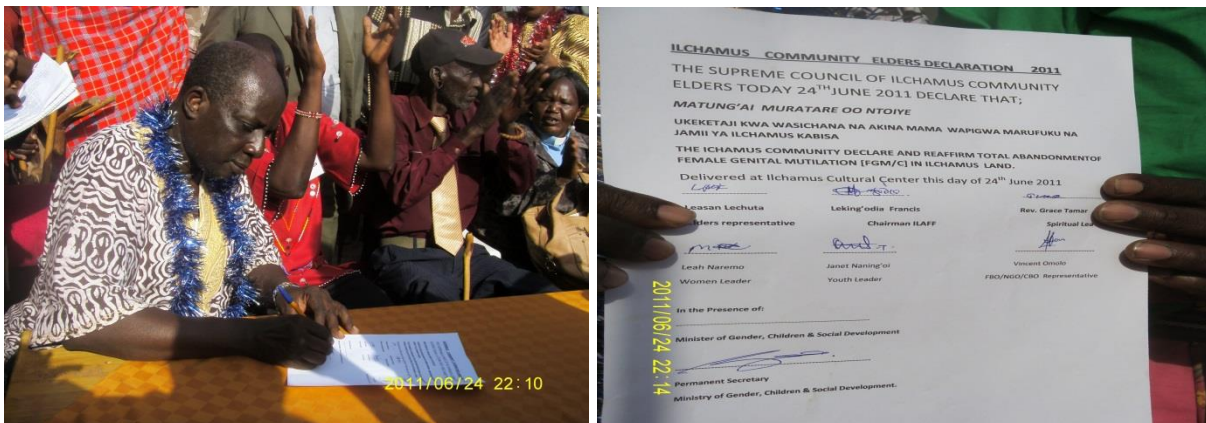
C. Maendeleo Ya Wanawake Organization (Kenya) (MYWO)

MYWO is a non-profit women's organization existing since 1952. Its active indulgence with gender issues was strongly influenced by the United Nations Declaration of the Decade for Women (1976-1985), after the World Conference for Women in Mexico City (mywokenya.org). The organization's mission is the quality improvement of the life of women and youth in rural areas (social welfare). Its main aim is uniting, nurturing and empowering women socially, economically and politically. MYWO provides a prominent voice for grassroots women by addressing various challenges that affect women lives. Its projects include gender equality, gender based violence, civic education, gender and governance, women and development.

The MYWO project coordinator situated in Nairobi - Caroline Murugor – elaborates on the organization's contribution towards FGM abandonment in Kenya. These involve MYWO's active support and implementation of laws addressing harmful practices like FGM and early marriages at community levels. MYWO further sensitizes community leaders on the need to abandon FGM. The organization is well known for its approach - 'Alternative Rites of Passage' (ARP), applicable to communities that practice FGM mostly as a rite of passage to adulthood. MYWO therefore applies this approach in only selected areas like Samburu, Baringo, Mt. Elgon, West Pokot, Kuria, Migori, Moyale, Isiolo, kisii, Meru and Tana River (K – Narrative Interview No.15, paragraph 1).

The alternative rites of passage also called 'circumcision by words' entails teachings from older women on how young girls can become best mothers and wives in future, without being cut. The ARP model aims at preserving the traditional knowledge passed on in the process of FGM such as hygiene, being a respectful woman and all about adulthood/motherhood. The response from communities is so far positive, due to the recognition of some positive (knowledge) aspects passed on during the transition process from childhood to adulthood. As a result, the number of children participating in ARP has increased steadily in the past years (K – Narrative Interview No.15, paragraph 2).

Also scientific research by Mohamud Asha, Radeny Samson, and Ringheim Karin (2006) shows that in December 2001, nearly 1000 girls and their families in Gucha participated in ARP, which included a five to seven day seclusion period culminating into ARP ceremony. Girls attest that ARP has helped to raise their self-esteem and confidence to resist both community and family pressure. The first original ARP were demonstrated in Meru, which

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resulted into formation of an NGO called Ntanira Na Mugambo, oriented towards ending FGM.

Identifying challenges, the MYWO project coordinator says that in Pokot for instance, *"the practice is so engraved on the minds of the people that some men insist on marrying only circumcised women with arguments that they can be trusted and will not indulge in adulterous behaviours. This threatens women and young girls who intend to marry. In fact, some of the girls after participating in the alternative rites of passage procedure, they later succumb to the cut. Nevertheless, real solution and eradication of the practice lies in changing people's attitude and mind-set"* (K – Narrative Interview No.15, paragraph 3).

D. Tasaru girls center (Tasaru Ntomonok Initiatives)

The TNI is a Kenyan community-based organization established in 1999 by Agnes Pareyio, to promote awareness on women's rights issues and to fight for the elimination of all social and cultural practices that are harmful to girls and women. Agnes' involvement in FGM abandonment historically evolves from her background (as a victim to the practice). Practically, she started in 1984 when she began working with Maendeleo Ya Wanawake as a district coordinator, campaigning against harmful traditional practices including FGM. In 1998 she encountered girls running away from FGM and realized then the urgent need of temporary shelter as girls awaited reconciliation with their families. It is then that Agnes Pareyio established Tasaru center based in Narok.

Elaborating in her own words, Agnes says *"I am a Maasai, and once a victim of FGM in my home village- the Enaiborr/Ajijik sub-location of the district of Narok North. Although I did not want to be cut, I finally did it to prove to the community, my mother, relatives and friends that I was not a coward, as rumor was spreading. It is only my father and friend at school who had tried to protect me from FGM. After my sad experience, I ensured to myself that none of my daughters would ever undergo the same experience. This motivated me to rescue girls running away from their respective homes due to FGM threats and early marriages. I started up the Tasaru center to protect the Maasai girls from the practice. The center offers counseling services and sensitizes on the dangers of FGM. Girls at the rescue center are supported both morally and socially. They are eventually returned to their families after reconciliation"* (K- Narrative Interview No. 16, paragraph 1).

TNI uses a multiple strategy to reach various stakeholders like community leaders, elders, chiefs and religious leaders, circumcisers, women groups, peer educators, women, girls, men

and boys. The organization ensures change in behavioral attitudes through mobilizing community members and sensitizing them about the dangers of FGM. TNI also stresses the importance of Education especially for girl child, because in the Maasai communities girls' education is not as prioritized as that of boys' hence early marriages. The organization further collaborates with the district children's officer and the administrative police (protection mechanism) to arrest and prosecute perpetuators. The center further supports alternative rites of passage activities by convincing parents to send their children to participate and spare them from FGM (K – Narrative Interview No. 16, paragraph 2).

Between September and December 2009, Tasaru Rescue Centre received fourteen new girls who ran away from FGM and early marriage. In 2010, 32 girls were rescued. In 2011 during my research visit, the center was hosting seventy-four runaway girls. Seven girls had left to pursue professional training courses and three girls are now working while supporting their families, making them role models to the younger ones. These initiatives have made greater contributions to end FGM in the Rift Valley provinces.

However some challenges observed include:

- Some elderly men who intentionally want to maintain the practice by continuously offering high bride price to circumcised girls.
- Some families criticize the center for spoiling their daughters through non-respectful rescue measures.
- Discussions between sexes are sometimes unproductive, because the Maasai community is male dominated.
- Women hold inferior positions when it comes to power and decision-making.
- Reluctance towards behavioral changes.
- FGM is performed secretly at night without accompanying ceremonies now, so as not to alert activists and girls are married off without prior preparation. This poses a challenge to rescue efforts.

As solutions to address some of the challenges:

- TNI holds different seminars according to sex to allow free participation.
- Women are encouraged to share their experiences
- Men are advised to support their families in saying No to FGM.
- TNI through its sensitization and awareness projects shows community the role of education and its contribution towards improvement of poor social-economic

conditions not only for the victims, but also families and community at large. Rather than bride price, education is very productive and guarantees long-term happiness.

7.3.5 Challenges towards abandonment

In Kenya generally, there exist individual groups like the Mungiki among the kikuyu ethnic group who recruit people in their movement that supports FGM. Likewise, some independent churches as well still support FGM (K – Kenya Human Rights Commission (KHRC), recording No.4). Moreover given my experience in different Kenyan communities, common beliefs like FGM abandonment being a western ideology tended towards black-marking particular cultures while deeming them evil, possess challenges to abandonment efforts. More so, the patriarchal dominated Kenyan societies still make it somewhat difficult for women and children to achieve their full rights - due to lack of platform to fully express these rights. Moreover poor social-economic conditions and poor infrastructures sometimes underscore the support against FGM. These points mentioned contribute to resistance towards change, even though attitudes about FGM may have changed.

7.3.6 Progress towards abandonment

However in my own view, the fact that several strategies are now community driven minimizes levels of outside influence and coercion towards FGM abandonment. This is a result of community/grassroots empowerment efforts, leading to self-criticism. Communities are thus increasingly identifying problems within their own set up and addressing them according to local knowledge, efforts, and context (e.g. the FGM declaration campaigns in Illchamus and Tasaru Center activities). Moreover, existence of village empowerment programs (e.g. MYWO and World Vision activities) has helped women gradually come out from closets and defend their rights and those of their children. A combination of these points and Kenya's reliable government support/priority towards FGM abandonment together with the favorable political atmosphere – has given room to CSO active cooperation in aligning strategies towards total abandonment.

Even study participants confirm a fairly improved FGM situation in Kenya. In participants' views, reasons attributed to behavioral changes include among others; improved and higher education levels of parents (25%), fear of prosecution due to government laws (20%), shunning traditional cultures in exchange for modern ways of life (16%), Husband support – (there is males' increasing preference for uncircumcised females that dilutes the significance

of FGM and marriage – 15%), strong Christian ties (10%) and plans to intermarry from none practicing communities (10%), family support (9%) and finally circumcision not being a cultural requirement (5%). Those in support of abandonment are 79% compared to 8% for maintenance. Indeed, 75% are clearly against circumcising their daughters in future as compared to 21% with intentions to socialize their children into the same practices, and the rest being none-decisive.

As seen from the responses above, communities of study have an outdated opinion about FGM. They are also more open-minded today about discussing FGM issues, hence the broken taboo surrounding the topic. Besides, CSO and government activities seem to have a tremendous impact on the lives of people at grassroots levels. Generally, I can conclude by saying that the 'road' towards progress today is more reliable and can be capitalized upon for future significant behavioral changes.

8 FGM IN GHANA

Ghana, a country of about 26,042,191 populations (World population review 2014) has 3.8% FGM prevalent rates according to 2006 Multiple Indicator Cluster Surveys (WHO 2008; UNICEF 2013). Prevalence are concentrated in the northern parts of the country and type II is highly documented (WHO 1998). Out of three groups, UNICEF classifies Ghana under Group 1 – countries with lowest FGM prevalence (UNICEF 2005).

Historically, previously known as the Gold coast, Ghana was a former British colony until independence in 1957 (F M Bourett 1960). It is the first country in Africa to free itself from colonial power with help/ leadership of Kwame Nkrumah (Kwame Nkurumah 1973) – Ghana's first president until 1966. Currently a constitutional democracy (E. Gyimah Boadi 2001), President John Dramani Mahama since 24.July 2012 now governs the country[19].

Geographically, Ghana lies along the northern coastline of the Gulf of Guinea and shares boarders on the west with Cote d'Ivoire, Burkina Faso on the north and Togo on the east. It is a culturally and geographically diverse nation comprising of 10 diverse regions and 75 ethnic groups.[20]

Statistically, the country relies mainly on subsistence/semi subsistence rural economy supporting the livelihoods of more than 80% of the population (Emmanuel Ekow Asmah, 2011). Ghana embassy statistics show literacy levels rate of up to 71.5% of the total population, males representing 78.3% and female 65.3%). Though prevalence depends on regions; Christianity is practiced by 71.2% mainly in the south, Islam by 17.6% common in the rural north and traditional/local religions 5.2% exist side by side with the mainstream religions.[21]

Distinguished with its mosaic of diversified cultural traditional values and practices, Ghana's most traditional practices are valuable elements in maintaining social cohesion and ensuring identity/belongingness. For instance positive traditional practices like the extended family support system, sharing, caring and respect for the aged, peacemaking and traditional means of settling disputes ensure social cohesion. Meanwhile negative practices such as FGM, widow inheritance, breast ironing and prohibition of certain foods assure belongingness, but marginalize women and girls' rights (GAWW 2010).

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[19]The Presidency Republic of Ghana, http://www.presidency.gov.gh/. Viewed on 29/12/2015

[20] Ghana Embassy, Population: http://www.ghanaembassy.org/index.php?page=population. Viewed on 11/02/2014

[21] Ghana Embassy, Population. Viewed on 11/02/2014

8.1 FGM prevalence in Ghana

While FGM prevalence in Kenya scatters countrywide covering almost all corners of Kenya given ethnic locations; in Ghana FGM is only highly prevalent in the North – Northern region, Upper west region, and Upper east (higher extent) and Brong Ahafo (lower extent). Meanwhile South of Ghana comprises of none practicing regions such as the Ashanti, Volta region, western region, eastern region, central region and Accra. Although FGM is not a cultural practice in the southern parts of the country, migrants from the four northern regions and neighboring Sahelian countries (Burkina Faso, Niger, and Mali) practice it in the areas in which they settle (Navrongo Health Research Center 1998).

Location of Ghana in Africa and the map of Ghana subdivided into political regions to help clearly identify FGM affected areas
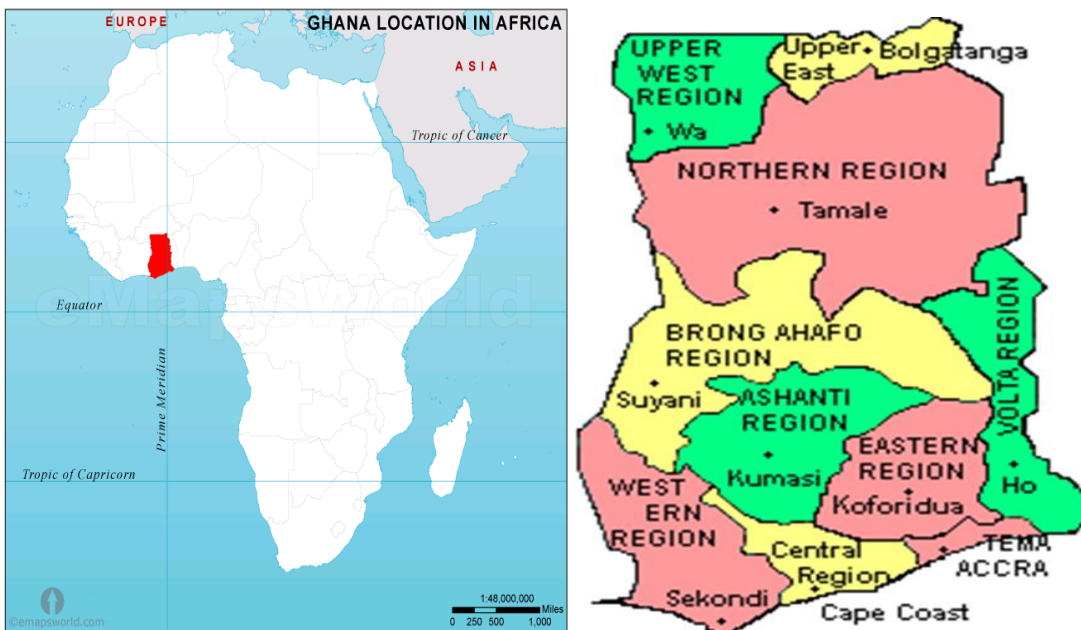
Combined prevalence for both Upper West and Upper East regions is 86%. In Kassena-Nankana District alone, 77% prevalence was recorded in 1995 (Navrongo Health research Center, 1998). Dorkenu A (1994) illustrates 97% circumcised women in the Northern region, from a study of 2,325 women interviewed.

Communities practicing FGM in Ghana, *(GAWW field study 2005).*

Regions/Districts Visited		Identified Communities
Northern	West Gonja	Wakawaka, Mankuma, Kong, Nakwabi, Tuna.
	West Mamprusi	Kunkwa, Kpasenkpe, Yizesi, Kadiri, Katigri, Yagaba
Upper East	Bongo	Namooah, Zoko, Yiliwonor, Balungu, Feo, Soe, Zorkor.
	Bawku Municipal	Binduri, Widana, Bogzua, Sangabulle, Zoasi, Kpalugu
	Kassena Nankana	Zokko, Kandiga, Kuruga, Mirigu, Sirigu, Kaasi
	Talensi/Nabdam	Yale, Shia, Kongo, Sakote, Dakote.
Upper West	Lawra	Brifoh, Lyssah, Ko, Guo, Boo, Tuma.
	Wa	Sing, Kpesiri, Nakori, Guo, Tokali, Komdeu.
Brong-Ahafo	Jaman North	Dorbor, Bonakire, Adadeɛm, Sampa, Dwenem.
	Tain	Banda Ahenkro, Gbao, Burohaani, Sabie, Bonyase, Bofie.

Unlike Kenya where several researches have taken an extra effort to show the percentage of FGM per ethnic groups, their behaviors and changes, and correlations (see Njeri Jane.C, Ian Askew, Jennifer Liku, 2001; Njue C, Askew.I, 2004), such systematic categorization of data is absent in Ghana. This makes it difficult to gauge prevalent levels and marked changes.

Just like most communities in Kenya, FGM in Ghana is also common at puberty as a rite of passage to adulthood and a key to marriage. However girls/women are also cut during pregnancy and/or at childbirth to prevent children yet to be born from becoming stubborn and unruly. Particular in Ghana, sometimes if a female dies without having gone through the procedure, FGM may be performed in order to accept the deceased into the ancestral world (Akweongo P, Appiah-Yeboah S, Sakeah E, et al. 2001; US Department of State, 2001; Matilda Abereso Ako, Patricia Akweongo, 2009). Although the practice is embedded deep

down in the cultures of practicing communities, there is no unitary historical origin of FGM in Ghana. However it is likely that the practice began through the influence of peoples to the north in Burkina Faso and Mali with whom the Kassena and Nankana share ethno-linguistic ties (Mbacke, Cheikh, Philip Adongo, et.al, 1993).

8.2 FGM in Kassena-Nankana District: Ethnic descriptions and prevalence

Map of the upper eastern region of Ghana with location of Kassena-Nankana District
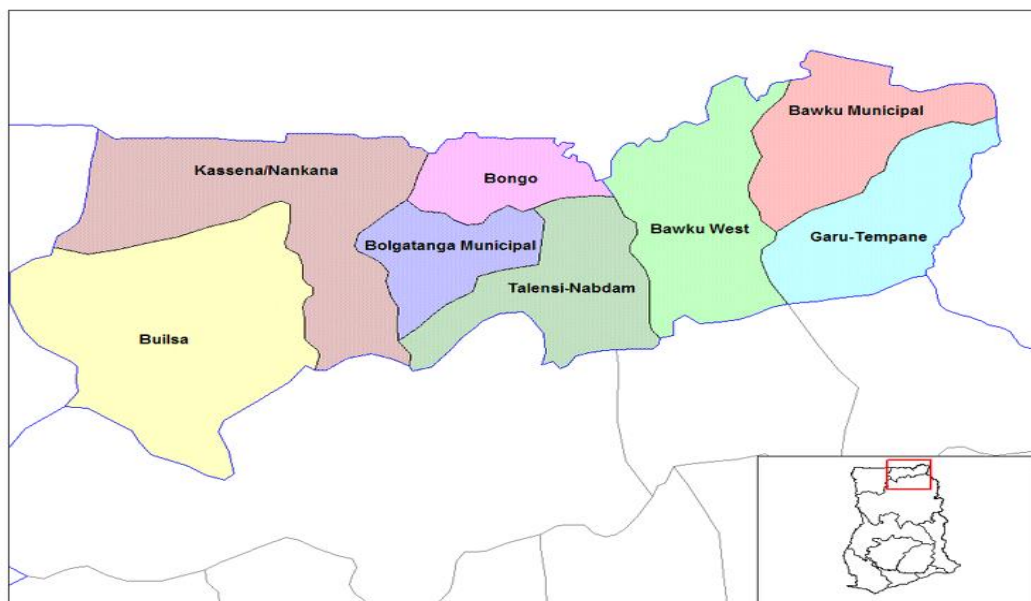
The Kassena-Nankana district is one of the poorest areas in the north of Ghana located in the Upper East Region. The district covers an area of 1,675 sq. km and is located at the border of the North. Bongo and Bolgatanga districts to the east, Builsa and Tumu Districts in the west and walewale district to the south surround Kassena-Nankana district. It is made up of 49% Kassem, 46% Nankam (ethnics making up the most population of the district and widely spoken languages) and 5% Bulisa (Ako. M, Akweongo, P. 2009).

Navrongo Demographic Surveillance System - NDSS (1993)[22] estimates about a third of the people to be Christians, 5% Muslims and the rest of the population as practicing traditional religion. Animist faith is dominant and guides daily life, economic decisions, health beliefs and other practices of the population. Despite of the differences, Kassena-Nankana district remains homogenous in cultures and traditional norms. For instance Nyarko Philomena, et.al

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[22] NDSS is a longitudinal household registration system, which was set up in 1993 by the Navrongo Health Research Centre (NHRC) to support research into the determinants of morbidity, mortality and fertility in an area typically representing Ghana's rural savannah zone. It started its baseline census in 1993, followed by compound visits at 90 day cycles to monitor demographic events.

(1993) identifies the district as male dominated, comprising of ten traditional paramount chiefdoms and characterized by traditional forms of village organization, leadership and governance. Male dominancy highly constrains women autonomy and decision making. The scholar further notes a strong traditional social structure influencing economic and social behavior at village and family levels (Nyarko Philomena, et.al 1993).

In 1999, the District's population was reported to be 140,881, slightly less than 1% of Ghana's population and about 15% of the total population of the upper East Region. Females account for 53% and males for 47%. The region is largely rural (90%) than urban (10%), its education attainment is quite low (Nyarko Philomena, et.al, 1993). About 65.5% of population aged 15 years have no formal education, whereas only 8.2% with senior secondary or higher levels of education (p.7). More females (74.6%) are uneducated compared to males (54.4%). Current school attendance among 6-25 age groups is lower for girls (48%) than for boys (54%). Meanwhile, about 55% of all the population aged 6 years and above have never been to school (Nyarko Philomena, et.al, 1993).

Ecologically, the district reflects characteristic of the vast Sahelian hinterland of Burkina Faso, Mali, Niger and the northern regions of Côte d'Ivoire, Ghana, and Togo (Sakeah Evelyn, et.al, 2006; Nyarko Philomena, et.al, 1993). Symbolized with climatic conditions of semiarid Guinea savanna of one rainy season, Kassena-Nankana's subsistence farming and animal rearing is increasingly constrained by decreasing rainfall, soil- erosion and depletion thereby affecting its agro-subsistence nature (Nyarko Philomena, et.al, 1993).

Low education and poor ecological conditions account for the high poverty levels and economic isolation among the Kassem and Nankam. Meanwhile, low education and high poverty can be correlated to FGM or vice-versa. FGM has been a fundamental feature of the transition to adulthood for Kassena, Nankana and Bulisa adolescent girls at least since the early 1900s (Adongo Philip, et.al 1998; 1998; NHRC 1999). It therefore affects females of the Northern Ghana in all ways, including disempowering them socially and economically.

Comparing FGM panel surveys of 1995 and 2000; in 1995 FGM prevalence was at 76% among the Kassena and 79% among the Nankana, with noted declines in 2000 at 53% and 54% respectively (NHRC, 1999). In 1995, 94% of women aged 35 years and above reported having been circumcised, compared to 26% of ages 15 - 19 years (Mbacke Cheikh, Philip Adongo, et.al, 1993; Adongo Philip, Patricia Akweongo, et.al, 1998), indicating generation

differences. However in 2000 panel survey, marked declines are identified in the very age groups. For instance from 94% to 83% of women aged 35 years and above and from 26% to 8% of those between 15-19 years (Adongo Philip, Patricia Akweongo, et.al, 1998); showing improvement within a period of 5 years, especially among the younger generations. Despite declines; individual status based on self-reports necessitates proper evaluation of intervention studies, for practical and ethical challenges resulting from criminalization of the practice in recent years instigates FGM denials (Oduro A.R, Ansah P, et.al, 2006).

8.3 Factors for FGM- concentration in Northern Ghana

Ethnicity is the most important decisive factor for FGM concentration in the North; its distribution affects prevalence levels. FGM is deeply entwined with ethnic identity wherever they are found (Ellen Gruenbaum 2001:102). However, even within the same geographical locality, the practice differs vastly by ethnicity and class (Abusharaf 2006). Consequently, among all socio-economic variables – ethnicity appears to have the most determining influence over FGM distribution within a country (UNICEF 2005:11).

Religious influence: FGM dates back beyond Christianity and Islam (Carr D, 1997), even though practiced by almost all religions including Christianity, Islam, Judaism etc. and Atheistic. The practice fulfills purely cultural doctrines (Lethome Ibrahim 2008, Momoh Comfort 2005, Obermeyer C 1999, WHO 1998, Muhammad Lutfi al-Sabbagh 1996, Nahid Toubia 1993). However religiously correlated (e.g. especially Islamic) reasons justifying FGM; shows difficulties in demarcating boundaries between religions and culture (Stewart M Loover, Knut Lundby. 1997), hence accounting for FGM – religious connections, persistence and high prevalence.

Despite the facts that mixtures of religions prevail in predominantly Christian Ghana, Islam dominates northern Ghana by 60%[23], hence possibly accounting for FGM prevalence levels in the North unlike South. The latest (2010) census shows 71.2% of Ghana's population are Christians, 17.6% Muslims, 5.2% traditional religionists and 5.3% not affiliated to any religion (Ghana Statistical Service 2012, p.6). Moreover, FGM is prevalently higher in Islamic- than Christian- countries/communities/regions (WHO 2011; UNICEF 2005; Momoh Comfort 2005; Jones Heidi, Diop Nafissatou, Askew Ian, Kaboré I 1999) as evidenced in the

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[23] Ghana Statistical Service (2012). 2010 population and housing census. Summary report of final results. Sakoa Press Limited, Accra. Available at http://statsghana.gov.gh/docfiles/2010phc/Census2010_Summary_report_of_final_results.pdf. Retrieved on 09.01.2016

Demographic and Health Surveys of 1989-1996 conducted in various (Kassamali, N. J. 1998 & Carr, D. 1997) and as currently confirmed by UNICEF and WHO (2014) researches.

Islam justifies FGM? It should be noted that Islam has more influence on behavioral practices of its followers – for it is not just theological – but also practical (Hussain Amjad 2009:239-242), less revolutionary and more conservative. A Hadith connects FGM to Islam, in a narration that took place between Prophet Mohammed and Um Habibah (or Um' Atiyyah) [24] as elaborated by an Islamic scholar — Sami A. Aldeeb Abu Sahlieh (1994)-a Palestinian-Swiss specialist in Islamic law. Prophet Mohammed is also said to have approved the act by stating; *"Circumcision is sunna (tradition) for the men and Makruma (honorable deed) for the women"* (Sami A. Aldeeb Abu Sahlieh, 1994:579. See also Thomas von der Osten-Sacken and Thomas Uwer, 2007; E.Herieka, J. Dhar. 2003). Meanwhile, a number of Islamic religious connotations in the Quran are interchangeably used to symbolize FGM (see Lethome Ibrahim & Sheikh Miryam, 2008). Correlating FGM to Islam has been dismissed by a group of Islamic scholars supporting FGM abandonment (e.g., Lethome Ibrahim & Sheikh Miryam, 2008) on grounds that even purely Islamic countries like Saudi Arabia do not practice FGM, misinterpretations of scriptures and individual based motives.

Influence of boarder communities across neighboring countries: FGM in the North of Ghana can also be explained according to geographical locations. The practice is a likely cultural diffusion from neighboring communities concentrated along Ghana's shared boundaries. For instance Cote d'Ivoire in the West and Burkina Faso in the North; whose FGM prevalence is 41.7% and 72.5% respectively according to DHS 2006 (WHO 2008), in comparison to Ghana's 3.8%. Togo on the other hand is the only bordering country (to the east) with less (4%) prevalence (UNICEF 2014). Similarly, type II is common among the four countries' (Ghana inclusive) mostly Muslim-population's affected groups (UNICEF 2013). Despite of differences in locations, common cultures, behavioral practices and belief systems cut across surrounding communities located in different countries.

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[24] Um Habibah (or Um' Atiyyah)—a woman known as an exciser of female slaves and said to have immigrated together with the Prophet. On their encounter, Prophet Mohammed asked if she still practiced her profession. The woman answered "unless it is forbidden, and you order me to stop it." Prophet Mohammed is then believed to having replied back to the woman saying, "…If you cut, do not overdo it, because it brings more radiance to the face (…) and it is more pleasant for the husband." (Sami A. Aldeeb Abu Sahlieh, 1994). Different Islamic religious scholars like Imams have dismissed FGM being a requirement in Islam basing on Quran arguments and other arguments like; the practice is condemned in Saudi Arabia, the center of the Islamic world. See- Sami A. Aldeeb Abu Sahlieh, (1994) To Mutilate in the Name of Jehovah or Allah: Legitimation of Male and Female Circumcision, *Medicine and law* pp 575-622

While trying to explain their similarities, a) possibly through interactions (e.g. through trade/economic activities & intermarriage which facilitate back and forth movement) these communities influence each other in behaviors or b) a possible existence of relatedness (relatives?) – Either these border communities were once united (one community) but eventually got divided in the process of demarcating geographical boundaries, hence ending up in different countries (see J.R.V. Prescott 1987; David Newman, "The lines that continue to separate us: borders in our `borderless' world" *Progress in Human Geography*, 2006, vol 30, no. 2, pp 143-161). J.R.V. Prescott in 'Political frontiers and boundaries' (1987) published by Unwin Hymann Ltd defines boarder boundaries as lines separating sovereign territories; a spatial system characterized by more or less exclusive boundaries that have become discursive constructs (and not static naturalistic categories) under inter-disciplinary approaches.[25] Partitioning Africa in disregard with people living within these territories was carried out with little attention of the cultural and ethnic character of the indigenous peoples (see J.R.V. Prescott 1987 pp 242-259), thus possibly separating identical communities with similar cultural characteristics.

Rural North/Development and urbanization in South: Meanwhile, because the southern part of Ghana is bordered by Atlantic Ocean, there is no direct influence of FGM practices. Absence of FGM in the south can also be associated with multi-culturalism and inter-race experiences given the fact that the region attracts tourists due to its location. The very factors have contributed highly to development and urbanization of southern Ghana, living the northern side rural. Development theorists (e.g. Donald J. Ziegler, Stanley D. Brunn & Jack F. Williams; World Urban Development 2003, pp1-46)[26] suggest that urbanization is a consequence of industrialization and economic development. Although, highly evidenced in developing countries is urbanization resulting primarily from rising and unrealistic expectations of rural people who flock the cities in search of green pastures – though often not finding it. Nevertheless, change in geographical location and challenges of meeting individual economic and social needs in urbanized cities, coupled with exposure to development and inter-culturalism – dilutes importance attached to FGM and its centrality when planning life.

Impoverished rural North: Ghana Living Standards Survey (2000) confirms that poverty rates are increasing in deprived areas of the country – Northern, Upper East, Upper West,

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[25]International Organization / Volume 55 / Issue 02 / März 2001, pp 215-250 Copyright © The IO Foundation 2001. DOI: http://dx.doi.org/10.1162/00208180151140568 (About DOI), Published online: 2003

[26] The authors are Editors of the Book – Cities of the World: World regional urban development. Third edition, 2003, Rowman & Littlefield publishers Inc. USA

Central and Western Regions. More than 50% of people there live below the poverty line and 30% live below the extreme poverty line of less than ¼ of a Dollar per day (GLSS 2000; see also Casely-Hayford.L, et.al, 2007, 2005, 2001, 2000). Poverty, low incomes- and low education levels are typical characteristics nurturing FGM - through ignorance/associated myths/community pressure, hopes in marriage to address the social-economic gap and for circumcisers as sources of income, high male dependency and women subordination. *"Out of the 18 countries covered by DHS or MICS, 12 demonstrate a higher prevalence of FGM/C in rural areas than in urban areas…"* (UNICEF 2005: p.6). Strategies against FGM today have been more diverted towards addressing the social-economic conditions and the gender gaps.

Education: Meanwhile, education as an explicit factor (especially girl child) in northern Ghana is lagging behind, yet a possible factor contributing to high FGM prevalence. Nii Armah Addy (2013, p 151) in his study "Contextualising the Underperformance of Rural Education in northern Ghana" quotes the National statistics of Ghana indicating the literacy rate among adults lower than 5%, and less than 40% of children up to 14 years attend school. The author explains that about 60% of children are out of school, most of whom are girls. Thus majority of children do not complete the compulsory nine years of basic schooling and consequently do not attain a basic level of literacy. However when addressed, education can improve gender imbalance situations, contribute towards general development and curb down FGM rates. *"Education, especially of women, can play an important role in safeguarding the human rights of both women themselves, and those of their children. Overall, daughters of mothers who are more highly educated are less likely to have under gone FGM/C than daughters of mothers with little or no education"* (UNICEF 2005:6). FGM-sequence can prove continuous if young generations are denied education opportunities. It should be noted that education is the main key to empowerment, if women are to make informed decisions and improve standards of living.

Limited multi-culturalism: Besides, an analysis of the 2000 Population and Housing census in Ghana showed that the proportion of inter-regional migrants in Northern, Upper East and Upper West were the lowest in the country (6.0 percent, 5.4 percent and 5.8 percent respectively). Other regions like Greater Accra and Western regions had much higher proportions of inter-regional migrants (36.9percent and 26.1 percent respectively) (Central Bureau of Statistics 1962 and 1975; Ghana Statistical Service 1987 and 2002). Migrations can help dilute the importance of FGM, through assimilations, intermarriages, adaptations,

integrations etc. As ethnics gradually diffuse and as generations change, FGM is very likely to eventually cease.

8.4 FGM in studied communities - Sirigu, Kandiga and Manyoro

Background Information

In 2012, I surveyed three communities almost neighboring Burkina-Faso. Sirigu, Kandiga and Manyoro, communities of study choice, are located in the upper east in Kassene-Nankana district – North of Ghana. Households are mainly grouped into extended family units or compounds, each headed by a male patriarch. Lineage customs, religious practices, marriage patterns and other social characteristics of the population are traditional.

FGM within the communities normally marks the rite of passage to womanhood and a key to marriage. However, unlike the Kenyan communities (e.g. Masaai) that practices FGM for the similar functions at lower ages - 12-14 years: circumcisions in the studied Ghanaian communities commonly affects ages up to 18 years - directly leading to marriage. Also, factors such as development of breasts, early menstruation and growth of pubic hair are additional criteria for performing FGM, because they indicate maturity. FGM may be performed in the village of the victims or that of the circumciser, depending on the latter's schedule.

However, FGM is no longer compulsory for girls nowadays. Change in attitude is associated with 'spiritual gods,'[27] whom upon consultations spare the girls from undergoing FGM (participants' view). *"It is often a girl's father or compound head who consults with a soothsayer[28] to determine if ancestral sprits designate a girl as being ready for circumcision or eligible for exemption from the practice,"* (Ghana, Narrative interview No. 1). In my view, human beings represent spiritual gods, whom upon sensitization (about the harmful effects of

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[27] Spirit gods in the African traditional religion are indigenous The African religions partly recognize a group of being popularly known as divinities. These beings have been given various names such as 'gods', 'demigods', 'nature spirits', divinities, and the like. These 'gods' are consulted in the everyday affairs and are believed to guide the people accordingly in different situations.

[28] Soothsaying is a traditional religious belief found among these communities. A soothsayer therefore acts as a spiritual medium between the world of the living and the dead. He/she passes over spiritual messages from the ancestral spirits to the living once consulted about particular issues. Soothsayers are believed to explain the past, interpret the present, and forecast the future. In the three communities, every lineage is headed by a male/patriarch in the traditional family system, who is responsible for consulting a soothsayer in family matters including whether girls were eligible for FGM or not.

FGM) amidst increasing campaigns eventually change their attitudes towards FGM. Thus, when consulted (by parents) to intervene within the spiritual world and give a feedback to the living – as medium of communication – spiritual gods- representatives nowadays pass on a message of abandonment.

8.4.1   Social-demographic characteristics of participants

During the survey, a total of 55 questionnaires were distributed. Fifty questionnaires represented communities and five - NGOs (personnel). Both Sirigu and Manyoro had a representation of 15 persons each and Kandiga 20.   Because of the limited number of participants per study community – resulting from limited time and resource challenges – data is therefore generalize without focusing on single community analyses. While single communities' analyses enables identify behaviors patterns unique in specific community, generalization of data may limit/under look such outcomes.

Out of a total number of 50 study participants, 90% were married and 10% single. Participants aged 45 years and above made up 56% of the study and the rest fell under 15 - 44 years old. More females (96%) than males (only 4%) participated in the study; because males showed less interest in questionnaire surveys, although a handful participated in discussions. Employment status shows 84% informal occupants (indulging in farming and herding) and only 12% formal occupants, with the rest giving no response. Sirigu and Manyoro were each represented by 30%, Kandiga 40%. Generally, majority (84%) participants had lived in their study areas for all their lives.

8.4.2   Practice: The distribution patterns of FGM

Includes on one hand - all respondents/study participants; and on the other - women analysis per FGM status (whether circumcised or not).

All respondents

According to the survey, 96% shows that FGM is no longer a common practice. Reasons attributed to such changes include fear of health complications (42%), cultural reasons (18%) e.g. FGM not recommended by spiritual gods, sensitization and awareness creation (16%) and government policies (14%). Nevertheless excisions accounts for 86% and Clitoridechtomy 12%; taking place mainly in the third quarter of the year (76%), without Infibulation traces. FGM takes place mainly at 18 years or above as indicated by 62%, purposely for marriage

arrangements, even though a decline to 11-14 years is identified. By the age of 20 years, most females in Ghana have already undergone some form of FGM. By the time of survey, 74% were already affected compared to 26% females who had escaped FGM. Younger ages between 15-26 years show significant behavioral changes than any other age group, signifying FGM- abandonment by generation trends. Indeed 40% of mothers, who participated in the survey and had FGM eligible-daughters, observed that none of their daughters had been cut even though they (mothers) had undertaken the procedures (victims).

However, about 10% admitted having cut their first-born daughters, preparing them for funeral roles in the future. A correlation between FGM and funeral (cultures) emphasizing circumcision of first-born daughters is given accordingly: "*First-born daughters carry their deceased mother's personal effects in the funeral process. Personal effects include, the piligo, a pot that a woman keeps as a safe for all her valuable and emergency items. Only a circumcised first-born girl is supposed to carry it during the mother's funeral. This pot is finally broken during the burial ceremony. When a woman dies uncircumcised, she will be buried like a man. She will be sent off without household accessories such as a calabash and a pot that indicates her femininity role accomplished in the world of the living*" (Ghana, narrative interview No.2; see also Ghana recordings, FGD no.1).

Decision making process is 42% influenced by family (parents) and 40% self-made. Given parental role in making FGM decisions; men (fathers) do not necessarily initiate FGM. However, their opinion in the matter counts as narrated by an elder woman. *"If the fathers as family heads do not permit circumcision of the daughters once consulted by the mother, then FGM is not performed"* (Ghana, Narrative Interview No. 3). Meanwhile, women (mothers) mostly influence daughter's decisions; as shown by male participants in Manyoro. I) *"It is the mothers who push their daughters to be circumcised in order to be positively represented in the village. If the daughter is not circumcised, the mother is seen as irresponsible."* II) *"If a mother does all that is necessary for a daughter, minus circumcision, she has failed in bringing up her daughter well."* III) *"Mothers, who witness their daughters being circumcised, are made proud and respected."* IV) *"Sometimes we are not even aware that our daughters have undergone FGM. But we are made to realize when our wives ask for the circumciser's payments"* (Ghana, Narrative Interview No. 4)

Explanations for the 40% self-made decisions as indicated by the survey are mostly ignited by outside pressure faced after or before marriage. One married woman elaborates, "*Once a*

woman gets married before circumcision, her father's compound ceases to have any influence. But co-wives, mothers in laws and sisters in law exert pressure until you give in" (Ghana, Narrative Interview No. 5a). Pressure may be in form of insults and mockery. An uncircumcised bride is denied full responsibility (e.g. cooking) in a new home. She is not even allowed to go at the backyard/garden *"because when she crosses a calabash plant, it withers/dries off/does not bear fruits"* (see Ghana recording, FGD No.1). Also, many other misfortunes that happen in the man's home may also be attributed to the uncircumcised bride. Tensions of co-wives flaunting their circumcision statuses and openly insulting uncircumcised brides; instigates pressure to undergo FGM, even though the husband may not have interests (Ghana, Narrative Interview No. 5b). In this case, FGM decision-making process is affected by change in a woman's status (for instance upon marriage) – which may diminish her autonomy.

Even though FGM in Manyoro and Sirigu is related mainly to health associated effects like excessive bleeding, infections and pains (62%) and social complications like sexual difficulties, none-satisfaction, and psychological disorders (30%): Kandiga raised more doubts about any such complications based on arguments that claims capitalized on nowadays never existed in the past. Meanwhile, traditional specialists/barbers account for 82% of all procedures done, no medical interventions are noted.

As observed in the three communities; not being circumcised means facing community/social problems (40%) or stigmatizations from family and community (40%).

As Abusharaf (2006:8) elaborates, "it is clear that this practice is entangled in an ideological web of social relations in a given community of practitioners. This conception not only illuminates the way in which ideology shapes practice, but also contributes to comprehension of how emotional ties to specific rituals take hold and prosper." See also the experience of Wairimu Ngaruiya Njambi (2004). Done usually immediately after the harvest of the early millet crop in August to sustain FGM celebrations and payments (Adongo.P, Akweongo.P, et.al 1998), type II (excision) is widely spread in Ghana (The US department of state 2001-2009), highly prevalent – 77% - among Nankana and Kassena women aged 15-49 years (NHRC 1995). Eldest daughters are highly affected and under more pressure of adhering to FGM in Ghana (USAID 2006:10). However, declines and positive changes are observed

especially between 15-24 years (UNICEF 2013 - GOV of Ghana[29]; A.R Oduro, P Ansah, et.al 2006) just like in Kenya (Jane Njeri Chege, et al 2001), Ethiopia (UNICEF 2012) and elsewhere in Africa (UNICEF 2012; 2005). Despite declines, pressure from co-wives is common in Ghana, hence enforcing FGM among fresh brides. Underlying reason is the fact that most marriages in Northern Ghana are polygamous and co-wives share compounds, headed by a single man (Adongo, P, Akweongo, P 1998; Mbacke, C., P. Adongo, et.al 1998). Medical complications are common (Mahran M 1981; Jones H, Diop N, Askew I, et al. 1999; WHO 1996 and 2008; Larsen U, Okonofua FE 2000; FORWARD 2000), depending on type performed (Shell-Duncan et.al 2000; Obermeyer 1999) with mild procedures having lesser risks (Obiora 1997:86-87): Nevertheless, not justifiable because FGM (no matter the type) violates a variety of (girl) children and women rights.

Women respondents

Out of 48 women participants, 37 were circumcised mostly at 18 years and above and were all married. Only 11women were not circumcised – from which 6 were married and 5 single. Basing on the study, clearly marriage plays an important role in accommodating FGM, whereas status (single or married) affects/influences prevalence. FGM is a key to marriage, through which children are born and kinship prolonged.

FGM defines feminine sexuality and gender roles (Abusharaf 2006). Moreover, observing marriage institutions (Beth Greene 1998) especially in FGM practicing communities; illustrates conditions of women in society that fundamentally reflect economic structures of dependency (Cole 1980).

The employment variable shows, out of the 37 circumcised-women - 34 have informal- and 3 formal jobs. Mostly the non-circumcised women occupy formal jobs, even though a few in number (only 11). Theoretically, FGM may influence employment status or employment status affects FGM. Uncircumcised women stand higher chances of finishing school and pursuing careers, whereas such chances are limited for circumcised women, who usually fulfill expected typical gender roles (e.g. marriage, childbearing and homemaking) after undergoing FGM. Consequently; employment variable is likely to affect or influence the empowerment status of women and decision-making process of being circumcised or not (or

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[29] Government of Ghana (Official portal) Female Genital Mutilation declines in Ghana: UNICEF Report. 24 July 2013. http://www.ghana.gov.gh/index.php/2012-02-08-08-32-47/general-news/2108-female-genital-mutilation-declines-in-ghana-unicef-report. Accessed on 19/06/2014

daughters' future-status), observable mostly in countries with lower FGM prevalence (e.g. Ghana and Kenya unlike Egypt).

8.4.3 Strategies implemented against FGM: Field experiences from organisations

Community survey

Given the community survey, government intervention constitutes 54% (e.g. Ghana Health Services) and NGOs 46% (e.g. Navrongo Health Research Center and Ghana Association of Women Welfare). Community based approaches (communities spearhead abandonment activities. Localized participation avoids criticism of foreign influence) account for 56% and health risk approach (offers breakthroughs into discussing the taboo topic but criticized for leading to Medicalization of FGM) incorporates 42% of abandonment methods used. Human rights approach as a stand-alone abandonment measure had no scores at grassroots communities of Ghana, possibly because it is highly associated with criminalization.

Geertz (1983) argues that laws and ethnography works by light of local knowledge, hence the need to involve grassroots communities in policy - formulations and sensitization.

Organizations' survey

Navrongo Health Research Centre (NHRC), Ghana Association of Women Welfare (GAWW) and Ghana Health Service (GHS) were pointed out by surveyed-communities, as organizations dispersing FGM-abandonment messages at grassroots. This constituted underlying choice criteria of (organization) inclusion and exclusion in the 2012 survey. Upon approach, GAWW was the only organization with on-going FGM projects. NHRC and GHS had ceased to work with FGM issues, even though had prior been actively involved with remarkable success (particularly NHRC), which will be the basis of the following discussion for both organizations. Possibly, positive remarks left behind in past interventions led to NHRC and GHS' acknowledgement at the time of the research.

A) Ghana Association for Women's Welfare (GAWW)

Founded in 1984 with main offices in Accra, GAWW is a non-government charitable organization working on women rights issues, particularly gender based violence at grassroots levels countrywide. GAWW is also a charter member of the Inter-African Committee on Harmful Traditional Practices Affecting the Health of Women and Children – IAC, hence its

underlying factor for full engagement with FGM issues in highly prevalence – Upper East, Upper West and Northern regions of Ghana.

Parallel to field interview No.6 – Strategy; Florence Ali, GAWW - the organization uses grassroots education to change tradition, superstition and beliefs about FGM. GAWW trains and initiates a group of people from the local communities, to take over abandonment activities outside established institutional frameworks. It involves local leaders such as community, ethical and political leaders to organize and conduct workshops against FGM. The organization has given community leaders prominent roles in the process, hence recognizing their importance in the communities and assuring GAWW support. The organization also encourages community leaders to form watchdog groups from their communities and alert the organization when FGM ceremonies are organized. GAWW intervenes by notifying the police if necessary. The organization also sometimes offers refugee to girls escaping from FGM. GAWW also uses brochures, graphic educational films and models on female genitalia to illustrate the procedures and sensitize on the harmful effects of FGM. GAWW further illustrates on the laws prohibiting FGM. Groundwork has made communities receptive, which has assured attendance of FGM workshops. In 2012 during field survey, the current strategy activity was GAWW undertaking consultations with the ministry of Education on incorporating FGM education and trainings into the public schools- and health curriculum. More so, working on a minimum budget, GAWW has won support of many traditional chiefs and influenced the explicit law banning FGM in Ghana.

In the Independent Newspaper of March 18, 2013[30] Florence Ali – GAWW leader informs *"we were the first civil society organization to bring the harmful effects of FGM on women and children to the attention of the general Ghana public at a time when the issue was taboo (...).* We were involved in pioneering the enactment of a law banning FGM in 1994 and its subsequent amendment in 2007. Our work has included research, promoting the implementation and influencing change in legislation on FGM, organizing public advocacy events and campaigns, educative and literacy programs and finding ways of assisting "circumcisers" to exchange their knives for other forms of viable employment" US department of State archives (2001-2009) confirms WHO in corporation with GAWW and MFCS (an Islamic NGO) having toured 210 villages in Volta region in early 1997 and

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[30] The Independent; Monday 18th March 2013. FGM in Ghana: What local African organizations are doing to eliminate female genital mutilation; Monday 18th march 2013. http://www.independent.co.uk/voices/comment/fgm-in-ghana-what-local-african-organisations-are-doing-to-eliminate-female-genital-mutilation-8537898.html. Viewed on 14/10/2013

identified 18 practitioners, to whom they provided information and sensitization about the practice.[31] Many of these circumcisers eventually gave up their work, but still need support to finding alternative means of income generating activities (GAWW 2010).

Challenges in my opinion are: Dealing with the supply side (the excisors) and not the demand side (practicing communities) may not guarantee behavioral changes. The possibility is high that circumcisers will fall back to prior behaviors, due to lack of or less sustainable sources of income on one side and increasing demand of those who want to be circumcised in exchange of payments on the other hand. In other words, when income activities identified to replace FGM are not well income generating as expected and sustainable, there is a risk of excisors performing FGM for additional incomes. Additionally, watchdog groups created from within communities may be vulnerable to violent attacks from radical groups, since they are perceived as enemies of own cultural tradition, fueling imprisonments/criminalization within their own communities. This calls for protective measures for watchdog groups. FGM has also become an underground activity because of criminalization – performed on minor ages (because are still under parental care) or across boarders (where law enforcement is inactive) or secretly within communities.

GAWW leader also criticizes the lack of NGO and government combined support to address FGM (Interview No.6 – strategy; Florence Ali, GAWW). In the independent newspaper, she states, *"Half-baked external solutions, whose simplistic narratives may satisfy donors and a Western audience, often obscure the real issues and the challenges we face on the ground on a daily basis."*

Nevertheless, noted progress includes remarkable declines of FGM prevalence, community cooperation and spearheading community activities towards behavioral changes, policy influence and receptiveness of FGM-abandonment activities at grassroots (Interview No.6 – strategy; Florence Ali, GAWW).

B) Navrongo Health Research Centre (NHRC)

Based in the upper Eastern region with its headquarters in Navrongo, NHRC was established in 1988 as a field site for a child survival study. Eventually in 1992, the Ministry of Health adopted the facility and its mandate broadened to include population and health problems with a focus to major causes of illness in Northern Ghana (Feldman-Jacobs.C, Ryaniak.S, et al.,

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[31] Ghana: Report of Female Genital Mutilation: 2001-2009 Archive for the U.S Department of State. http://2001-2009.state.gov/g/wi/rls/rep/crfgm/10100.htm. Viewed on 14/10/2013

2006, pp 10-18). FGM being one of the causes, NHRC officially started collecting data on FGM in 1995 as part of an ongoing surveillance system that records demographic events in the entire Kassena-Nankana district. Apparently, a clinic-based study of pregnant women seeking prenatal care in 1996 confirmed all three types of FGM being practiced – especially excision affecting ages 15-49 years (Feldman-Jacobs, C. et.al 2006). Consequently, in 1999 followed a launch of the dual program of action and research by NHRC called the Navrongo experiment, in collaboration with local government (GHS) and NGOs (Philip B. Adongo, et al., 2005; Feldman-Jacobs C, et.al. 2006). This experiment meant to test and compare FGM interventions and strategies, with focus on different groups. Survey took place each year, resulting from five rounds of data collected from 19,000 interviews in six villages. The main objective was to accelerate FGM abandonment in the Kassena-Nankana district and to measure impact of various strategies on reducing FGM in the rural society. The project ran for 5 years (1999-2003) with funding sources from USAID, Action Aid Ghana, Maata N Tudu and Swiss Embassy Accra.

Strategies tested to accelerate FGM abandonment included (Philip B. Adongo, et.al 2005; Feldman-Jacobs, C. et.al 2006) education and livelihood training, involving extensive community engagement and mobilization, reproductive health education, literacy and numeracy training.

The education model alone aimed at sensitizing about reproductive health, health effects of FGM, menstrual cycle, marriage, pregnancy, childbearing and childcare. The intention of the model was to replace the family education that girls traditionally received as part of rites of passage to adulthood. Night education using FGM videos and discussions at various central locations mainly targeted men and working groups, while clinic programs targeted expectant mothers. Health education programs at school, singing and drama competition among different groups of females also aimed at capturing the attention of school going children. Meanwhile, radio programs captured the tuned in listeners. Discussions incorporated cultural expectations regarding adolescent girls and women, and also sought to reinforce positive expectations and provided lessons for discarding negative harmful practices. Education strategies were associated with 93% reduction in FGM incidence, relative to no intervention exposure (Philip B. Adongo, et.al 2005).

On the other hand, livelihood and development models meant to increase the economic empowerment of females, through trainings on production and marketing of crafts and micro

lending to women groups. Other livelihood skills included basic bookkeeping, managerial skills, identification of income generating activities, and identification of sources of finance, skills necessary to produce items that would sell within the community, research and marketing skills. Combined exposure to both strategies was associated with reduction in circumcision, although results suggested that problem-focused community mobilization substantially reduced FGM incidence. Yet, additional livelihood interventions had no incremental impact (Philip B. Adongo, et.al 2005).

Following field experience – view I (Ghana, NHRC recordings No. 7): One of the facilitators, researchers and publisher of the above analyzed studies narrates the process taken and challenges faced in implementing activities in the upper East. In his words, *"After circumcisions, the girls have at least one year to get married. We (facilitators) decided, instead of us trying to eradicate it* (FGM)*, let us look for the source… We were now finding innovative ways… All people gave us problems, especially elderly. When we* (facilitators) *started with night programs* (an intervention)*, we showed the videos clips (in a video, they were circumcising a young woman and she was crying). One; it is against* (community) *culture to expose a woman's part… Two; when we were letting them* (women) *sing anti FGM songs, they* (elderly) *also criticized that… We* (facilitators) *are making the women to insult themselves because almost all of them were circumcised… All the songs were anti FGM, insulting, like trying to tell them* (community) *that FGM is not good; they* (women) *composed songs, very beautiful songs for senior competitions that we* (NHRC) *organized. So criticizers were saying that those who can insult well were always the first ones - (It was though the song competition aimed at finding out those who can insult women well). Songs like "if you are circumcised, it means you have no gate, you just enter… or if you are circumcised, it means your vagina has no teeth…"* were nice songs that could score marks. *But to them* (criticizers), (women) *are insulting themselves, because they are all circumcised…"* (See Ghana, NHRC recordings No.7).

The NHRC informant further elaborated that protectors of the tradition were keen about promiscuity, hence the need to circumcise children when they were still virgins. Underlying factor was the fear that women coming from big towns/cities (the southern part) were not circumcised and already exposed to promiscuity, thus the fear of 'bad' behavioral influences. Cutting girls meant protecting them from bad influences and assuring virgin brides.

When facilitators pointed at the sharing of unsterilized instruments during FGM process - circumcisers claimed washing instruments before re-use at virgin girls. Hence, arguing against claimed disease transmission from one person to the other.

According to the informant, justifications for FGM included arguments like *"if the clitoris touches the child's head, the child will be stubborn. You cannot control the child. So they were giving points and telling us, why should we stop? Nobody ever died during circumcision. If you die, there is a reason, because you refused to confess your immoral acts. They even believe that, that* (FGM) *is a spiritual thing"* (Ghana, NHRC recordings, No.7).

About the medical complication theories like bleeding to death, pains and delivery complications, *"some woman came and confessed that she had given birth to about ten children, without any such complications."* As claimed, women do not go to hospitals - deliveries take place home by the help of traditional birth attendants free of charge and are safe. Given difficulties at birth, women argued that even the non-circumcised die during operations, so there is no way that woman vaginas are affected by being elastic or not at birth. On the issue of pain after or during FGM – pain seemed to be bearable; *"after circumcision, women get up and dance."* The elderly people also compared piercings to pain and FGM to delivery - where the joys of giving birth covers or goes beyond the pains underwent during birth-process, thereby calling for celebrations. About sexual satisfaction, "*that is an imaginary thing… women are happy with what they get…"* (Ghana, NHRC recording No.7). However, men views show that if a woman is not able to satisfy them sexually, they are ready to look for sexual satisfaction outside their marriages or relations (see Ghana, Men's debate, recording No.6). Women are strictly forbidden to do such.

The facilitator admits that it was very difficult to influence the communities. *"The good thing the law was there. Therefore, we used force and one circumciser was arrested… So who will circumcise them?"* Moreover, circumcision is not carried out by just anyone. If one dies for instance, the heir has to be appointed within the family to take over the job. This is one of the reasons why the practice has reduced. *"The circumcisers are not there. Initially, they used to cross boarders, and do it from there, or invite them over. Now, they are afraid, because of the law. Then also, the distance is letting them down."* It was a battle to influence behavioral changes, because community members were arguing out all reasons sustaining the practice (Ghana, NHRC recording, No.7).

Field view II (Patricia Akweongo (author of several FGM materials in Ghana & head of the Navrongo experiment), University of Ghana - public health department, recording No. 8): When the law banning FGM passed, Navrongo added a question on FGM. In the study done, 78 % of the women were found having been circumcised. The problem was even higher in the East of Kassena-Nankana district.

Given the conspired strategies, interventions targeted adolescents because by the age of 18 years, girls were already circumcised. NHRC intervened with a five-year project, from 18 years and below. By the end of the project, the prevalence had declined in the district. The first year after implementing the project, 11% reported having been circumcised. After four to five years, reporting were now only 3%. It was a four-cell intervention strategy involving a) education and livelihood activities (making soap and weaving, poultry, make food), b) education on health effects, c) a combination of both mentioned strategies, and d) the control arm, where no intervention took place. These strategies were formulated on principles such as engaging adolescents and giving them empowerment skills. Otherwise if not actively engage, adolescent girls get married faster.

"Another issue was about empowerment. If you are empowered, you can negotiate, you can refuse to be circumcised. But when you don't have any negotiation skills, you don't have any power." This was the basis of designing interventions. People who were outside school were also well targeted by the livelihood arm. "*When dealing with people outside school, you got to actively mobilize them in a calculated way.*" About 70% of girls were not in school. Parents do not easily allow their children to go just anywhere anyhow. With the livelihood skills, this was of practical benefits and a reason for letting girls attend such engaging activities. It should be observed that FGM is not all about cutting; it involves also teaching girls life skills. *"So we were replicating the traditional activities in a modernized way, minus the cut."* Results showed that with intensive education, people are likely to stop FGM**.** FGM challenge continues and hence the need for continuous activities. However, the main challenge in it is lack of funding (Ghana, Patricia Akweongo[32], recording No.8).

Despite of the past initiatives against FGM, the center has no current activities about the practices. The NHRC administrator in 2012 confirmed that the center was having Malaria projects ongoing. FGM was not any more a focus area and the people who were intensively

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[32] Patricia Akweongo was among the coordinators of the five-year Navrongo experiment project. Together with other scholars, she has published a number of books and papers about FGM in Ghana. By the time of research (2012), she was working at the University of Ghana, in the public health department.

involved eight years back, had all left the center - apart from one person. This person participated in the study as seen in the Ghana, NHRC recordings No. 7.

C) Ghana Health Services (GHS)

GHS (www.ghanahealthservice.org)[33] is a public service body established under act 525 of 1996 constitution. It is an autonomous executive agency responsible for implementation of national policies under the control of ministry of health through its governing council. GHS' special emphasis is primarily health care at regional, district and sub district levels. The body promotes health mode of living, good health habits, performs functions relevant to the promotion, protection, and restoration of health.

Despite study participants from grassroots mentioning GHS as an active organization against FGM in their communities, personal efforts to find out FGM strategies and general comments on FGM activities from the organization itself indicated no footmarks of active involvement. One GHS top official clearly noted, *"The body collaborates and relies mostly on research that is made by other organizations"* (Ghana, Narrative Interview No.7). Indeed, Phillip B. Adong (2005) confirms that the Navrongo Health Research Centre (NHRC) collaborated with the Ghana Health Service in 1995 and conducted research to understand FGM practices in Nankana-Kassene district.

Generally, the inconsistent reports from both the community and organization itself fail to give a clear view on the role played by government institutions in ongoing abandonment campaigns. Consequently, the question that cuts across my mind is – what kind of influence/impact does GHS have at community levels? Though this question remains unanswered, one organization criticized the government for borrowing its speeches against FGM, yet there is no political will and motivation to tackle the practices.

From my side, not much can be written about GHS, later on its contribution towards FGM abandonment. Even my additional efforts of contacting other government institutions that might have direct concerned with FGM – like Ministry of Health, Ministry of Women and Children's Affairs (MOWAC), The Ghana Central Police Station (GCPS) to get the government view and strategic contributions towards abandonment also confirmed no positive

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[33]Ghana Health Service, http://www.ghanahealthservice.org/aboutus.php?inf=Background. Viewed on 22/02/2012

stance of involvements whatsoever. Following several visits on appointments, there was no single success of even attaining a written report, conversation or an interview on FGM issues. Rather, I was tossed around from one office to the other. Apparently, such governments have been criticized for failing to give FGM issues the attentions they deserve and being reluctant in taking actions (WHO Bulletin 2004; Brennan Katherin 1988-1989).

8.4.4 General challenges towards abandonment and recommendable solutions

The fact that most local organizations still heavily rely on financial support, limits local NGOs activities and their field of maneuver. In addition, there is increasing worry about the loss of particular advice and counseling that women give their daughters, because reproductive issues are now discussed openly and extensively as part of FGM intervention strategies. Similarly, girls no longer hold their mothers' teachings with high regard because of 'outside' influence and trainings offered regarding reproductive and children rights issues, which issue is worrying parents. There is also deep concern about term-use in public spheres (e.g. vagina and clitoris) during FGM abandonment campaigns, which demoralizes community cultures. Arguments indicate that reproductive organs are private. They should be discussed sacredly and audiences ought to be defined. Meanwhile, girls already circumcised may fail to get husbands, because of the current males changing preference of uncircumcised girls. Lastly, limited government participation raises queries of priorities in gender balance and developments at local levels.

As solutions: NGOs should try to make the best out of the limited resources at disposal and avoid heavily relying on aid. This can be done by for example recruiting local experts from surrounding communities and cut on costs and expenses used to maintain highly qualified personnel. Mothers should be trained and given the opportunity to lead the discussions in reproductive and sexual field instead of recruiting outside experts. This implies that NGO activists should take a (supportive) back seat and let community members take a driving seat in identifying problems and finding solutions. The down-top influence in abandonment strategies should highly be considered to allow active participation and use of local expertise to formulate socially and culturally accepted ways of tackling FGM. This will also offer solutions to selecting language use for preferable audiences. Further still, just as religious leaders are making all possible ways to delink FGM from religion, cultural leaders should also do the same (delink cultural beliefs such as funeral rites, ancestral spiritual connections from FGM) and results be well document as proof. International pressure may also be necessary to

enforce gender balances and local developments at grassroots through aid allocation pressure technique.

8.4.5 Progressive reports and opportunities against FGM

Conclusively: Despite considerable evidence of the continuing social value of FGM, there is some indication that support for the practice is eroding and the prevalence of circumcision declining. Indeed, progress against FGM in studied communities has been rated by 90% of study participants as 'good'; which shows a positive attitude towards project engagements and readiness for FGM abandonment. Out of the 74% circumcised participants, 40% observed having spared their daughters from FGM. Underlying factors for declines and change in behavioral practices include fear of health complications (42%), decreasing role of culture (18%), increase in sensitization (16%) and government policies (14%). Whereas none of the participants supported maintenance of FGM, 94% were clearly for abandonment.

In my opinion, ridicule once directed to fostering FGM, is now directed to deriding the practice. However, shifts of change towards targeted groups for stigmatization (circumcised women) needs to be checked in time. In addition, the weak significance of FGM to husbands has diluted the relationship between FGM and marriage through changes in male marriage preferences. More so, although fears of women's sexuality once provided a rationale for FGM practice, there is evidence that sexual perceptions of uncircumcised women may be contributing to changing social acceptance of uncircumcised women.

Opportunities to be relied upon include the fact that people are willing to abandon FGM and ready to change their behaviors. Once social and economic conditions at local levels are improved, there is a likely possibility that FGM abandonment and behavioral sustainability will be highly observed. Changes among the youth towards FGM practices indicate increasing possibility of FGM free future generations in Ghana.

9   FGM IN EGYPT

Egypt is one of the countries with the highest FGM prevalence in Africa, thus being categorized under Group 1 (UNICEF 2005). With a recent population estimate of over 82 million people (World Population Review 2014; see also www.escwa.un.org[34]), Egypt's latest Demographic Health Surveys (2008) reveal 91.1% aged 15-49 years having undergone through some form of FGM.

Given its background – geographically Egypt is located on the northeast corner of the African continent. It is bounded on the north by the Mediterranean Sea, on the south by Sudan, on the east by the Red Sea, and on the west by Libya. Historically, the country was incorporated into the Ottoman Empire in 1517, became a British Protectorate in 1882 and gained full independence in 1952 (CIA 2010). Dominant religion is Islam (mostly Sunni) making up to 90%, Coptic 9%, other Christian 1%. Egyptian speaking Arabic are 99.6% and 0.4% others (CIA 2010). Social-economic developments indicate Egypt as a lower-middle income country, with much of the population living in poverty – particularly on the countryside.[35] Female literacy rate is lower than that of males (Fatma El-Zanaty and Ann.A.W 2001), with female estimates at 58% and men 75% (GIZ 2011). Female participation in the labor force represents only 18% of male participation, literate population in rural areas is two-thirds the literate population in urban areas. (Fatma El-Zanaty and Ann.A.W, 2001; see also Nawar Laila, 2010[36]).

9.1 FGM prevalence in Egypt

Egypt Demographic Health Survey (EDHS) show a decrease of FGM from 97% in 2000 (El-Zanaty F, Ann Way 2001), to 96% in 2005 (El-Zanaty, Fatma and Ann Way 2006) and eventually to 91.1% in 2008 (El-Zanaty, Fatma and Ann Way 2009), with significant changes in the later records. WHO Bulletin estimates affected female students per governorate to be 85.5% from Luxor city, Assuit 75.5%, Beni Suef 73.1%, Sharkia 73.9%, Cairo 36.5%, and Port Said 17.9% (Mohammed A Tag-Eldin; et.al, 2008). Median age of FGM is 10 years, however in Upper Egypt girls are cut at much younger ages than in Lower Egypt (UNFPA-

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[34] The demographic profile of Egypt, http://www.escwa.un.org/popin/members/egypt.pdf. Viewed on 06/05/2011

[35] World Bank (n.d.) Data: Egypt, Arab Rep., http://data.worldbank.org/country/egypt-arab-republic. Accessed on 23/03/2013

[36] Nawar Laila: Socio-Economic Characteristics of the Population, Egypt. http://www.statssa.gov.za/assd2010/Presentations/6th_ASSD/Dr%20Laila%20Nawar-Egypt.pdf. Viewed on 06/05/2013

Egypt[37]). Types 1 and II are common (Al-Hussaini TK 2003), medical personnel account for three quarters of procedures undertaken (UNFPA Egypt).

Declines are observed in behavioral change analyses of those supporting FGM-continuation – from 82% in 1995 to 63% in 2008 (UNICEF 2010). Despite higher prevalence among mothers, generation trends show improvement by 69% of daughters affected as per the Egyptian ministry of health and population study (Mohammed A Tag-Eldin, et.al 2008). UNFPA's (2008) technical report on global consultations of FGM associates these declines with government bans and policies (e.g. 2007 anti FGM decree passed by the Ministry of health, the 2008 child law amendment passed by parliament criminalizing FGM), which were strengthened after the death of a 13-year-old girl in the governorate of Minya, who died in the hands of the doctor during circumcision (UNFPA 2008).

The death-developments sparked political-religious activism, including Susan Mubarak's (the then first lady of Egypt) personnel engagements in the campaigns ending FGM.[38] The supreme Muslim council issued a Fatwa against the practice, on ground that FGM has no Islamic basis (GIZ 2011). According to the research and information service section of the refugee review tribunal in Australia (2008:10), *"The Grand Sheikh of Al-Azhar (Mohamed Sayed Tantawi), the Grand Mufti (Ali Gom'a) and the Minister of Muslim Religious Endowments (Mahmud Hamdi Zaqzuq) expressed the views, that FGM is condoned by the Holy Qur'an and by the teachings and traditions of the Prophet Muhammad…"* Despite such activism; traditional-, customary- and religious beliefs coupled with Islamic conservative regimes still hinder the substantial progress of FGM abandonment in Egypt.

9.2 Reasons for highest FGM-prevalence

Enormous factors contribute to FGM universal trends in Egypt as compared to other countries (e.g. Kenya and Ghana).

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[37] UNFPA Egypt: Who performs it and when. http://egypt.unfpa.org/english/fgmStaticpages/8b9eaf39-33d5-4ff5-924b-7e0b76d1091d/Who_performs_it_and_when.aspx. Viewed on 10/03/2014

[38] „ Egypt's First Lady Suzanne Mubarak stood in the Regional Conference for Combating Violence against Children (June 2007) to announce the National Campaign for Eradicating FGM "The Beginning of the End". Mrs. Mubarak, Chair of the National Council for Childhood and Motherhood (NCCM) Technical Advisory Committee formed a high level action committee which included ministers of Health, Information, Awkaf, Education, Higher Education, Social Solidarity, the head of El Azhar, Dar El Ifta, the Orthodox Church Representative, and the Medical Syndicate. Moreover, H.E. Mrs. Mubarak requested that all actions should be coordinated under the NCCM body." Cited from: Abandoning FGM in Egypt, http://www.powregypt.org/upload/Attachment%203.En..pdf on 24/06/07

Originality: Though there is no clear knowledge of origins of FGM, cultural theorists indicate probable FGM's historical roots to be the Nubian region of the horn of Africa – recognized today as Egypt and northern Sudan (ORCHID project 2012). Also, the first historical reference to FGM can be found in the writings of Herodotus, who reported its existence in ancient Egypt in the 5th century B.C. He was of the opinion that the custom had originated in Ethiopia or Egypt, as it was being performed by Ethiopians as well as Phoenicians and Hittites (Taba, A.H., 1979). The practice is dated back around 200 BC, performed by both the upper-ruling and lowest-slave classes – most probably for distinction and fidelity purposes and others as a mark of enslavement and subjugation. Scholars like Toubia, Izett (1999), Elchalal U, Ben-Ami B, Gillis R, Brzezinski, A. (1997), state that FGM was practiced in ancient Egypt, as a sign of distinction among the aristocracy and traces of infibulations can be found on the Egyptian mummies. Moreover, the term 'Pharaonic circumcision' commonly used in Egypt stems from FGM practices by the ancient Pharaohs (ORCHID project 2012). Greek physicians who visited Egypt described the procedure and explained its purpose as the reduction of the female sexual desire caused by enlargement of the clitoris from its rubbing on the women clothing (Comfort Momoh 2005). A Greek papyrus in the British Museum dated 163 B.C. also mentions circumcisions performed on girls at the age when they received their dowries (Hanny Lightfootklein 1991). Today, Egypt hosts the highest prevalence FGM cases than any other country. UNICEF (2005) endorses FGM practices in Egypt cutting across all classes of people and is limitedly affected by class or geographical locations

Enslavement: Another theory suggests that FGM was practiced within the slave classes to maintain the labor economy without social destructions such as pregnancies, childbirth etc. As Mackie Gerry (2009) states, the custom was originally employed by slave traders in order to make their females more productive. According to the Orchid project (2011), *"Mackie quotes writings from 1609 which show the practice having spread to Somalia where a group had 'a custom to sew up their females, specially their slaves being young to make them unable for conception, which makes these slaves sell dearer.'"* It is likely that FGM spread from Egypt to other parts of Africa especially along slave trade routes of river Nile and neighboring countries of the Nile – depending on kind of relationships (socio-economic) with Egypt.

1994-1996 Decree amendments: Besides, Egypt's history has also shown some extent of accommodating the practices through the decree amendments of the past, which promoted medicalization of FGM instead of abandonment (UNFPA publication, written by Mohammed

Farid, 2008). For instance, the 1994 ministerial decree prohibited FGM to be performed by non-medical practitioner. In other words, FGM became officially legal in well-equipped health facilities such as public and central hospitals. The 1996 decree prohibited FGM in any health facility, except for high-indicated cases. Here, FGM continued to be practiced under pretense of doctors' prescription (highly indicated cases). According to the 2005 EDHS, trained medical personnel accounted for 75% of FGM cases. However, eradicating FGM gained momentum only in June 2007 after the tragic death of a 12-year Badour Shaker during an FGM operation in a private clinic near Minya (in Upper Egypt), followed in August by another FGM-related death of a 13-year old in a Nile Delta village in Gharbiya.[39] In June the Egyptian Ministry of Health and Population issued a decree (271) - closing a loophole in the previous 1996 decree - banning everyone, including health professionals, from performing FGM in governmental or non-governmental hospitals/clinics. Nonetheless, damages made by earlier decrees could not be easily addressed by the 2007 decree. Medicalization of the practice had already taken high stance among paramedical and today; FGM is practiced underground by many health professionals to supplement their incomes.

Religious requirement-mistaken beliefs: FGM is also believed to be a religious deed that is sanctioned by Islam, a dominant religion in Egypt making up to 90% of its believers (CIA 2010). Several DHSs clearly present the significant role played by religion towards FGM – stating prevalent comparisons amongst Christians and Islamic countries or communities and showing higher prevalence amongst Islamic believers (P. Stanley Yoder, Noureddine Abderrahim, Arlinda Zhuzhuni 2004, see also UNICEF 2005). Underlying factors for the FGM-Islamic linkage is the false Quran interpretations, hadiths missunderstandings and Islamic words-usage that ascribe and interlink FGM to Islam – as explained, but also criticized by Ibrahim Lethome et.al (2008) an Islamic scholar, head of the council of Imams and lawyer in Kenya. Also, the Al Azhar Supreme council for Islamic Research - the highest religious authority in Egypt - issued a statement explaining that FGM has no basis in the core Islamic Sharia or any of its partial provisions; hence delinking FGM from Islam. Basing on these arguments, FGM in Egypt is universal because of a) country's Islamic background, b) associated with religious (Islamic) justifications and c) misinterpretations of religious - scriptures and other sources. Comparatively, Ghana is predominantly Christian (71.2% and Muslim 17.6% - www.ghanaembassy.org), the same applies to Kenya (Christian 80% and Muslims 10% - Republic of Kenya 2012). FGM- countrywide prevalence in the two countries

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[39] UNICEF; http://www.unicef.org/egypt/media_4115.html. Retrieved on 22.02.2014

is lower than in Egypt, though highly prevalent in individual communities (depending on ethnicity), especially those with Islamic affiliations.

Women rights situation as strategy for Islamic-political motives: Also, women issues in Egypt continue to be regulated to a subordinate position for political expediency. The state in its attempt to contain the Islamists has subordinated women issues including FGM abandonment, to its own concern for security and legitimacy. Nemat Guenena and Nadia Wassef (1999:50) reveal that, *"the Egyptian government's reluctance to legislate against FGM can be understood as due to the prevalence and sensitivity of the practice, and, also because it still enjoys wide support as a rite of passage signaling the end of childhood and the beginning of womanhood. The state has its own agenda, which does not necessarily include women or allow their concerns to occupy a front position. On the other hand, placating and containing the Islamists is a priority for the state, whose very existence depends on maintaining a balance between its own ideological requirements and those of the Islamists."* Islamic movement as an umbrella term describes the militant violent wing of the movement; which is against the social-political alternatives in Egypt (Nemat Guenena & Nadia Wassef, 1999; Sherifa Zuhur, 1992). *"During the 1970s, the Sadat regime encouraged the resurgence of the Islamist opposition in order to undermine the influence of the left. As a result, Leftists and Islamists were embroiled in a bitter competition… and were unable to effectively cooperate in order to expand the scope of political liberalization and democratization"* (Dina Shehata 2010:33), hence undermining women rights issues

Following Sadat's assassination on 6.october 1981, Mubaraka regime placed the opposition under constant threats of persecution. In the 1990s, Mubarak regime heavily relied on repression in order to ensure continued demobilization of popular sectors including oppressing human rights groups and also heavily applied divide and rule strategies between Islamists and secularists while ensuring their weakness and fragmentation (Dina Shehata 2010). Amidst continuous political struggles, women issues in the meantime were not government priority, mainly because of focus on power struggle. Islamists have eventually used FGM and the maintenance of the Islamic tradition to mobilize political support.

Conservative Islamists regimes: The past three decades have witnessed the growing influence of Islamists challenging both the state and government institutions. Moreover, Islamic activism entails the commitment of bringing into practice the norms and codes of behavior ascribed to Islam, women and gender issues being at the core (Nemat Guenena and Nadia Wassef, 1999). When the International Conference on Population and development

(1994) was declared successful in Egypt amidst Islamists protests, three major issues (contraception, abortion and FGM) were tackled. *"Islamists claimed that the west placed FGM issue on the conference's agenda to distort the image of developing countries, especially Islamic ones and divert attentions to the exploitative politics of the West"* (Nemat Guenena and Nadia Wassef 1999:49). Appeals were made by Islamists urging women to retreat in private spheres, to increase public veiling, and strengthen Egypt's traditions including adherence to FGM (Lila Abu-Lughod 1998). According to Elizabeth Heger Boyle (2002), a prominent religious leader Sheikh Gad el-Haqq issued a religious decree recommending local clerics to encourage families to circumcise daughters just as they encouraged individuals to pray, arguing that the practice is a religious ritual. Consequently, women and their bodies has become the repository for tradition and Islamic virtue. As Islam remains an ideal and idiom in the Egyptian society, particular segments of society express it differently. Although majority do not condone violence, many people have become more conservative both in outlook and in behavior (Nemat Guenena & Nadia Wassef 1999:49), which explains the resistance attitudes from both men and women to make calls for equitable statuses and ending FGM practices.

Women rights a nonstarter in conservative Islamic countries: Women rights activists have thus all along had to place women rights issues under various political umbrellas such as liberalists, socialists or Islamists; however, with short-lived changes and a list of challenges. Women activists have found difficulties in pushing their agendas ahead due to Islamic boundary constrain (e.g. Law 32 of 1964 restricting NGO autonomy). Their agendas include the 1920s demands of abolishing polygamy among other issues and have even expanded today to cover FGM, reproductive rights and violence against women (Nemat Guenena and Nadia Wassef, 1999) but with limited success. NGOs dealing with human rights issues are still working under political stress from both the governments in power on the one hand and Islamists on the other side. Also, NGOs are continuously critiqued for propagating western influence, which renders activists vulnerable to violent attacks. As Kassem elaborates, "W*hile the regime's Islamist opponents remain the main focus of coercion and repression, secular political activists, Human rights activists, homosexuals, workers, and voters have all been increasingly targeted over the past years"* (Mayeh Kassem 2004:187). The unstable grounds that activists occupy to fight FGM and related human/women rights issues, has led projects aiming at FGM abandonment a nonstarter in the region.

Political instabilities: Moreover, constant political instabilities in the country have failed to favor - CSO campaigns against FGM aiming at behavior changes and sustainability, human rights activism and advocacy. Given recent political developments, Sadat's assassination in 1981 led to Mubarak' reign until 2011, within which insecurity, power struggle and political demonstrations constantly characterized the regime. Followed by President Mohamed Morsi in June 2012 – 03, July 2013, his term in office was also characterized by turmoil. After being forcefully ousted out of power, Adly Mansour occupied the power gap until 8.June 2014, who later handed over the presidential seat to Abdel Fattah el-Sisi the current incumbent president. Courses of power change and struggle have led to deterioration of FGM activities. It remains uncertain, a) the future of FGM activities given the Egyptian politics, b) how much political attention will be directed to such activism and c) what impacts will FGM projects still have at local levels.

In summary, many people are still conservative about FGM practices. To most Egyptian women, FGM remains a deeply rooted normal practice, expected of each woman, in fulfillment of their religious obligations. Therefore, activism against FGM is mainly considered western influence. There appears to be little room for change, because of both political and religious influences. This is also confirmed in my 2013 surveys in Cairo, Fayum, Assuit and Benisuef.

9.3 About Cairo, Fayum, Assiut and Beni suef

Cairo, the capital of Egypt, located in Lower Egypt, hosts over 17 million people (Keith Sutton, Wael Fahmi 2001). Lower urban fertility levels coupled with increasing predispositions towards nuclear families impact on Cairo's population change, although population density remains high in the inner cities and much of central Cairo (Keith Sutton, Wael Fahmi 2001). It is regarded as one of the world's mega cities (H Richardson 1989) with increasing sub-urban population growth and the center of economic activities.

Meanwhile, Fayum is a very fertile region and depends on agriculture due to perennial water supplies from the Nile occupying about 1,729 km². The main center of the region is Medinet El- Fayum, deriving from the crocodile god, a dominant cult in the region (Richard Alston 1995:17).

Assiut governorate is located 375 km south of Cairo. Its total population in 1996 was 2,802,185, and the rural population represented 72.76% (CAPMAS 1997).

Beni Suef located about 115 km south of Cairo on the west bank of the Nile is near to Fayum. It occupies an area of about 1,322km² and hosts over 2million populations.

The three governorates (Fayum, Beni Suef and Assuit) are located in Upper Egypt, an impoverished part of the country, characterized as rural with less educated populations and high birth rates, than the rest of the country (see UNDP/INP 2003). Illiteracy rates of Upper Egyptian women are 20.3% compared to the national urban rate of 78.5% (Nicholas Hopkins and Reem Saads 2004). In these areas, Female subordination is tied to the dynamics of family life and patriarchal familiarity. Young girls are married into houses headed by their husband's father, where they are subordinated not only to the men, but also, to senior women such as mothers in laws (Marcia C.Inhorn 1996). A set of laws and customs, primarily family laws based on male authority, ensure female subjugation (Lama Abu-Odeh 2004, Gharda Karmi 1996). Moreover, regarding family matters, Egypt has made reservations on Article 16 of CEDAW (Equality in marriage) on grounds that the law of the various religious and ethnic communities in the state (Marsha.A Freeman/UNICEF 2009) determines matters of personal status. While invoking the sharia law in such matters, Karmi.G (1996) states that; Muslim societies affirm the will to keep their families under traditional Muslim law.

According to WHO Bulletin Assuit hosts 75.5% affected female students, Beni Suef 73.1% and Cairo 36.5% (Mohammed A Tag-Eldin; et.al, 2008). These percentages do not include females that are out of universities (married or single), or attending primary levels of education. This implies that the actual percentages of those affected are possibly much higher, than the estimates given here. WHO Bulletin further indicates girls being cut at much younger ages in Upper Egypt (where the three surveyed cities - Fayum, Beni Suef and Assuit - are located) than Lower Egypt (e.g. Cairo) even though median age is 10 years. FGM persists because of beliefs that it moderates female sexuality, assures girl's marriageability and is sanctioned by Islam. The whole matter is charged with emotions and paranoia, makind it difficult to attempt a cool evaluation of the rights of women under Islamic influence (Gharda Karmi 1996). The sensitivity of FGM prevents people from engaging in rational debates, for fear of being branded as Muslim fanatics or as enemies of Islam.

9.4 Survey in Cairo, Fayum, Assiut and Banisuef

Research in Egypt carried out in 2013; included 115 randomly selected participants from Fayoum (Salakhana and Gharb Tarawuniyet communities) - 34 respondents, Beni suef (Bush community) - 24, Cairo (Marg Jadida community) - 33, and Assuit - 24. Organizations that

participated include National population council of Egypt, Centre for Egyptian Women Legal Assistance, and EBESCO care.

9.4.1 Social-demographic characteristics of participants

Out of the total number of 115 study participants, 73.04% were females and 29.96% males. Categorized by age, 73.04% were above 27 years, and the rest below 26 years. Marital status indicates 70.43% married, 16.52% single and the rest either divorced or widowed. Occupationally, 55.65% were not employed (especially women) compared to 28.70% with formal (mostly men) and 15.65% informal employment. Education status shows 47.83% having attended at least a higher institution of learning, 30.53% (mostly women) illiterate and the rest either with only a primary or secondary education. Participants were also categorized per type of residence, 58.56% were in a semi-rural, 34.78% in the rural and the rest in the urban set up. Those in urban residences came mostly from Cairo, while semi-rural and rural residents were noted highly in Fayoum, Beni suef and Assiut. Governorate categorization represents Fayoum with 29.57%, Cairo 28.70%, Benisuef 20.87% and Assiut 20.87%. Participants' periods of stay in study areas include 53.91% of those who had been residents for over 10 years and 26.09% for all their life. The rest had resided in study areas either for slightly more than 4 years or less than 3 years. Hence, showing that participants responded as experts of FGM, given their experiences collected through out there stay in study areas

To discuss the employment and education status as seen in my empirical study, in relation to other researches – results indicate women being mostly affected:

Marsha.P.Posusney, Eleanour.A.Doumato (2003) illustrates women situation in the Middle East as follows. One theme in Islamist agenda in Middle East is the idealization of women as wives and mothers who stay at home, care for their families and raise a new generation of good Muslim. Controls and limitations placed on women have been supported by those regimes that rely on communal or family alliance for support. Such alliances are patriarchal and tend to represent the very groups that emphasize male control over women, with moral, cultural and religious values at a forefront. Consequently, as mothers become dedicated to the noble calling of family, domesticated womanhood partly helps regimes deal with unemployment problem by opening up employment opportunities for men. This may be done, at the expense of exploiting educated and employed females.

Assaad Ragui (2003) also reports on gender inequalities in employment (public) sectors and women's vulnerable position in the labor market. He argues that the loss of public sector jobs through government retrenchment and privatization affects women disproportionately. In addition, women mobility is constrained by social norms and household responsibilities (see also Heba Nassar 2003), coupled with their increasing focus on family life through marriage roles.

Lila Abu-Lughod (1998) reports on media's role in framing women in Egypt as home makers. Women's career ambitions have been depicted negatively, even in media, in order to emphasize their homemaker roles. In a television series "the Hilmiyya Nights" aired in the late 1980s and 1990s; women education and work ambitions were openly discouraged. The series emphasized female participation in family roles that did not necessarily require education.

Naguib Karim (2012) has summarized Beckers' (1981) classical works of marriage market, which suggests that in the low income countries, marriage is a critical aspect of a woman's life – in the face of low education and few employment opportunities outside the role of wife and mother.

9.4.2   The practice of FGM and its distribution patterns

Discussions are re-divided into a) all (115) participant and b) only women (84) responses.

All respondents

Age brackets of participants was 93% - 21 years and above. FGM was stated widely and commonly practiced by 53%. Those arguing against were only about 36%, the rest were not sure. Clitoridectomy (type I) accounts mostly (86%) of all types performed, taking place especially in the second quarter of the year (April, May, June) - as indicated by about 53%, the rest percentages being scattered in the remaining three quarters. Reasons of performing FGM in the second quarter of the year include the moderate weather condition (summer), which allows faster healing of the wound (see Egypt, Population Council, Recording No.3). FGM is mainly practiced at homes - 77%, even though hospitals still account for 20% of the practices. Traditional circumcisers - called daya undertake 64% of all circumcisions and about 30% are done by health personnel. Many parents argue seeking health personnel' advice in FGM matters, which is usually positive. In other words, girls are rarely spared. Fundamentally, family decisions making - of whether a girl should undergo FGM or not,

account for 97%. Existence of any kind of socio-health complications is highly denied by 68% and accepted by only 29%.

Only women

Circumcised: From a total of 84 female respondents- mostly aged 21 years and above, 70 (83%) were circumcised, basically for cultural reasons (76%), although religious influence also plays a role. About 59% were cut between 4-10 years and 36% between 11-14 years. Almost 73% were married and without employment, and only 14% with a formal occupation. Meanwhile, 44% are illiterates and only 34% achieved higher institution of learning-education. Semi-rural based circumcised participants account for 70% and rural 28% - located in Cairo (31%), Assiut (28%), Fayoum (24%) and Benisuef (15%); majority having lived in these areas for more than 4 years. Home is the place where FGM mainly takes place (87%) under family decisions/influence (98%); with 20% accepted medical complications (the rest percentages see no correlations between FGM and complications). A behavioral maintenance attitude among the cut women is 60% compared to 34% of those willing to abandon FGM. More activism is therefore needed among the already circumcised, to alter decisions and promote behavioral change attitudes.

Uncut: Comparatively, only 14 women (about 17%) reported having not been cut. They were mainly below 21 years. More than half the number reported being single (otherwise the rest married) and having achieved mainly higher institutional education – with no illiterates in the category. These factors appear to have partly influenced their free-FGM status. Considering participants' reasons given for not undertaking FGM were the outdated practice and self-empowerment attitudes, less evidenced among the circumcised group. Half of uncut women were formally occupied and the other half non-employed, with no informal category. A half of participants reside in Cairo and another half in Fayoum, under a semi-rural and urban nature of environment for over 4 years mainly. Despite of not being circumcised; their opinions about place of FGM reflected mainly home than hospital and major decision makers – about girls' FGM status - as only family (parents) influenced. Unlike those that had been cut, all the non-circumcised females supported FGM-abandonment.

In my opinion, despite of being few in number, results from the uncut category of women is very promising; mainly because of their ages (less than 21 years can be perceived as future generations who are likely to also protect their children from FGM). More so, they are not circumcised, yet they all support abandonment. Literally, the category can be used as peer

educators to influence behavioral changes and can be relied upon for sustainability of changed behaviors.

Comparing my results from both categories of women (cut and non-cut) with other researches in the field,

UNFPA confirms a representative study done by the Egyptian Ministry of Health in 2006 among school girls aged 10 to 18 years in ten governorates. Although the study concluded that 50% of the girls had been circumcised, percentages were higher amongst daughters of uneducated parents/mothers, as opposed to the daughters of women who were university graduates (www.childinfo.org and egypt.unfpa.org).[40] FGM prevalence is lower in younger age groups. Such generation differences/ declines have also been confirmed by UNFPA (http://egypt.unfpa.org).

9.4.3   Strategies against FGM used by case study organisations

Unlike in Kenya and Ghana where criteria of choice of organization to be studied depended solely on participants views at grassroots – who mentioned several organizations implementing different abandonment strategies within their communities: In Egypt, organizations selected for study (in 2013) were randomly chosen by the researcher – after participants failing to give examples of institution working with them at grassroots to prevent FGM, even though they had identified NGO activism/involvement. Randomly selected NGOs were based in Cairo (e.g. National Population Council, EBESCO Care and Centre for Egyptian Women Legal Assistance.), unfortunately not balanced up to represent the four surveyed cities. Although I had traced a handful of NGOs in Fayoum, Benisuef and Assiut by reference, most denied having FGM projects, while some probably withheld the information on purpose – possibly because of political insecurities and threats towards women rights activities and human rights in general, which was totally devastating.

Before I go into in-depth NGO strategy-discussions, I would like to first briefly highlight upon community (115) views given in this category – contributing to my random NGO choice of selection

Community survey

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[40]UNICEF, Egypt DHS 2000, 2003, and 2005: Egypt FGM/C country profile. http://www.childinfo.org/files/Egypt_FGC_profile_English.pdf. Viewed on 13/06/2013; See also FGM/C in Egypt: Prevalence Rate and Prospects. http://egypt.unfpa.org/english/fgmStaticpages/0c3b708e-9c55-4b05-994f-a437f89a81d9/Egypt_Prevalence_rate_and_Prospects.aspx. Viewed on 13/06/2013

Institutional involvement into FGM activism appeared 48% unknown; 23% positively known – particularly NGOs (15%) using basically sensitization and awareness methods (22%) but with no specific NGO example mentioned. Meanwhile, 15% clearly denied institutional engagements whatsoever, suggesting that behavioral changes are personally motivated without institutional interference.

Organizations survey

A) Center for Egyptian Women Legal Assistance (CEWLA)

CEWLA is a non-governmental organization founded in 1995 by Azza Suleiman, who having worked at the Egyptian Organization for Human Rights in 1994 witnessed tragedies suffered by female relatives subjected to torture and pressure by their male counterparts. According to Suleiman, she started working in the political field when still a young girl, motivated by the inequality and injustices women face in their daily lives as second class citizens.

Located in the Boulaq El Dakrour region, CEWLA is one of the most active organizations in the field of women's rights issues. Ms. Azza Suleiman has collaborated with Equality Now (www.equalitynow.org)[42] on campaigns to combat violence against women with a strong focus on female genital mutilation. CEWLA raises awareness of laws about human rights principles within grassroots communities and provides legal aid to mainly the impoverished women. Apart from advocating against FGM, CEWLA also campaigns against honor crimes, and discriminatory family and divorce laws in Egypt.

Correlation between divorce laws and FGM: CEWLA believes that girls commonly undertake FGM (type-I) at ages 9-10 years, to trim possible sexual lusts, ensure chastity, promote fidelity in future marriages and prevent promiscuity. Promiscuity, prostitution and adultery are punishable acts in Egypt, aimed specifically at women. According to CEWLA Foundation (2008) clarifications about Egyptian gender discriminatory laws, the Penal Code No. 58 of 1937 is full of discrimination against women. The penalty for adultery differs from sex in the articles (274) (277) (237) (274) in terms of punishment and alleviated circumstances. Even the application of the law 10 of 1961 related to fighting against prostitution, discriminates and targets women. Article 9 (c) stipulates the punishment of

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[42] Azza Suleiman. Advocating for Equal Rights for Egyptian Women. Equality Now. http://www.equalitynow.org/partner/azza_suleiman. Retrieved on 10.10.2014

persons who used to practice prostitution and debauchery, but its application is intended to punish women, not men.

CEDAW convention intends to achieve the equal opportunity between men and women internationally and can be invoked in this case. However, Islam, Sunna and the Koran do not tolerate such changes, which is the reason beneath Egyptian reservations made on CEDAW article 2 (condemning any form of discriminations against women) and article 16 (state parties should take measures in matters relating to marriage and family relations) - (CEWLA Foundation 2008). In my opinion: Whereas discrimination of women is commonly evidenced on domestic levels; with family playing a greater role of socializing children into different (gender discriminatory) cultural and religious norms and values – critically implies that even FGM issues remain in Egypt deliberately a marriage and family matter, requiring purposely no political intervention. This accounts to high FGM prevalence and persistence – without analytical reflections; because to most Egyptian women, FGM seems natural and normal.

Despite flexible voices that raise solutions to uplift women injustices in personal status-legislations; Egypt's adopted reform-legislations are partial rather than total, not practicable for women and are unacceptable for men. For instance, the five legislations established under Egypt's Islamic family law of marriage and divorce: (1) the law of 1920; (2) the law No.25 of 1929; (3) the law No.44 of 1979; (4) the law of 1985; and (5) the law of 2000 (see CEWLA Foundation 2008; also[43]). Therefore, change is required in the traditional roles of men and women in society/public and family to stimulate gender equality. Eventually, FGM can be easily addressed based on such changes.

Field experience: According to CEWLA leader's narrative interview No. 1, though FGM affects females – they highly perpetrate the practices. Mothers are the main decision makers and socialize their daughters into conformity. In hospitals, private clinics or homes – it is females responsible for performing the practices. *"They should not be much blamed, for the Egyptian society is based on gender inequalities right from grassroots to top offices of power. Moreover, decision makers and law enforcers are men. FGM practices are male enforced and women are socially and psychologically socialized into conformity without second thoughts. That's why women find FGM a normal practice and believe it is an Egyptian culture. It will surely take time to de-construct such minds and to purposefully reconstruct them in a systematically gender based equality attitude. We therefore need to target the young*

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[43] http://muslimdivorceinusa.com/islamic-women-divorce-laws-in-egypt/. Retrieved on 12.01.2014

generations and integrate civic education and empowerment methodologies right from earlier stages of learning, if we are to deconstruct the discriminative gender frameworks from mind, body and action."

Strategies used by CEWLA to combat FGM include (i) legal approach, as explained by one of the CEWLA lawyers. *"In 2008 and 2009, the organization handled 10 women cases against FGM in Cairo and Aswan, one barber was jailed for the act"* (Egypt, narrative interview No, 2, CEWLA lawyer). In my view, the approach enforces laws by scaring away perpetrators, protecting those at risk and proving just to the victims. However, criminalization is also likely to push the practice underground or expose women that seek legal support to the point of prosecution – to violent attacks. Protective measures should thus be put in place for survivors or those willing to file FGM cases in future. For, it is likely that the lack of such measures hinders filing of more cases and puts women in a compromising situation.

Back to survey results: Another CEWLA approach (ii) sensitization and awareness model aims at educating/training religious leaders and doctors, and finally bring them into communities to talk to the people against FGM. Religious leaders are targeted because a) they command respect and meet important decisions in communities; b) during Friday sermons and other religious gatherings or functions, religious leaders can use the opportunity to detach FGM from Islam. One social worker (Egypt, narrative interview No. 3) demonstrated that *"the organization teaches religious leaders (influential and strategic people) until when their attitudes change. This helps the organization penetrate further to the communities to sensitize the people as a top down method of spreading CEWLA activities."* In my view, this is a viable method of operation, though targets only few religious leaders whose attitudes about women inequality-position has vehemently changed and therefore willing to address the situation. However, religious leaders committed to FGM abandonment suffer critics of being western influenced and having taken bribes to teach against own cultural and religious values – often also being vulnerable to violent attacks

Still under the sensitization approach, doctors are also targeted because a) they also play a major FGM decision role of daughters' status once consulted by parents; b) they indulge in performing FGM in private clinics mostly for economic reasons. Thus, when brought aboard, doctors can support behavioral changes by spreading messages of abandonment and discouraging patients to undertake FGM.

Additionally, (iii) the reconciliation model backs up the later approach to bring together and rebuild relationships between run away girls and their families/parents. Usually, during sensitization, attitudes of girls change faster than that of their parents – stimulating sometimes separations and family misunderstandings. CEWLA address this by convincing parents that abandonment is a measure towards empowerment, and sometimes bringing in religious leaders to convince parents about family reunion by use of Quran teachings (Egypt, narrative interview No. 1, CEWLA leader).

Progress: Given survey results, informants from CEWLA note a slight reduction of FGM practices in the past years.

Challenges: However, informants also inform that women nowadays do not want to come for legal advice and protection due to domestic pressure and threats from their husbands. CEWLA also notes that it is difficult to handle FGM as a legal issue, because, it is a culture that is not supposed to be questioned by law or authority. If the topic is not carefully handled, it may lead to spark of violence attacks particularly from men who are less willing to accept women equality. Other obstacles such as political instabilities, absence of state of law, ignorance of law, religious discourses that undermine women rights, accuses of implementing foreign agendas, etc., undermine CEWLA projects and restrict achievements.

Way forward: conclusively, informants agitate for continued strength to fight the women struggle for equality until normality is achieved – within the daily lives of communities. While legal illiteracy is common among all segments of Egyptian society, media, police, various professions, politicians, religious clergy, etc. need to be educated to handle women issues using human rights perspectives.

B) EBESCO CARE

Another organization, EBESCO CARE (Egypt, narrative interview No.4), is a small NGO located at the outskirts of Cairo. The National Population Council of Egypt sponsors its FGM projects. The organization deals especially with FGM in Ain-shams, Esbetnakli and Boola – Christian areas/communities. According to the interviews with the director, Type I is the most prevalent kind of circumcision among the mentioned Christian communities. Women/mothers are reported to be at the fore front in undertaking decisions concerning daughters' FGM status. Common age of FGM range from 9-12 years in EBESCO's communities of operation. The practice is said to be done to reduce prostitution among particularly singles until they can secure marriages, as a rite of passage to adulthood and also for fidelity reasons especially

among the married. FGM has been reported by EBESCO to be universal amongst the poor and illiterates and common in rural areas, hence the organization's target groups and communities where it operates.

Audience: FGM activities targets mostly mothers and grandmothers as major decision makers of girls' FGM status on one hand and girls because they are the victims on the other hand. Men are also to some extent partly included in abandonment programs because they enforce the practices (e.g. as husbands who do not want to marry the uncircumcised women, as heads of family meeting all family decisions, etc.). EBESCO does not operate with 'dayas' (traditional barbers) simply because of their decreasing role in indulging or performing FGM. Instead, the organization targets medical personnel because they are increasingly practicing circumcision despite the bans.

Using an example of the governorate of Menya (Ghada Barsoum, et.al. 2009:77), where the Governor announced the shutdown of 36 unlicensed private clinics for performing FGM – shows proof of high levels of medicalized FGM. Though Menya example is far from EBESCO's communities of operation; is however partly one of the reasons for targeting health personnel within its three-Christian communities of operation. Probably there exist already rumors about medicalization of FGM within the communities, which direct information may have been deliberately withheld during survey. Nevertheless, clearly identifying health personnel instead of Dayas (traditional circumcisers) as target group within EBESCO's operations against FGM – implies to me as a researcher – that FGM medicalized cases already occur and are well known about.

Fact is, the communities of EBESCO's focus – host many unlicensed private clinics, which despite their illegal operation (without licenses), provide health care to the densely populated mostly poor populations living in Ain-shams, Esbetnakli and Boola. More so, possessing no license does not necessarily imply disqualifications. Some private clinics, though with qualified personnel, may fail to meet government requirements or bureaucratic processes for establishing medical centers – hence their illegal operation (but with a good cause of treating people whose incomes are very low to meet the costs of standard clinics). FGM comes on board within such clinics as a top-up income mechanism for poorly paid health personnel.

To EBESCO, before medicalization temptations (FGM operations) stamp firm foundations in its communities of operation or get spread from one private clinic to the other – risking clinic bans/closures as 'political step' (like the Menya example); it is better to protect the operation

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of private (unlicensed) clinics without compromising community health at large and hence EBESCO's health personnel target as a preventative method.

Strategy: The mainly used models of intervention include sensitization and awareness approach and health approach. These models are preferred, because of their simplistic form, inexpensive; less criticized and easily engages participants into discussions. Despite of EBESCO's acclaimed achievements in its abandonment projects such as; reductions in prevalent rates, people accepting to discuss FGM openly, women fixing time and participating more and more in the community projects, the organization also realizes and confirms that the road towards complete behavioral changes is far way ahead.

Obstacles highlighted in this case include the high levels of illiteracy rates that affect outstanding decision making, causing high levels of ignorance. The lack of employment opportunities further leads to less economic empowerment, high dependency on male members as fathers or husbands – who eventually influence women decisions into succumbing to FGM without choice left. Also, importance attached to early marriages (e.g securing virgin girls who have not yet been exposed to sex) and alluring statements attached to FGM as rites of passages to womanhood instigate persistence. Moreover, the values attached to traditional values and norms associated with FGM, combined with limited community workers/volunteers to sensitize communities upon harmful practices and value attachment – due to lack of enough funds and political threats – lessens/destabilizes the importance of EBESCO activities. When these factors are added up, women are easily manipulated into performing FGM practices by politicians, community leaders and male members of family to secure their (women) own social-economic wellbeing.

The way forward is to achieve community empowerment by increasing education opportunities for both men and women, improve social-economic conditions of especially women, and offering women psychological support. If these issues are fully tackled, FGM will not be a problem to eliminate.

   C) National Population Council (NPC)

The Population Council is an additional NGO that renders support towards FGM abandonment in Egypt. It began in 1977 with the Middle East research awards program and established a regional office in Cairo in 1978 (Population council-Egypt). The organization seeks to improve the well-being and reproductive health of the population of Egypt by achieving a humane, equitable, and sustainable balance between people and resources. Its

projects are engaged in capacity building and research on locally defined population issues. More recently, the Council's work has been broadened to address issues related to reproductive health, health-care reform, transitions to adulthood, sexual and gender-based violence, FGM and capacity building (www.populationcouncil.org).[44]

NPC (Egypt, National Population Council, recordings No.3) reports FGM being done at the age of 8-12 years during January and February by health personnel either at home or in hospitals.

Strategy: NPC uses the Social norm approach, youth networks and the economic approach – providing economic assets to women through saving and micro credit – with the aim of achieving female economic empowerment. According to the NPC informant, *"... we have been working on FGM for 12 years (...). We tried to target FGM as a separate unite, it turned out that it is not really giving a big effect that we were expecting. Right now we have adapted a new approach* (e.g. comprehensive approach to focus on social norms), *including 40 practices associated with culture and tradition"* (e.g. proper education, violence against children, extracurricular activities in school, environmental issues, equality, etc.). FGM is a cultural practice that took on religious aspects. In the NPC used comprehensive approach, concentration is not only put on FGM but rather all negative religious and cultural practices that appear to affect humans. The aim is to inspire people to question all negative practice (including FGM) and themselves. Because FGM is done for community perception (due to community pressure), those that have crossed the lines are provided with a safe public space – not to do FGM to their daughters. Once a critical mass has been reached, changes will emerge (Egypt, National Population Council recording No.3).

Challenges: Recently, *"there are many security problems faced. People are very violent about foreigners. They are very irritated to see foreigners coming to talk to them about their culture."* More so, there are dynamics that ensure high male dominance over females, whites over black, rich over poor. This kind of dominance was not obvious during the Mubarak regime, though it was there. However, in Morsi government, such dynamics are noticeably very high and reject any kind of advocacy that may lead to women empowerment. Further still, there is an increase of Gender based violence and its promotion, especially from the freedom and justice party. One of the president's consultants of women affairs openly advocated for FGM in Medias. Yet, she is a medical doctor – working in university in public

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[44] Population Council, http://www.popcouncil.org/countries/egypt.asp. Accessed on 07/06/2013

health department. After she was attacked, she came back to media, and denied her previous speech, advocating for FGM. Meanwhile, an Ex-parliamentarian was also advocating for children marriage and against women issues. Most of the female icons of the freedom and justice party were against female empowerment and equality issues – despite of themselves being females. Even Morsi's wife was never seen in the public space, which rather implied, that women belonged to homes or in private spheres. The party was also against the UN statement against Gender Based Violence (GBV), which led to a huge revolution within feminists' communities (Egypt, National Population Council recording No.3).

Consequently, the European parliament threatened to stop aid, because of low human rights and women rights status. President Morsi made a political move and called a meeting, as an initiative for ending violence against women. However, this was a media show. *"The president should have taken steps towards approving and adopting an agenda of the UN statement of ending violence against women. Instead, he built a women initiative, which will go for three months, selecting what the Egyptian women want…"* (Egypt, National Population Council recording No.3)

Progress: NPC notes that there is no progress towards abandonment (stand 2013); because of lack of political support, high levels of insecurity within communities, ignorance and limited access to mass media. There is fear that what had been achieved (FGM abandonment progress) in Mubarak regime will all be lost during Morsi's term of office – being that Morsi belongs to a conservative Islamic party – who would rather see the sharia law prevail than human rights (Egypt, National Population Council recording No.3).

My experience: In support of NPC's progress report above, my own experience shows that even big institutions that had prior been actively involved in FGM abandonment like the National Council of Childhood and Motherhood (NCCM) appeared to have stripped off FGM project from its agenda come 2013. Although NCCM had prior actively reported about FGM and carried out several activities together with Suzanne Mubarak (wife of ex-president Mubarak)[45], following my several visits on appointments (about the topic) in different offices – no single information was released. I sensed skeptical and hesitant attitudes, for some workers – following my occasional visits – became sympathetic and were willing to

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[45] See The National Council for Childhood and Motherhood within the framework of stop FGM Campaign AFRO-ARAB Expert Consultation Legal Tools for the Prevention of FGM (The Cairo Declaration against FGM) under the Auspices of H. E. MS. Suzanne Mubarak. Cairo, 23rd of June 2003. http://www.childinfo.org/files/fgmc_Cairodeclaration.pdf. Retrieved on 09/03/2014; See also UNICEF-Egypt: Fresh progress toward the elimination of female genital mutilation and cutting in Egypt, http://www.unicef.org/egypt/media_3875.html. Retrieved on 09/03/2014

cooperate. However, it appeared that upon consultation with their bosses or higher offices, they eventually pulled out. In other words, information was available, but deliberately withheld – probably because I was an African researcher but connected to Germany University. Yet given the 2013 human rights situation, the Egyptian government was under pressure for reformations from western governments, which were even threatening to cut off financial aid. Perhaps NCCM became skeptical about motives of my FGM research, even though I had thoroughly explained myself. Or was I in a right place at a wrong time? On the other hand, the 2013 Egypt's political insecurities threatened human/women rights activists, especially those that were working closely with the ex-Mubarak regime. Could that have affected NCCM's FGM project activities and eventually research cooperation?

In my opinion; since Morsi supported (indirectly) FGM and his predecessor Mubarak against FGM, NCCM can be seen as an example of institutions that loyally serve governments in power. Having failed to informatively support my research, NCCM eventually forwarded me to National population council (found within the same building/block), to whom am very grateful for their boldness and strength to cooperate and informatively support this research.

The way forward remains unclear for activists depending on political situation and regime in power. If FGM activities will ever get attention again or not or women rights in general, is the question of government willingness to address such issues – and how persistent activists are willing to be.

9.4.4   Variables affected by maintenance attitudes

Following community surveys, generation-variations in maintenance attitudes are clear. Attitudes are stronger per additional age group or increase in age. Category of attitude is also highly affected by marital status. Accordingly, 73% of those who supported FGM were married. Likewise, occupation status causes variations in attitude. Those unemployed and supporting maintenance were 56% compared with 19% formally employed. There appears to be no big difference between variations in education following the fact that 42% with higher institutional level of education supported FGM; just as 41% of the illiterates. Meanwhile, geographical locations also influence attitudes. Those leaving in semi-rural areas favored highly maintenance (54%) and almost none in urban locations.

9.4.5   Progress and opportunities towards curbing down FGM

Despite the challenges, this study associates FGM abandonment progress with 14 (17%) girls and women that were not circumcised, all of whom supported abandonment – as shown by the survey.

Despite Egypt's universal prevalence characteristic, those that escaped FGM can be referred to as positive deviances[46] - given such uncommon attitudes (David R. Marsh, et.al 2004; David R. Marsh, Julia Rosenbaum, et.al 2002).

In the survey, underlying factors against FGM among the non-circumcised females were sensitization and awareness (36%), government laws and criminalization (18%), and family support (11%). Amidst lack of religious and political will to address FGM, behavioral changes supported by the above-mentioned factors – no matter representative percentages – cannot be undermined.

Despite low institutional indulgences towards abandonment activities, information against FGM spread 83% (out of 115 participants) per word of mouth, implying that the survey participants were quite familiar and aware about harmful effects, even though familiarity was accompanied by less change in behavioral attitudes (51% maintenance) compared to 44% abandonment attitudes.

There seems to be less family and community associated difficulties (e.g. stigmatization) resulting from not undergoing FGM as seen by 71% of the total surveyed participants. This shows the increasing acceptance of uncircumcised females within high prevalence communities.

Despite the practice being highly accommodated, general results from the survey assess improvements in behaviors and attitudes thereby accounting for the deductions. However; if more effective and practical political and religious support against FGM were to be counted on – progress would be higher that reported here.

Opportunities here generally involve the existence of laws and policies against FGM, which activists can still capitalize upon or refer to – for promotion of change. Moreover, Egypt can

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[46] The approach suggests that a positive example (of people who have not undergone FGM leaving amidst practicing communities, and who have attained a certain degree of success) be used as community examples, for the community to get assurance and later emulate such examples. See also The United Nations University. http://archive.unu.edu/unupress/food/fnb23-4s.pdf#page=129. Retrieved on 12/03/2014

still be held responsible for human rights injustices, because it is a signatory to most of the rights conventions, including those illegalizing FGM. Besides, even though political threats have rendered several FGM projects helpless, a handful of NGOs have not given up on women issues.

9.4.6 Challenges and recommendations to address the loopholes

Individual, social and political groups support FGM. Examples included religious leaders, circumcisers, health personnel, elderly women, men and politicians. An institution encountered during research manifested (Morsi) government promotion of gender based violence and lack of support of human rights activists – leading to minimum progress towards abandonment. This was associated with the spread of Islamic-political ideologies, leading to violent attacks aimed at activists – making activism limited in scope and capacity.

There is need for sensitization, training and awareness projects targeting specifically politicians and Islamists in order to change attitudes towards gender issues. This follows the fact that people with power (politicians and religious leaders) misuse power to promote gender inequalities, traditional and religious values and norms – rendering no opportunity for local voices (women and minority groups) to determine these changes.

 In the medical field, medical personnel have neglected to offer advice to patients who seek to perform the practice under medical care. Instead, they have manipulated the situation for economic gains by advising most mothers who seek daughter's circumcision opinion, to go ahead and perform the practice under medical care. This gap needs to be seriously considered by activists through pushing for medical awareness programs. Setting up FGM curricular studies in medical institutions and making such courses compulsory in the medical field of study. Additionally, creation of information desks and counselling services about FGM in hospitals and clinics is advisable. Lastly, strengthening the effective and practical use of the laws against medicalization of FGM is critical, given the fact that FGM is nowadays highly clinicalized.

Traditional barber should not be neglected for further sensitizations, just as NGO surveys show. Whereas FGM has increasingly gone underground or medicalized, activists cannot rule out the fact that dayas are still engaged in such activities. More efforts are needed, to continuously target them (Daya).

The non-conducive political atmosphere that activists work into, coupled with systematic incitation of public violence needs to be reformed.

In conclusion, the main challenge remains how to promote women rights amidst strong Islamic rule of law? Could the change in governments be an opportunity to a fresh start for human rights activism – especially those directed towards gender based violence? While these questions remain unanswered, they may act as 'food of thought' in the struggle against FGM in Egypt.

10 COMPARATIVE ANALYSES OF FGM PRACTICES IN KENYA, GHANA AND EGYPT

Patterns of FGM prevalence emerge when countries are grouped by region. In the countries of Northeast Africa (Egypt, Eritrea, Ethiopia, and Sudan), FGM ranges from 80% to 97%. In East Africa, FGM is markedly lower and ranges from 18% to 32% (28 too Many, 2013). In West Africa, there are marked variations in prevalence rates between countries. For instance in Sierra Leone, Gambia and Burkina Faso, prevalence ranges from 94% to 74%. In contrast, fewer than 6% of women are circumcised in Ghana and Togo (WHO Bulletin 2012).

Apparently; as the survey shows and basing on previous analyses – being married, older, having less education, low income and Muslim are all variables – associated with increased odds of having been circumcised, no matter country wide FGM prevalence rates. Nevertheless, there are variations across samples. For instance, those supporting continuation of FGM and in favor of having daughters circumcised in the future were inconsistently associated to the above-indicated variables. This was so mainly in Egypt.

Comparing results in the three countries; discussions are split up into five parts

 a) Social demographic characteristics: comparisons are made within social demographic variables, women status (circumcised and not circumcised) and general attitudes towards FGM (maintenance and abandonment)
 b) FGM practices: aims at elaborating generally more on FGM (as a practice) in relation to all participants views
 c) Strategy: reveals strategies towards abandonment both in respect to participants' opinions and institutional strategies
 d) Progress: considers mainly survivors of FGM and general maintenance and abandonment attitudes across countries
 e) Analysis of field based - NGO intervention model

10.1 Comparison of social-demographic characteristics

A total of 265 participants from the three countries indulged in this research. Kenya contributed 100 (38%), Ghana 50 (19%) and Egypt 115 (43%) participants; of whom – 20%, 17% and 30% respectively – adding up to 67% were married. The rest (percentages) being either single or divorced. Mainly 21 years and above made up the study; 34%, 18% and 40% from Kenya, Ghana and Egypt respectively – totaling to 92%. Generally, very few (8%) respondents aged 15-20 years participated. The survey did not have a balanced gender

representation as wished, fact being that females were most willing to participate than men. Females included 27% Kenyans, 18% Ghanaians and 32% Egyptians summing up to a total of 77% females compared to 23% males. Gender disparities were a result of men distancing themselves from the study due to ideologies – that the issue was a women concern. Considering the occupation status, Kenya has the highest figure of formally occupied (22%) respondents, followed by Egypt's 12% and then Ghana's less than 3%. In otherwise a total sum of 37% were formally occupied, most of whom are Kenyans. Ghana has the highest (16%) informally occupied, whereas highest unemployed (24%) respondents are Egyptians. Most participants had lived in study areas from between – more than 10 years and all their lives – 26%, 18% and 35% from Kenya, Ghana and Egypt respectively.

10.1.1 A social-demographic comparative analysis across circumcised- and non-circumcised females

A total sum of 77% Females (205 females from a total of 265 participants) to be analysed include 27% Kenyans (73 females = 27 circumcised, 32 not, 14 non-responses), 18% Ghanaians (48 females = 37 circumcised, 11 not) and 32% Egyptians (84 females = 70 circumcised, 14 not).

Majority circumcised participants were also married (52%), with Kenya having 9%, Ghana 18% and Egypt 25%. Single and not circumcised in the three countries added up to 12%, with Kenya constituting the highest percentage. This implies that marital status is likely to affects FGM prevalence, with variations in countries. Those married are most likely to undergo FGM than singles.

Age bracket 21years and above (unlike 20-15 years) made up the most (61%) affected females across all countries; 33% Egyptians, 18% Ghanaians and 10% Kenyans. Variations of those affected are clear per country and generational differences cannot be ruled out. Survey statistics shows (apart from Kenya) in Egypt and Ghana, the older the ages, the higher the number of those affected. Younger girls below 20 years are highly spared from FGM; whereas those above 21 years and above are already affected. However, follow ups are required to find out if the genitals of the uncircumcised girls below 20years will still be intact after a given period of time. Should results be positive (e.g. genitals intact for the next say 5-10 years), then promotion of successful behavior changes and sustainability would have been achieved.

Employment variations also show; those circumcised having mainly informal occupations or no employment at all. In Kenya for instance, 10% informally employed had undertaken FGM compared to 14% formally employed and not circumcised. In Egypt, 25% affected females were unemployed and only 5% formally employed. Ghana's 17% of the affected were informally employed.

10.1.2 A comparative analysis across female abandonment and maintenance attitudes

In Egypt, 20% circumcised females are willing to maintain FGM, compared to 12% of those circumcised with abandonment attitudes. All non-circumcised females (7%) – single or married, supported abandonment. Egypt is distinguished with the highest FGM prevalence (both in this individual survey and generally in other documented country wide studies (e.g. DHS, MICS). Also, high maintenance attitude (rather than abandonment), in regards to this study, is recognizable, especially among the already affected women and girls. Moreover, willingness and importance to socialize also daughters further into the same practices, were as well highly evident – especially among the already circumcised females and male counterparts.

On the contrary, despite the fact that majority Ghanaian female respondents were circumcised, no woman in Ghana supported FGM to be carried out further. In other words, none supported maintenance. Ghana's 17% circumcised females all supported abandonment, in addition to all those (5%) that had not been circumcised. However, Ghana's only two male study participants failed to give particular views (none-responses).

Meanwhile, Kenya's reactions were very unclear for both categories of women. This is associated with the low responses, likely to have been intentional, in regards to high levels of criminalization at the time of research (2011)

More married participants, who are against FGM, are scoped mainly in Ghana, rather than Egypt, with unclear results in Kenya.

With exception of both Kenya and Ghana, a handful of singles supporting FGM in Egypt are detectable.

Although generation trends were generally observable in all three countries – with much younger generations supporting abandonment, Ghana and Egypt were exceptional – for even

amongst older ages (e.g. above 45 years) quite a big number of abandonment attitudes were observed.

In regards with the occupation variable, all Ghana's almost 20% informally occupied (both circumcised and non-circumcised females) were for abandonment. Ghana's case is unique, for no matter the employment status, abandonment attitudes prevail above all. In contrary, Egypt's 25% unemployed circumcised women all had maintenance attitudes. These attitudes also highly occur amongst Egypt's formally employed than its informal occupants. Meanwhile, Kenya's attitudes amongst majority formally employed participants were mainly for abandonment and maintenance attitudes common among the informally occupied.

Measuring attitudes in relation with periods of stay, Ghana is not affected, for no matter how long participants had lived in study areas, only abandonment attitudes are portrayed. Contrastingly, Egypt's maintenance attitudes increase with increasing periods of stay, but steadily fall back among categories of participants living in study areas for all their life. Dissimilarly, Kenya's maintenance attitudes are higher among those that had spent over ten years in studied areas and recede amongst those living in studied areas for all their life. Egypt and Kenya have similarities of withdrawal of maintenance attitudes amongst participants living in studied areas for all their life. Explanations appear to be either historical bad experiences undergone or heard about; or recurring/persistent awareness and sensitization leading to a change in attitudes per change in generations.

10.2   Comparison of FGM practices

Given the total of 265 study participants from all the three countries, 18% Kenyans, 15% Egyptians and no Ghanaian – agree FGM being still widely practiced. In disagreement are 23% Egyptians, 18% Ghanaians and 13% Kenyans. Accordingly, the practice is believed to be most widely practiced in Kenya than Egypt and non-existent in Ghana.

Classifications indicate mainly 16% clitoridectomy (type 1) cases performed in Kenya and about 6% infibulations (type III), with excisions (type II) almost non-existent. Contrarily, infibulation is absent in Ghana, clitoridectomy almost non-existent and excision mainly present by 16% (for comparisons about type II mainly performed in Ghana see; A.R Oduro, P Ansah, et al 2006; E Sakeah, H V Doctor, et.al 2006). In Egypt, 38% clitoridectomy is mainly performed, excisions almost do not prevail and no infibulations at all. Similarities indicate; no infibulation cases in both Egypt and Ghana; clitoridectomy commonly performed in Egypt

and Kenya with less excision cases and excision performed at varying degrees in all the three countries.

Whether the total number of 205 female participants underwent FGM or not, self-reports show 23% Kenyan, 7% Egyptians and 5% Ghanaians not circumcised and 34% Egyptians, 18% Ghanaians and 13% Kenyans circumcised. Here, Kenya represents the least and Egypt the most – FGM affected women.

There is a distinguished variation in regards to ages affected. Whereas Egypt's most affected are lower ages (4-10 years), Ghana's are already adults (18 years and above) and Kenya's are middle aged (in-between childhood and adolescent: 11-14 years).

Reasons for undertaking FGM are similar and are aligned mainly along cultural than religious values, even though variations are evidenced per ethnicity (e.g. in Kenya), community (e.g. in Ghana and Egypt). Cultural-values representations are 23% each in Kenya and Egypt (despite quite a number of non-responses), and 17% in Ghana.

Traditional practitioners commonly perform FGM, with varying magnitude per country. In Kenya and Ghana for instance, traditional barbers account for 18% (besides high non-responses) and 15% respectively, with no notable medical personnel involvement. In Egypt, 28% traditional and 13% medical – personnel are involved.

A similarity is observable, given main decision makers in the girl's FGM status. Family influence plays a biggest role; in Egypt 42%, Kenya 29% and Ghana 8%. Ghana is the only country with substantial figures (almost 8%) representing self-made decisions. Meanwhile, Kenya is also the only country with no self-made decisions at all, despite its history of 'Ngaitana' (meaning: self-circumcised girls in 1956 when FGM was banned by christian missionaries and colonialists – see Lynn M Thomas 1996; Bettina Shell-Duncan & Ylva Hernlund 2000).

There are variations in periods when FGM takes place. Preference is mainly the fourth quarter (October, November, December) of the year in Kenya, third quarter (July, August, September) in Ghana and second quarter (April, May, June) in Egypt.

Complications (especially health-related) associated with FGM cut across all countries, with acceptability of 28% in Kenya, 13% in Egypt and 12% in Ghana. Denials are highly observed in Egypt (30%) than either Kenya or Ghana.

Challenges faced by non-circumcised girls, appear to be more of community social problems (e.g. stigmatization and ostracism) than family related, as similarly noted in the three countries, but with variations in prevalence.

10.3   Comparison of FGM abandonment strategies

Whereas surveyed Kenyans and Egyptians indicate more NGO efforts towards accelerating FGM abandonment, Ghana on the contrary highlights more government efforts.

A number of approaches against FGM are in use, characterized by sensitization and awareness model. Common approaches in use included mainly community based frameworks (e.g. rites of passage approach, generational dialogues, training change agents within and not without communities, community public declarations etc.,), cutting across all the three countries, with variations in magnitude and application.

Additionally, the health approach model (comprising of sensitizing health professionals, trainings on health associated effects, considerations in change of health curriculum, integrating sexual and health studies or workshops with particular focus on FGM in the general education curricular right from primary to institutional levels, improving health, social and psychological support of victims and introducing follow up methods, etc.,) against FGM appeared to be more welcomed in Ghana and Kenya than Egypt. Whereas Egyptian participants highly disassociated health consequences of FGM from the procedures or practices, both Kenya and Ghana realized the health harmful effects associated to FGM, hence variations in acceptance of the model. This model needs to be strengthened, for it offers change of curriculum possibilities and education model, which eventually could be one of the best procedures towards future behavioral changes and sustainability especially amongst younger generations.

The human rights model or legal approach appeared to have less influence in Kenya, Egypt and Ghana. The approach is disfavored because of its criminalization nature. Nevertheless, when critically analyzed, the most favorable – community based- or health approaches encompasses a degree of human rights model characteristics like say empowerment intentions, information dissemination, strengthening individual decision making capacity in relation to harmful practices, gender equality, children and women protection and above all human rights respect. Therefore though the model (human rights) is less used as a direct and standalone approach, it is twisted within other (community) favorable models and achieves more or less the same intentions. However, more clarifications about this model ought to be

done at grassroots. Grassroots communities need human rights trainings, and eventually the model needs to be incorporated to suit the local context. Also, it is important to involve communities in laws and policy frameworks formulations, so as communities can easily identify with such political measures. When active engagement and participation at grassroots is strengthened and facilitated, only then can politicians and activists guarantee easier identification, acceptability and popularity of laws and policy frameworks at grassroots.

The implementation of abandonment measures is not without challenges. As identified in the three countries, particularly Kenya and Ghana, mainly associated challenges are economic related (e.g. organizations are worried about: how to fund FGM projects sustainably; without project durations/time limits and without heavy reliance on donor funding). This is then followed by the social threats (e.g. community incited violence against FGM projects and individual or social groups – religious and traditional – recruiting and supporting FGM practices) as seen mainly in Egypt – hence hindering implementation activities against FGM and behavioral changes.

Political challenges e.g. less political involvement in (cultural) FGM matters, due to fear of losing votes, have been noticed in all the three countries, but with variations. In Egypt for example by the time this research took place (2013), there was no political cooperation whatsoever. The then Morsi government has been criticized by activists and organisations e.g. National population council, for supporting and promoting FGM during presidential campaigns and throughout the term of office, leading to poor women rights conditions. In Kenya (research in 2011), although government through the ministry of gender and children played its political part towards formulations and passing of policies against FGM (e.g. the children's act of 2011, supporting and facilitating public declarations etc.,) – nevertheless, some politicians have been criticized for trying to destabilize and hinder policy measures from going through during parliamentary debates. In Ghana (research in 2012), GAWW criticized lack of government motivation and political reluctance in FGM issues.

10.4   Comparison of the progress against FGM

Despite the challenges: Out of 205 female respondents, a total of 28% from all the three countries were not circumcised. This to a certain extent can be interpreted as progress, for all the surveyed ethnics or areas (e.g. Somalis and Maasai in Kenya, Kassena-Nankana in Ghana and Egypt's Benisuef, Fayoum, Assiut and Cairo) are almost universally affected. In other

words, even though all female in the surveyed areas are expected/must undergo FGM; those who survived are 'heroes?', hence behavioral changes.

Furthermore, the fact that survivors are mostly younger generations below 25 years, who mostly likely would not enforce FGM to their own children as well in future, implies the possibility of coming/future generations being FGM-free.

Variations of survivors of FGM can be seen per surveyed countries. Out of the total 28% circumcised females, 16% were Kenyans and 12% Ghanaians and Egyptians. Following single country analysis, Kenya's most female participants were not affected like their counterparts in Ghana and Egypt. Even though self-denials (denying having undergone FGM/under reporting) cannot be ruled out, however, in this sense progress in behavior changes are indicated more in Kenya than either Ghana or Egypt.

Although, despite Ghana's most female surveyed participants being highly affected, nevertheless all (be it survivors or those affected) supported abandonment – hence progress in change of attitude.

Such kind of attitudes (where all support abandonment) neither occurred in Kenya nor Egypt, where maintenance attitudes were clear – even among some uncircumcised females. For instance in Egypt, almost half of surveyed participants supported and wished to maintain FGM as a well-known 'beneficial' cultural norm. Majority were also willing to socialize their daughters into this harmful practice, which in my opinion – is absolutely wrong.

All in all, less risks of girls being circumcised is mostly evidenced in Ghana, moderate in Kenya and higher in Egypt. Despite the challenges, survey shows best progress in Ghana, better in Egypt, and good in Kenya; which indicate clear variations in (a) impacts of strategies against FGM, (b) actual willingness to change behaviors and attitudes and (c) sustainability of changed behaviors and attitudes.

10.5   A comparative analysis of field based - NGO intervention model.

Henceforth, NGO intervention models are comparatively analysed to help identify their strength, gaps and limitations in relation to field surveys

10.5.1 *Sensitization and awareness model*

Information about FGM is spread to a wider audience by use of traditional methods and local languages. For instance World Vision Kenya and CEWLA- Egypt conducted mainly seminars

or workshops to sensitize masses in Kiswahili and Arabic respectively. Meanwhile, songs, poems and storytelling were very symbolic in Ghana through GAWW activities in Nankam and Kassem local languages. Each country's information dissemination (against FGM) is not limited to these particular types of communications (mentioned above), although appeared to be the commonly used methods amongst surveyed communities. Locally oriented simple methods of communication allow participation and easier understanding of messages put across to different audiences.

Sensitization and awareness approach was a typical method used by nearly all institutions – with the aim of conveying information to as many people as possible – to accelerate abandonment. Groups of audiences targeted included women, men, traditional and religious leaders, pupils, youths, doctors, nurses, teachers, circumcisers, traditional midwives and media personnel. This was so especially in Kenya and Ghana. Messages dispersed to as many audiences as these allow critical reflections between groups and mutual solutions. However, in Egypt, due to the political instabilities, the model was restricted mainly to women groups and carried out occasionally. Considering the context under which FGM takes place, men appear to be the main perpetrators as heads of families, husbands and major decision makers. Sensitizing women alone (e.g. in Egypt) is likely to bring not much significant changes. For as long as gender equality remains a problem, women will still exist as subordinates, incapable of making own decisions under strong patriarchal influences – hence the need to address men as well, to allow gender sensitive critical reflections, support and collective solutions.

Activities were conducted at locations convenient for grassroots participants. For instance in Ghana, people communed mostly under shades of trees in particular places or at community leaders' compounds or in market places. In Kenya, forums and seminars were mainly organized at community churches or classrooms at nearby schools. Choosing places commonly known and used by communities gives a feeling of belongingness, ownership and identification, and hence allowing high participation. In Egypt, due to political insecurities, women met at EBESCO and CEWLA offices for FGM seminars to transpire. However, such arrangement is likely to limit participation due to; a) lack of knowledge of fixed dates of sensitization, b) likely involvement of transport costs coverage for participants; c) home issues (house wives expected to stay at home) and d) rigidity in time and place. On the advantageous side, NGO personnel security is guaranteed, without necessarily exposing them to 'violent' masses within communities through 'open air activities'.

Activities usually involve trainings and discussions lasting not more than two hours. Messages put across emphasize the harmful effects of FGM, women or children rights violated by the practices, religious and cultural views against FGM – fitted into grassroots context (e.g. everyday life, daily activities, social relations, living conditions, etc.) to allow easier understanding and to generate discussions. Though two hours are not enough to bring about serious impacts, continuous/frequent activities are likely to lead to thoughtful reflections (e.g. the Longoswa forum in Kenya) and eventually significant impacts.

Religious messages target audiences who uphold religious views and justify FGM along religious lines, e.g. especially Islamic audiences (like Somali in Kenya and Egyptians). Religious leaders are thus often invited as experts to talk to communities about 'proper' religious expectations of Christians, Muslims and Pentecostals and to delink FGM from religion. Because they are highly respected and influential people, religious leaders successfully convince their followers to change behaviors and attitudes. However, challenges appear to be problems of winning influential community members to the abandonment side and to eventually act as change agents in their own communities. At times, even those religious leaders who change their attitudes face fears of openly stating their abandonment opinions, for the sake of community trust and honor (e.g. some Imams in North eastern province of Kenya – among the Somali communities, and in Egypt) – hence hindering change by influence.

Meanwhile, cultural messages, passed on usually by cultural leaders or community elders during sensitization and awareness sessions – aim at analyzing and reflecting on all cultural views attached to FGM (e.g. rites of passage to adulthood, virginity myths, marriage-ability, honor, funeral fulfillments, appealing to gods and ancestors, etc.) and detaching such views from culture – in order to promote good practices. The challenge here is also winning over the community leaders and elders. Being that they are the gate keepers of culture, cultural norms and practices; introducing changes against own cultural values or questioning long standing traditions are likely to face criticisms and not openly welcomed. There is a risk of activists being seen as imparting western cultures, values and influences into local communities, which is negatively seen. Therefore such resistances should be expected. However, appropriate moves need to be calculated (e.g. time investment into sensitization projects targeting only influential people and decision makers, sensitivity and understanding needed, cooperation and keeping calm once the situation goes out of hand, and above all, much patience to allow self-reflections and contemplation).

Eventually, working with facilitators and authoritative figures (e.g. community elders, religious leaders, women leaders, social workers and medical personnel) from within targeted communities and localizing campaigns to suit local needs – gives attendees a sense of ownership and a trusted platform to discuss such taboo-associated issues. This eventually allows openness and prepares grounds for mutual discussions to take place.

Discussions held are not exclusively about FGM, but include other topics like poverty, reproductive health, children rights, early marriages and education. This was so at least in Kenya during the Longoswa and Mailwa forums organized by World vision Kenya, Namanga branch (located almost at the Tanzania boarder) in the Maasai region. In Ghana, social-economic daily hardships faced by communities in their daily lives are addressed in relation to FGM (e.g. as seen in NHRC and GAWW activities). In Egypt, issues affecting women in private spheres such as marriage, polygamy and health concerns are discussed together with FGM topics. Therefore sensitization forums need to suit particular contexts at grassroots. The need to thus study and better know the communities first – before implementing any project, is advisable.

In none of the countries, is FGM discussed independently – as a standalone theme. In other words, FGM is tackled together with other different topics, in relation to communities' daily life and activities. Several issues are first discussed, before FGM comes on the table, due to a) its sensitivity and b) FGM not considered a problem that requires urgent attention, in relation to daily life challenges/deteriorating social-economic conditions (e.g. lack of food, clean water, housing/accommodation, education, employment, health facilities, etc.) at grassroots. Now, depending on financial budget or other resources (like human) and fixed periods/time of project durations, addressing FGM in combination with other topics can prove time and resource consuming. Moreover, changes in behaviors and attitudes are not to be guaranteed within sensitization sessions, for they are usually warm up activities before actual implementation of various methods (e.g. public declarations, alternative rites of passages, community dialogues, etc.) is put in place.

Nevertheless, sensitization and awareness model is likely to successfully change attitudes and behaviors of those individuals already at contemplation stages (of whether to undertake FGM or not, not willing to undertake FGM but under social pressure and therefore probably waiting for outside support and affirmation to confirm attitudes against FGM) and not conservative die hard willing to maintain FGM at all costs. For the latter group, such forums may generate

useful information (leading to self-reflection and critical-analysis) that is likely to eventually lead to contemplation stages, though may not necessarily guarantee changes.

After communities have been exposed to program messages agitating for abandonment and exposing off consequences associated with the practice, it is very likely that decisions to abandon FGM may easily be arrived at. Community abandonment programs may not necessarily aim at converting the decisions to undergo FGM, but rather strengthen the resolve of those whose decision is somewhat tenuous, and creating conditions in which rights can be introduced (Izett, Susan and Nahid Toubia, 1999; Nahla Abdel-Tawab & Sahar Hegazi, 2000; CEDPA, 2000).

As far as method analysis and documentation is concerned: NGOs in charge of sensitization and awareness forums often times take notes on the seminars held, speakers involved, attendance records and participants' reactions. However, very few conduct impact assessment sessions to check on the influence of the approach towards behavioral attitudes of participants. More so, when evaluations are done, indirect indicators (like turn-ups and participants' reactions) are relied upon for impact assessment. Therefore, pre and posttest measurements need to be considered, to evaluate the impact of awareness raising forums.

10.5.2 Health model

This further approach particularly sensitizes about the health effects of FGM and targets health related professionals and institutions or areas to disburse information against FGM – for instance; clinical studies, sexual, reproduction and health studies in schools and political policy reformations in health sectors.

It also targets as many audiences as possible and puts particular emphasis on health personnel. Health personnel are argued not to alter women reproductive organs in any way. Reasons as to why reproductive organs should not be altered accompany the model (e.g. explaining detailed use of each part of the genitals and importance of being intact). Sensitization is also made about the laws governing health professions against FGM performance. Health personnel are also taught on how to handle FGM patients. This is evidenced mainly in Kenya through the ministry of gender, children and social development and MYWO, and in Ghana through GAWW activities, likewise in Egypt through EBESCO care.

Nevertheless, various governments through their ministries of health need to put systematic policy measures and health action plans in place; in order to psychologically, socially and medically support FGM survivors and those at risk. Otherwise, individual institutional/NGO activities are limited in scope, capacity and finance. Further, improvement of already existing health facilities in outlook, services and equipment, coupled with continuous health personnel trainings depending on occurring problems – need to be highly considered, to suit community increasing health needs (e.g. handling fistula, infibulated women, clitoris reconstructions, etc.)

The health model in relation to explaining health effects of harmful practices offers most times an entry point into discussing taboo topics (e.g. FGM) at grassroots. However, its effectiveness is compromised when communities seek alternative measures to avoid health hazards.

10.5.3 Human rights model

Additionally, the Human Rights model brings into light and addresses mainly the gender inequality problem. It has been effective in raising awareness; improving literacy levels (especially for women) and has forged way outs to socio-economic development plans for (women) empowerment purposes. Amal Abdel Hadi (2006) has examined the significant shifts in attitudes that led a Christian village called Deir El Barsha in Upper Egypt to abandon FGM without deliberate outside intervention. This shift was linked to development efforts involving the Coptic Evangelical Organization for Social Services (CEOSS) and local leaders. Campaigns were not targeted specifically to the problem (FGM), but a more fundamental change in gender relations in local society. Empowerment projects enabled women to review FGM and persuaded village leaders to use their influence to abolish the practices (Amal Abdel Hadi, 2006). Indeed the case for this village suggests that women empowerment has substantial influence towards behavioral changes, and proves that local efforts can be very effective in stopping the practice.

Based on the CEOSS example, CEWLA in Egypt integrates the HR model in its projects amidst political challenges, hence achieving limited success. Meanwhile, the model has gained momentum in Kenya especially through MYWO and Ministry of gender projects against FGM (see Asha Mohamud, Samson Radeny and Karin Ringheim, 2006; Jane Njeri Chege, Ian Askew & Jennifer Liku 2001; Humphres Evelia, Maryam Sheikh, Carolyne Njue & Ian Askew, 2007). In Ghana, the HR strategy achieved formidable success through the

Navrongo Health Research Centre's (NHRC) five-year project (see Charlotte Feldman-Jacobs and Sarah Ryniak, 2006).

Educative and sensitization programs that include human rights, reproductive health, gender relations and economic empowerments give women confidence to participate in community level discussions, which eventually changes women positions in societies (Diop J Nafissatou and Askew Ian, 2006). Provided with the opportunity of self-determination; women are likely not to be any more captives of their roles as housewives, subjected to the hegemony of customs and traditions that are detrimental to them (Diop J Nafissatou and Askew Ian, 2006). Several reasons attributed to FGM are evidences that this social practice aims at controlling women's sexuality, resulting into altering women genitals, to keep them in line with patriarchal norms and ideologies.

Education on human rights and gender relations along with information about FGM helps women understand that FGM must be viewed as an integral component of their rights, their roles in society and community development. If the political will is present, empowering women within local communities while respecting their own wisdom and experience is one of the most effective ways of combating FGM.

However, the geographical reach of the approach is limited and somewhat expensive to reinforce in terms of belief, money and work force.

10.5.4 Community involvement approach

Similarly in several communities in Kenya, FGM has been part of the ritualized communally organized process – marking the girls' coming of age and their preparation for marriage. MYWO realized that cutting was a symbol of this transition. Together with PATH (Program for Appropriate Technology in Health), MYWO designed a program called the Alternative Rites of Passage (ARP), which preserved the social meaning of the ritual while eliminating the harmful part of cutting (Mohamud Asha, Radeny Samson, and Ringheim Karin, 2006; PATH/MYWO, 2000). Aiming at community empowerment, focus was put on the rural districts of Kenya to include Kisi, Meru, Narok, and Samburu. While using this community-based and involvement approach, those directly involved in the practice are placed at the center of MYWO's activities in mobilizing for social change.

CEWLA in Egypt, GAWW in Ghana, and World vision Kenya also rely on influential members of the community to act as behavioral change agents. (See also Nahla Abdel-Tawab

& Sahar Hegazi, 2000; GAWW 2005, World Vision Kenya 2002 & 2008; Melanie Feuerbach, 2011). Religious leaders, peer educators, health personnel, community elders, women groups, social workers, media personnel, teachers, parents and politicians are trained through workshops and seminars in order to perform their roles without barriers. There are no variations in the course content depending on either groups or level of knowledge. The content usually aims at passing on skills to help combat FGM at community levels.

However, very few workshops targeting grassroots educators include trainings on communication and persuasion skills (see Training Kit Prevention and Elimination of Female Genital Mutilation among Immigrants in Europe, 2002)[47].

Besides, participants are rarely guided on how to integrate anti FGM messages into their daily activities. Apart from that, no systematic follow-ups on trainees are made after workshops to determine whether skills acquired during workshops are exclusively in use at grassroots levels. Finally, very few organizations have managed to specify agendas of activities for facilitators to follow. Among all the researched institutions, CEWLA maintains informal relations with trainees, who usually inform the NGO about their problems and inquire on proceedings where necessary.

Moreover, prompting families to re-evaluate this tradition (FGM) requires sensitivity of their cultures and requires understanding towards deeply held beliefs. Consequently, transforming FGM practices requires multiple prolonged approaches and using various actors to raise awareness and mobilize for change.

Locally based actors help best – to develop effective strategies that promote abandonment and behavioral changes, in line with community's local context. Therefore using community based and involvement strategies show promise, by use of a multi-faceted approach in an integrative manner to addresses knowledge, attitude and actions.

10.5.5 Community positive deviances (peer educators & ambassadors of change)

Under the community umbrella, the use of positive deviances is common. Community members that have earlier defied the practice are further trained and used as change agents to convey FGM abandonment messages. For instance traditional circumcisers that have given up the trade, girls that have escaped FGM, parents that have supported their daughters' cause of

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[47] Training Kit Prevention and Elimination of Female Genital Mutilation among Immigrants in Europe. http://ec.europa.eu/justice_home/daphnetoolkit/files/projects/2002_040/tranning_kit_2002_040.pdf. Accessed on 17.10.2014

not undergoing FGM, men that have accepted to marry the uncircumcised girls and community elders who openly speak against the practice.

NGOs like GAWW in Ghana, World Vision Kenya and EBESCO in Egypt – identify these categories of people and finally work with them for positive influence. For instance field survey shows that in Benisuef (Egypt), one girl who suffered health effects of FGM turned out to be a strong advocate against FGM; in Marigat (Kenya), a 12-year-old girl who ran away from home because of FGM has been used as an example of positive deviance and a peer educator. Among the Illchamus community (Kenya), one university student became a positive defiance after defiling the norm at an earlier stage as a result of one death caused by FGM within community, which she had heard about.

The positive deviance approach is a convincing one because shared stories, experiences and messages against FGM come from community members themselves and these told stories are part of a community's history. Such messages are more persuasive and can easily spark changed attitudes due to the powerful ideologies they inhibit. Once individual attitudes have shifted; family- and eventually community attitudes will follow suit.

The problem with positive deviance model is building self-esteem of the positive deviances and convincing them to declare openly their status – without exposing them at risks (e.g. stigmatization and ostracization). It is therefore recommendable that in the process of identifying positive deviances, NGOs should work with a possibility of risk outbreak and violence attitudes aimed towards positive deviances (which may have long been successfully escaped). Protective measurements should therefore be readily available.

In typically circumcising communities where FGM prevalence are universal (such as Egypt), it is very difficult to identify positive deviances who defied the norm because of fear of being exposed. However once a few positive deviances are identified and agree to share their stories during say community forums – this eventually encourages other positive deviances to move forward and openly declare or share their stories.

10.5.6 Public declarations

Within practicing communities, people fear to damage their reputations by stopping the practice individually, not until the matter is brought into open. Mackie Gerry (1996) suggests that holding public declarations against the practice, enables individual families to know that

a critical mass of significant others also hold the same views; which eventually becomes a new social convention for that group.

In regards with the survey, Kenya has set an example of public declarations – as seen in West Pokot, Meru, Kuria and Marakwet – under the UNFPA & UNICEF joint programs support, together with the Ministry of Gender – unlike Ghana and Egypt.

Public declaration model adds sense of security towards opinions and expectations of others, which would otherwise have made individual families uncertain about other's attitudes towards abandonment (Mackie Gerry 1996).

In conclusion, each model has its strength and weaknesses and each approach is suitable for behavior changes in a unique way. There is no model that can be used in isolation. However, it is necessary to create a social and political environment that combats FGM for the maintenance of the new behaviors (abandonment attitudes). In building a positive environment, the role of media towards advocacy and political support should be emphasized and integrated in programs advocating against FGM.

Experience has shown that long standing beliefs and practices cannot change easily. It requires long-term efforts and commitment without deadlines.

In addition, improving the social, economic and political status of women is a way forward, towards sustainability of behavioral shifts of those who decide to abandon FGM.

11. DISCUSSIONS

The following part aims at discussing results from the survey with focus on:

a) disentangling the practices,

b) progressive observations as opportunity for behavioral changes and future predictions

c) identification of loopholes in progress towards behavioral change and sustainability

d) Personal recommendations by illustrating the insight model - 'cross network FGM abandonment projects for and with the community' - with the hope of contributing towards FGM abandonment acceleration.

e) Conclusion remarks.

11.1 Disentangling the practices

11.1.1 FGM reinforces virginity as key to Marriage

Results from Kenya, Ghana and Egypt indicate most participants as married with few singles and rare divorced cases. Survey further shows that married participants were highly affected by FGM (at the ages 4-10- in Egypt, 11-14- in Kenya, and by 18 - years in Ghana). Common ages of marriage are usually from 15 years onwards. Probably the reader wonders how and why the two variables influence each other in countries where FGM is highly prevalent (e.g. especially in Africa). FGM is connected to virginity and marriage as a means of (a) ensuring virginity, (b) reducing sexual urges of a woman, (c) or preventing any likely sexual temptations before and after marriage. Enhancing marriage-ability is an often mentioned reason for undertaking FGM as seen in several researches (e.g. Gruenbaum 2001; Shell Duncan 2001; UNFPA 1997; WHO 1986; UNICEF 2013 & 2014; DHS and MICS studies, etc.).

It should be noted that marriage is an important institution highly adorned in Africa (see John S Mbiti 1973 & 1991; Lee 2007; Ronan Van Rossem, Anastasia J. Gage 2009). In many African communities, a woman achieves full respect from her community, when she is married and bares children. Only then, is she seen as a complete woman. The presence of marriage institution can be explained not only by structural demands, but also by women's access to status, rights and authority. Beth Greene (1998) clarifies that by studying women and marriage, only then, can we more accurately understand women's significance in the social structure.

In communities where this study project took place, marriage remains an honorable deed (for the girl, her family and relatives) – expected of every female at a particular time. However, marriage does not come easily without sacrifices. Virginity has to be maintained at the time of marriage. Not being a virgin has damaging social consequences to the individual (girl) as well as the parents (family). Virginity is a marriage requirement that eventually (even after marriage) is based upon to measure the reliability of sexual behaviors of a married woman/girl – a guarantee of being sexually faithful to a husband once married. Virginity of a woman also ensures fatherhood of the husband – without having to doubt the DNA of the off-springs/children. A virgin girl thus brings honor to her family within the community.

It is gender discriminative – that a woman's role is reduced to sexuality and motherhood whereas men's sexuality is left untouched or untamed? For there are no same/equal standards expected from both sexes in as far as sexuality is concerned. Whereas men are free to engage in polygamous acts and no remedies for male virginity are put forth, women are strictly condemned for doing such 'immoral' acts. FGM can be seen as an example of cruel preventative methods of taming female- and not male sexuality, hence nurturing gender discrimination.

11.1.2 FGM hinders empowerment

The study further shows most circumcised females characterized by informal occupation (e.g. in Ghana), unemployment (e.g. in Egypt) and lower education levels (especially in Kenya and Ghana). Characteristics of such nature are believed to commonly influence FGM, especially amongst countries/communities whose FGM levels are not universal (UNICEF 2005; DHS 2003; WHO 2008). Without empowerment (through education and employment opportunities), social and economic independence of women is limited, hence depending on males as husbands, fathers and brothers for social-economic security. Meanwhile, the independent-decision-making process for females is also affected, hence exposing women to vulnerable and subordinate positions.

Empowerment perspectives are based upon different theorists like social, political, and social-psychological and organization and management theorists. According to the critical social or feminist theory of empowerment, conditions of the oppressed groups need to be improved (Kuokanen & Leino-Kilpi 2000). Disadvantaged groups are in a subordinate position, struggling to improve their conditions and to attain liberty (Bradbury Jones, Sambrook & Irvine 2007). Empowerment in the context of FGM can be critically looked at in line with the

historical role of women and the social structures women find themselves into, which contributes highly to making females subordinates both in the private and public life - in social, economic and political arenas.

Freire (1973) once suggested education as a plan for liberating the oppressed people of the world, in concern for local grassroots community based initiatives. Empowerment in this sense is closely related to power. Traditionally, power was understood as an isolated entity and a zero sum, usually possessed at the expense of others (Lips 1991; Weber 1946). Recently, power is shared as a means of strengthening 'others'. Thus shared power opens possibilities of empowerment and is conceived as "a multi-dimensional social process that helps people gain control over their lives" (Page & Czuba, 1999, p. 25).

For political scientists, the process of giving power to the people (Angelique, Reischl, & Davidson, 2002; Nelson, 2002) was a major concern. Political scientists were especially interested in the progressive social position of the disadvantaged, including women (Gallway & Bernasek, 2004; Gerges, 2004), ethnic minorities (Weissberg, 1999) and the disabled (Kay, 1998).

In the context of FGM, understanding the forces that nurture and sustain the practice is important. That way, information, messages and activities can be tailored to audiences accordingly (Rigmor C Berg & Eva Denison, 2013). Exposure to education (allows questioning/analyzing FGM in an intellectual manner), social-economic resources (foster independency, improve power relations, raises assertiveness and self-confidence) and power sharing (addresses discriminations in decision making) are factors, which when addressed are most likely to allow women question harmful cultural practices (e.g. FGM, breast ironing, widow inheritance, etc.). Eventually, changing geographical locations or urbanization can help get rid of peer- and community pressure, especially when migrations are done into locations where FGM is not social norm or custom. Kenya's- and Ghana's low countrywide FGM prevalence are clearly influenced by variables such as education, employment, geographical location, urbanization, etc., as indicated by the study.

However, in some cases like Egypt – with universal FGM prevalence status; the need to preserve identities and the desire for belongingness is stronger – that sometimes, even education, urbanization, employment and change in geographical location may not necessarily influence change in behavioral practices. That apart, even migrants from countries where FGM is commonly practiced (e.g. Sudan, Eritrea, Somalia, Egypt, Guinea, Senegal, etc.) have

continued to observe these practices even within receiving communities in Europe, USA and Canada where FGM is not practiced (Elgaali et.al, 2005, Chalmers and Hashi, 2002). Consequently, FGM amongst diaspora communities in Western countries is being thoroughly studied (EIGE 2013, ENEGE 2015), criminalized (Anika Rahman & Nahid Toubia, 2005; Leye, et al.2007, UNICEF 2005a; WHO 2006) and a few cases successfully persecuted, for instance in France (Anika Rahman & Nahid Toubia 2005) and elsewhere in Europe (Leye & Sabbe 2009) amidst several critics.

Explanations for such clinginess to harmful cultural practices, confirms that FGM is a deeply rooted custom that in some cases supersedes social classes, or locations to describe particular identities. Therefore, Absharaf (2006) suggests the need to analyze particular contexts within which FGM has come to be accepted and upheld; as described for instance by Boddy (1998), Gruenbaum (2001) and Shweder (2002). Besides, Benedict (1934) recommends viewing history in its widest sense to give an account of acceptances and rejections of FGM.

11.1.3 Cultural myths enforcement mechanism hinders behavioural changes

The fear of tasting the 'unknown': While tradition covers the main existing deeply rooted myths surrounding rationalization of FGM, each ethnic group has its own different version of these myths given on by ancestors. In Ghana for instance, I found out during my research that in Sirigu and Kandiga, it is believed that if an uncircumcised woman crosses the backyard (where usually gardens are), the plants wither. More still, an uncircumcised woman is not welcomed by the ancestors at the time of death/burrial, and she is buried like a 'man' (i.e. without part of her belongings – usually collected in the piligo/pot).

Joseph Campbell (2001,p 1-2), a mythologist, associates myths to metaphors. "A whole mythology is an organization of symbolic images and narratives, metaphorical of the possibilities of human experiences and the fulfillment of a given culture at a given time". William E Smythe (2003) explains that pre-modern ancestors used a diverse array of myths to come to term with aspects of the world that were beyond their direct experience or explanation (e.g. the origin of the world, the mystery of death, etc.). Ancient myths thus, exemplified more a phenomenological system than a scientific one, and the mystery of the origins of experience is still very much with us.

Our ancestors thus employed metaphorical projections from the world of the concrete and familiar. According to William E Smythe (2003), to see something metaphorically is to see it

in terms of what it is and what it is not. Metaphors thus play a distinctive role in psychology, unlike the (closely related) role it plays in natural science disciplines.

Putting FGM in the framework of myths, in rigid and remote communities – even with global information, changes and knowledge – the possibilities of changing the mythological status quo surrounding FGM is minimal and inconceivable. Information that comes from the "protectors" of cultures (e.g. elders, chiefs, religious and traditional leaders) is accepted with minimum opportunities of challenging such knowledge. Social-psychological ignorance, stubbornness and the fear of going against the social norms and customs (to attest the unknown) makes women in particular perpetuate FGM practices repeatedly. Traditions appear to offer solutions to all community problems through utterances like, "this is the way our ancestors did it." (See Kenya, men discussion, recording No. 8).

Apparently, superstitions that accompany FGM are sometimes too strong, that even health problems associated with FGM (see WHO 2000, 2006 & 2008) are treated usually as witchcraft (e.g. among the Maasai), spiritual gods not being appeased (e.g. in Ghana), traditional customs not well followed (e.g. Egypt) than factual directly related health effects of FGM.

11.1.4 Addressing generation - differences

In Ghana older ages (45 years and above) made up a substantive number of surveyed groups than Kenya and Egypt. For the study, it implies that there is certainly no shortage of social practices and arrangements that fall within the remit of ageism (Nikolas Coupland 2004, p. 97). The issue of age does not deflect research interests, rather by acknowledging older age participation and their resonance fosters appreciation of adult or aged theoretical contribution to social sciences. Presetting an agenda for ageing research in terms of FGM surveys contributes to what Nikolas Coupland (2004) calls social disenfranchisement, particularly when the process of disenfranchisement is part of the proper agenda of critical research.

Exploring and examining adult's attitudes towards experiences of their own aging and future old age, can address factors that may influence policy and sustainable social change towards FGM: Not forgetting that adults are more skilled in managing and addressing social problems of the like. Whereas younger lives can offer opportunities for continued development, change and growth; attitudes of aging will influence the ways adults manage and experience the latter part of their lives. A combination of resonance of these ages or generations (to address FGM)

is very likely to lead to sustainable results of change in behaviors. Besides, it works towards inclusivity [in points of views] and irons out discriminative-strategies (e.g. considering youths) towards FGM abandonment.

Although it is highly believed that adults are rigid to change than youths (Jeanette N. Cleverland, Sockdale M, Murphy R.K 2000:42) even as shown by some FGM researches (WHO 2008, UNICEF 2005, UNFPA/UNICEF 2013, etc.); nevertheless my research shows systematic variations. Ghana (in particular) represents will for FGM abandonment no matter the generation differences per age category. In Egypt rigidity towards abandonment grows steadily with increase in age. In Kenya, there is a clear-cut of lower ages supporting abandonment than older generations.

11.1.5 Strategies of abandonment

Enthusiasm and devotion of behavioral changes are rationalized on several grounds. Adoption of comprehensive strategies that have persuaded people to change their attitudes is increasingly being used (by different institutions working towards FGM abandonment). Besides, culturally acceptable, participatory and sensitive methods encouraging behavioral changes are more carefully considered and in use today (e.g. in Kenya and Ghana) than in the past (e.g. in Kenya - during and after colonialism - resistances overwhelmed FGM abandonment campaigns – see Thomas Lynn, 2003; Jomo Kenyatta, 1938; Kershaw Greet, 1997; Pedersen Susan 1991). Also, collaborative efforts between communities, government, NGOs and INGOs appear to be more shouldered today (See UNFPA/UNICEF 2013; Mohamud Asha, et.al 2006; Amal Abdel Hadi; 2006; Nafissatou J.Diop and Ian Askew 2006; Abusharaf 2006), especially in Kenya. Clearly, where resistances are faced, it is recommendable that strategies are critically analyzed to see if they fit in a particular community's context.

11.1.6 Male representation

Even though the study aimed as much as possible to get a gender representative based overview about FGM, several men intentionally avoided the research – claiming that it was women issue. This was so especially in Ghana, unlike Kenya and Egypt where at least almost three-quarters of male participated in the study. However, generally considering the total number of women (205) who participated in the three countries, male active participation (60) is considered to have been lower.

FGM being partly an emotional subject, Snell et.al (1988) indicate that men and women emotional disclosure vary as a function of their own gender and personal characteristics of the disclosure recipient. While women are more willing to discuss their feelings with others – especially women recipients, Mosher and Sirkin (1984) suggests that in Hispanic cultures, the masculine identity requires that males display a cool aloofness from others.

11.1.7 Perpetuation of FGM

Despite low male participation, both sexes have a lot to do with FGM perpetuation. Women for instance derive social status and position within society from their roles as wives and mothers, and by socializing their daughters into the same female roles (Gruenbaum 2001, Yoder et.al 1999). When it comes to daughters' FGM status, women mainly play an influential role as mothers undertaking the decisions and organizing FGM related ceremonies, and as circumcisers performing the practices (in preparations for adulthood, marriage, etc.).

My research shows that in Ghana, women are responsible for paying off the circumcisers with millet flour during harvest seasons in exchange for their services (FGM procedures). In Egypt, its women who mainly consult with the doctors/health professionals to have FGM approved. In Kenya, women provide the cloth and a new dress to the circumcised girls as a symbol of congratulations on being formally adults. More views about female perpetuation of FGM are elaborated upon by Nahid Toubia (1995), Marie Bassil Assaad (1980) and Comfort Momoh (2005) among others.

Meanwhile, men's involvement in the FGM perpetuation framework (See Daniel Gordon 1991; Carr D,1997; James Whitehorn et.al 2002, pp 161-170; Hoda Rashad, Magued Osman, & Farzaneh Roudi-Fahimi, 2005; UNICEF 2013) include: -

As heads of families, men influence almost all kinds of decision-making and their decisions are conceived as final and of more importance – in patriarchal societies. Final consultations given daughter's status in FGM matters involves men (in most communities), who then give their final opinions and either passively or actively participate in the social-economic arrangements of final FGM ceremonies (which usually take place in the compound of the girl who has been circumcised).

It should be noted that family compounds and homes are headed by men. Therefore, there is no way, men can deny responsibility of FGM celebration functions held in family compounds, or what has prior taken place – calling for such celebrations. Usually, men as fathers or

husbands are very much aware of such social norms within their own communities. Sometimes they are being engaged as cultural or religious leaders or elders responsible for keeping in place – traditions, customs and norms of a particular community. Men as fathers or husbands are also much aware of ages and periods when such ceremonies usually take place. In this sense, men can decide to protect and support their daughters in time, prior particular ages and periods of circumcision – that are well known to them. Failure to do that shows full consent or approval. In this case, women just fulfill their socialization responsibilities as mothers- with full approval from men.

During FGM ceremonies, usually relatives, village elders and other community members commune, to celebrate coming of ages. Sometimes, one function is organized, to celebrate and welcome a group of new adults recruited (through FGM). Male actively participate in such functions, as they (a) undertake or fundraise financial expenditures incurred on such ceremonies, (b) responsible for the spread of information concerning FGM ceremonies to male members of the community (e.g. chiefs and elders) and patrilineal relatives.

Also, as husbands, men prefer to marry circumcised women, giving no chance to the un-cut girls. Men are well aware of the stigmatization the un-cut girls go through in communities that strongly or universally practice FGM. Men contribute to this stigmatization by intentionally preferring to marry 'only' circumcised girls/women. There are very few men within practicing communities, who will accept marring non-circumcised women. For even within male groups, the pressure and stigmatization exist, particularly when one decides to marry an uncut woman. Because of fears of not securing a future husband, leads to women's involvement in further FGM perpetuations. In this case, male sustain FGM by demanding to marry only circumcised women, which is a rational decision undertaken by males.

My own experience from field study: in Kenya, men as compound heads and fathers are responsible for bargaining and receiving dowry (in exchange for daughter's marriage) in relation with FGM status. Among the Maasai for instance, a circumcised girl receives twice as much dowry as an uncircumcised girl. Such economic gains trigger FGM and can be seen as means of upholding the practices/enforcement mechanism. In Ghana, fathers are responsible for consulting with spiritual gods concerning daughter's FGM status approval. In Egypt, upon marriage, husbands expect to receive virgin brides. FGM helps maintain virginity or control female sexuality. Expectations of virgin brides or controlling female sexuality has also partly influenced ages at which female children get married (below 18 years) or circumcised (0-14 years) in many countries where FGM is prevalent. Sharmon Lynnette Monagan (2010)

explains that – if women have multiple sex partners or are sexually active, they are branded as being promiscuous. However if men go off with such unbridled regards, they have no fear of being stigmatized; instead men are revered for their conquest.

Conclusively, as religious and cultural leaders, men act as gatekeepers and enforcers of social norms and traditional values (in both religious and social-political circles). Therefore, male hierarchical and power structures reinforce FGM practices – whether directly or indirectly.

11.1.8 Historical power hierarchies in correlation with current sexual inequalities

Religious scriptures: Sharmon Lynnette Monagan (2010) shows in the genesis story of humankind's fall from grace – women being described as a weaker gender, as illustrated by the serpent's approach to Eve and not Adam. The bible (in Genesis) represents a Woman as a sexual being, who, having been seduced by the serpent, eventually also seduced Adam into eating the 'forbidden fruit', thereby disobeying God. This is the reason as to why God put man in charge of woman – in relation to the Genesis-chapters in the bible – where Adam (man) was put in charge of Eve (woman).

In this context, women's sexuality is seen as powerfully destructive and therefore needs to be tamed (by man) to avoid possible problems like the ones that occurred in the 'Garden of Eden'. In reference to the genesis bible story, not only does man derive his authority from God, but also his mandate to provide leadership and correction to his wife and children – in order to progress toward redemption. From the genesis chapter/religious teachings, it is evident that virginity and sexual modesty is central in defining a righteous and honorable woman.

These biblical narratives are evidenced in the daily lives of contemporary society where patriarchy overrides social, economic and political structures. At worst, women's virginals in Africa have been transformed, to control feminine sexuality for 'women's own good' and for the protection of "man-kind".

Scientific scenes: In addition, the social Darwinism theory in seeking to apply the biological concepts of natural selection and survival of the fittest, declares men as more aggressive in nature and women as more nurturing, thereby each gender self-preserving itself. These selections are accorded given gender roles that reflect men as protectors and providers of females and their offspring. Meanwhile, women are described as baby bearers, natures and housekeepers.

Sharmon Lynnette Monagan (2010) asserts that to some feminists, the gender role-selection theory rationalizes the shocking male behaviors of promiscuity (e.g. men's capability to rape yet intolerant to infidelity, predisposed to abandonment, prone to male dominancy, capable of producing several children at once) .Women on the other hand have to be more selective in matting, due to limited reproductive resources, being mindful about a suitable mate and energy allocated to pregnancy and childcare.

Therefore, as pointed out by Sharmon L.M (2010), social-biologists illustrate that promiscuous men over time, create more of them (with such characters), whereas nurturing women alike reproduce more of their nature, hence the repetitive reproductions of genetic differences over generations.

In the context of FGM, societies that are more inclined to patriarchy usually lack solid women rights (Sharmon L.M 2010). In most of these societies, male dictate what is considered acceptable female images. Women comply in exchange to gaining marriage opportunities and higher social statuses. Social harmful practices like bride abductions in India, foot binding in China, breast ironing in Ghana, FGM in Africa, though cut across generations, location and time, have an invisible hand of patriarchy. These practices continue to be socially accepted, whereas they maintain legitimacy in male dominated social structures.

11.2 Progressive views as opportunities for behavioral changes

Numerous examples of resistances against FGM (for example girls running away from FGM and saying no to early marriages, some families that are supporting daughters decisions not to undergo FGM, circumcisers giving up their traditional roles, girls' persistence to get educated instead of submitting to marriage pressures, circumcised females working towards behavioral changes/as change agents within their communities, etc.) demonstrate community receptivity and willingness to change. Such changes also illustrate how women initiate and achieve social transformation in accordance with their own interests. Successive examples of behaviors bracketed above, also show that cultural traditions are not static. FGM practices have finally come to be challenged by the very principles and morality which they claim loyalties.

Although most female participants in the study project had undergone through FGM – with substantial variations per country; nevertheless, FGM was not any more being widely/commonly practiced (like in the past) – as noted by most participants. Reasons related to such changes included; fear of medical complications, outdated traditions, high sensitization and government policies against FGM.

In Ghana for instance – FGM appears to be outdated. Despite fathers' continuous consultation of the spiritual world through soothsayers – whether daughters should undertake FGM or not – soothsayers' attitudes about FGM today are increasingly changing – leading to steady protection of girls against FGM. Such behavioral changes can also surely be confirmed from Ghana' abandonment attitudes, where by none of the participants supported maintenance of FGM (like e.g. Egypt with high maintenance attitudes).

In Kenya, where government policies against FGM and fear of being criminalized – play an important role towards behavioral changes, cultural transformations and behavioral changes were also observable (e.g. in Meru, west Pokot, Kuria and some Maasai areas). Gwako, E. L. Moogi (1995) also observes progressive campaigns among the Ameru and west Pokot communities.

Despite absence of universal women rights standards in grassroots communities, Ghana and Kenya in particular, are examples where some communities at grassroots continue to experience change due to exigencies of development and new forms of administrative systems, which are potential sites of social transformations.

More findings generated from the study also show a shift from rigidness and stigmatization - to acceptance of uncircumcised girls. This can be related to progress, as far as behavioral changes are concerned. In the past uncircumcised females were hardly accepted. Within their own communities, uncircumcised females commonly underwent through stigmatization, ostracism, isolation from community life/functions, insults and stood risks of not finding husbands. This kind of discrimination trend is currently under transformation. There is a remarkable reduction in vulnerabilities of uncircumcised women and girls. The trend of acceptance is also improving slowly by slowly each day. Uncircumcised girls are also increasingly being identified and indulged in behavioral change activities – as positive deviances. Community –violent (verbal or physical) attacks towards positive deviances and attacks on their families, is not any more common (especially in Kenya and Ghana), like in the past (with exception of Egypt – due to conservative Islamic political motives).

Behavioral changes of the kind can be connected to Absharaf (2006:16) statements, which show that communities are not fixed, isolated or immune to deliberate collective transformations. Absharaf further shows that people are not rigid beings unable to respond to changing worldviews around them. Forces of change within conforming societies have led courageous women and men to modify and eradicate FGM. Whereas attempts towards

abandonment of FGM in Africa are not new, globalization (facilitating open boarders (migrations, urbanization, multiculturalism, communication, learning more about other cultures) has brought this matter to the world's attention and stimulated intense international involvement in the issue. Today International and development agencies, professional organizations, NGOs and governments play actively various roles (e.g. technical, financial, social and political) in supporting abandonment projects – initiated by women groups at local levels (see Samiha el Katsha et.al 1997[48]; UNFPA 2004; WHO 2008; UNCF 2010; UNICEF 2014). These institutions have also campaigned vigorously against FGM for the past two decades. Even though progress has been slow, from a social, legal and medical perspective, ending FGM is not only warranted, but necessary[49].

According to UNICEF's global data base, 2014 (p,4)[50] that compares population growth and FGM estimates in prevalent countries - "If there is no reduction in the practice between now and 2050, the number of girls cut each year will grow from 3.6 million in 2013 to 6.6 million in 2050. But if the rate of progress achieved over the last 30 years is maintained, the number of girls affected annually will go from 3.6 million today to 4.1 million in 2050." UNICEF shows that steady growth of populations comes with risks of more girls and women being cut and predicts that if nothing is done, 325 million women and girls will be cut by 2050, but if progress remains stable, 130 million girls will be protected. The future looks different depending on where a girl lives. In Ghana, for example, the prevalence of FGM among girls aged 15 to 19 years is now 2 per cent, one quarter of what it was 30 years ago. At the current rate of progress, the practice in that country will be virtually eliminated before 2030. In Kenya, half of adolescent girls were subjected to cutting 30 years ago. The figure could be as low as 10 per cent by the end of this decade, and with minimal acceleration the practice could be eliminated within a generation." (See other countries in the declining category - UNICEF 2014, p.4). Countries like Egypt, Guinea, Somalia and Gambia (e.t.c.) on the other hand require urgent intervention to accelerate abandonment.

In conclusion, slow declines of FGM prevalence demonstrate the need for continued work towards elimination of FGM. This requires prolonged action and investment at many levels,

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[48] Samiha el Katsha et.al (1997) Experiences of Non-governmental Organizations Working Towards the Elimination of Female Genital Mutilation in Egypt. http://pdf.usaid.gov/pdf_docs/pnacd857.pdf. Retrieved 10.08.2014

[49] The dynamics of social change: towards the abandonment of female genital mutilation/cutting in five African countries. Florence: United Nations Children's Fund Innocenti Research Institute; 2010.

[50] UNICEF Global Data Base (2014). Female Genital Mutilation/Cutting: What might the future hold? http://data.unicef.org/corecode/uploads/document6/uploaded_pdfs/corecode/FGM-C-Brochure-7_15-Final-LR_167.pdf. Accessed 11.02.2016

recognizing that there is no simple solution to the problem. Further interventions ought to be non-directive, cultural-context specific and multifaceted to be of practical relevance. Interventions should not only motivate change, but also help communities establish practical means by which change can occur, and eventually sustainability.

11.3 Identification of loopholes: Why slow progress and limited declines?

11.3.1 Community attitudes and behaviours

Unsustainable changes in attitude and slow declines in relation with my field research can be established in relation to study participants who supported maintenance of FGM practices (mainly in Egypt) and those willing to circumcise their daughters in future, despite level of awareness about FGM facts.

Also, there are FGM modification scenarios like a) medicalization of FGM to limit health consequences, b) transformations from extreme to lesser cut to reduce severity of injury, c) crossing boarders to perform FGM in areas where FGM is less criminalized, d) decline of age at which FGM is performed and e) less or no functions/celebrations after FGM to avoid criminalization upon realizing that ceremony arrangement is in relation to FGM, hence pushing FGM underground.

Some Somali communities in Kenya for instance – are resorting to a lesser cut (from infibulation to excision) to address severity in injury, whereas some Maasai communities are resorting to medicalization as a modern trend of addressing possible health harm and age decline strategy with less ceremonial scenes. This modification has also been identified amongst the Abagusii of Kenya (Gwako, E. L. Moogi 1995).

In Ghana, some Nankam and Kassen ethnics in the Sirigu and Manyoro communities have been reported in the past, for crossing boarders to Burkina Faso to have FGM performed.

In Egypt, medicalization of FGM has become recently rampant, found even in private clinics at the outskirts. El Guindi Fadwa (2006) has also indicated that among the Nubians of Egypt, women have been changing the procedure even though they still presume that continuing the ritual is a valuable way of enhancing and socially validating women's embodiment.

Moreover, within intermarrying communities where FGM is universal (for example in Egypt), the desire to have girls married at whatever cost – is sufficient enough to sustain the practices – especially when FGM is the condition for marriage. FGM being done out of love, mothers thus ensure that their daughters are also cut (socialization) to have a 'good' future and not to

undergo any kind of discriminations or vulnerabilities within their own communities (FGM done without intention to harm). Daughters themselves may also ensure that the cut is made (e.g. in Ghana where possible ages of FGM can go up to 18 years), so that they can be recognized as full adults and have legitimate marriages.

Because decisions to cut are interdependent, the challenge is to move collective community decisions – rather than individual – to a stable ground – whereby girls must not be cut in order to acquire husbands (FGM as a key to marriage) or be fully recognized as adults (FGM as a rite of passage to adulthood). These decisions should be openly declared by all members of the community, to show readiness towards change and also confirm support of those community members willing to change their attitudes and behaviors towards FGM. Otherwise, lack of collective support towards behavioral changes, is likely to threaten individuals or individual families to go through the abandonment process alone (for fear of stigmatization and ostracism), hence FGM persistence.

Individual choices made at dissimilar time may affect independent decision made towards abandonment, because of fear of sanctions. Whereas, collective choices made at the same time is likely to increase abandonment attitudes and stability in behavioral changes – as a result of the new commitments decided upon by a collective 'whole' (community) (See UNICEF 2005 & 2010; G. Mackie 1996; 2000; 2003).

11.3.2 Strategies

Community declarations: Since collectiveness limits individual risks of undertaking the abandonment choice alone, communities should therefore be encouraged to undertake abandonment oaths as a whole and signing off declarations against FGM performances, in order to support those in the stages of abandonment.

Confidence gained through FGM declaration abandonment activities (collective method of abandonment) for example – made TOSTAN – a Senegal based NGO prosperous in its FGM abandonment activities in Senegal (Molly Melching, 2001; Nafissatou J. Diop, Amadou Moreaum & Hélène Benga, 2008; UNFPA, 2010). The same approach is also being tried out in other surrounding countries, with considerable success.

Alternative rites: Similarly, MYWO in Kenya through its alternative rites of passage approach (collective method requiring community engagement and participation) – implemented in communities practicing FGM as a rite of passage to adulthood – has also won

considerable behavioral changes especially among the Ameru communities (Jane Njeri Chege, Ian Askew & Jennifer Liku, 2001) and now being replicated in other communities (e.g. among the Maasai – sponsored by World vision) in Kenya – with hope that changes will be viable and sustainable in the near future.

Social norm approach: Moreover, prevention approaches that provide normative feedback are growing by leaps and bounds in popularity. Evidence is mounting that such programs are effective when correctly implemented. Growing interest in social norms interventions that correct misperceived social norms, pluralistic ignorance, and spiral of silence, false uniqueness and false consensus (A.D. Berkowitz 2004) are currently being used by several institutions that are directing efforts towards FGM abandonment.

There are different types of norms (A.D. Berkowitz 2004, p.12). One kind of norm refers to attitudes or what people feel is right based on morals or beliefs (injunctive norms). A second type of norm is concerned with behaviour, i.e. what people actually do (descriptive norms). The social norm approach thus provides a theory of human behaviour that has important implications for health promotion and prevention. It states that our behaviour is influenced by incorrect perceptions of how other members of our social groups think and act. Correcting misperceptions of group norms is likely to result in decreased problem behaviour or increased prevalence of healthy behaviours.

The social norms approach was first suggested by H. Wesley Perkins and Berkowitz in 1986 in an analysis of college student alcohol use patterns. The study determined the regular overestimation of college students and the extent, to which peers were supportive of permissive drinking behaviours. Results were that this overestimation predicted how much individuals drank. Recommendation (from the authors) that prevention efforts focus on providing students with accurate information on peer drinking attitudes and behaviour (Perkins & Berkowitz, 1986; Berkowitz & Perkins, 1987a) represented a radical departure from traditional intervention strategies that provided information on abuse and negative consequences and concentrated primarily on the identification, intervention, and treatment of problem users.

In the FGM context, adhering to social norms or not is associated with rewards and punishments, sufficient enough to maintain/support or abandon FGM. Social norms facilitate FGM continuity across generations, among changing populations and they constitute an ongoing record of the history of social practices (Jack Knight and Jean Ensminger, 2001).

Social norms entail cultural beliefs – a special component of culture that governs interaction between people, their gods and other groups – without these beliefs being empirically discovered or analytically explained (Avner Greif 2001).

Interconnected traditional beliefs associated with FGM are used as enforcement mechanisms not to break the social norms (UNICEF 2010), a challenge that is causing ethical dilemmas. Belief systems however, must be individually and holistically rethought, studied upon and eventually documented – in order to isolate FGM from social norms. Communities must be enlightened about the facts that FGM traditional beliefs are baseless, as a strategy to improve and approve behavioral changes and eventually sustainability.

Critics about the growth of social norm approach, as shown by Allan Berkowitz (2004)[51], include concerns expressed about its efficacy in general and with specific populations in particular. Some of these concerns arise from findings that may be attributable to implementation problems such as inadequate exposure to messages, and strategies that are not faithful to the model. Another problem that may mask program success is lack of adequate evaluation. Other concerns are spurred by debates about important issues in the field – for example, whether social norms should be part of a larger package of interventions or whether it can be implemented by itself, and whether campaigns should be directed at more homogeneous sub-groups rather than larger communities. Finally, other criticisms may be based on misinformation about the approach or lack of familiarity with research evidence.

Health harmful approach: Meanwhile, strategies against FGM that criticize circumciser's experiences, age and eye problems, use of crude - and unsterilized instruments, hygienic environment and conditions under which FGM takes place – though create awareness on adverse health consequences of FGM and contributes towards breaking the taboo – may instigate solution-seeking (e.g. better conditions in which the procedures can take place in order to minimize the extent of harm – medicalization of FGM) and not necessarily behavioral changes.

Sensitization and awareness: WHO (1999) shows, there is a difference between what people know and what they actually do. Several communities seem to understand the harmful effects of FGM because of increasing information dissemination, sensitization and awareness campaigns. This knowledge has led to change of attitudes about FGM, though accompanied

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[51] A.D. Berkowitz (2004), The social norm approach: Theory, research and Annotated Bibliography. http://alanberkowitz.com/articles/social_norms.pdf. Accessed 14.02.2015

with less actual behavioral changes towards abandonment and sustainability. Therefore, understanding the complexity of local knowledge on the custom and considering women's standpoint is critical.

Human rights principles: Besides, imposed messages that tend to demoralize local understanding (Abusharaf 2006), without making beneficiaries (grassroots FGM-prevalent communities) of such knowledges part of it may be seen as western centered and not context specific. Rosalind Petchesky (1998:1) as quoted by Abusharaf.M.R (2006:17) highlighting on such messages, comments, *"until we know more about the local contexts and ways of thinking in which women in their everyday lives negotiate reproductive health and sexual matters, we cannot assume that reproductive and sexual rights are a goal to keep, and therefore one that has universal applicability"*.

There is no doubt, deliberately addressing human rights principles can bring about transformative processes. However, as Mackie and John LeJeune's (2009) explain, the complexity of FGM practices makes it crucial to understand the social dynamics of abandonment by examining the role of social sanctions and moral judgments.

Laws and policy measures: Besides, several countries in Africa have criminalized FGM through legislation (L.P. Sanderson 1981; B. Ibhawoh 2000; A. Rahman & N. Toubia 2000; E.H Boyle, et.al 2001; E.H. Boyle 2005; C. Momoh 2005; WHO 2006; M.A. Ako & P. Akweongo 2009; UNICEF 2010; UNFPA-UNICEF 2014; UNICEF & UNFPA 2015). However, difficulties have arisen on who to hold responsible (parent or circumciser) and how to enforce the sanctions. Moreover, criminalizing FGM without addressing social norms, have pushed FGM practices underground and has led FGM being performed by the inexperienced (UNICEF 2010). Consequently, FGM victims with medical complications have been discouraged from seeking medical care or social-psychological support services, putting their lives in danger. *"Passing laws is a necessary but not sufficient measure if these laws do not take into account local views"* (Abusharaf 2006, p.9). Geertz (1983:168) suggests that the most fruitful way to negotiate abandonment is putting local knowledge into account and draw attention to a wide range of cultural views.

Religious approach: Also, religious and cultural values have in many communities mutually reinforced FGM (UNICEF 2010). FGM has mistakenly been assumed to be mandated by religious doctrines, especially those connected to Islam. Abdallah D. Raqiya (2006) explains that many Muslim leaders consider the practice a 'makram'— a teaching of lesser importance

instead of strictly prohibiting it. Even the Arabic word for circumcision - 'tahara or tohara and Sunna' - meaning purity implicates the practice as Islamic. Also, a hadith supporting a limited form of FGM – has misled many Islamic scholars and followers into believing that the practice is legitimized by Islam. Generally, the positions of Islamic views about FGM remain controversial. Many Islamic leaders and scholars have failed to clarify on the practice, yet their teachings remains ambiguous. This permits a variety of opinions regarding the practice, which eventually shapes attitudes about FGM.

For instance, most Somali women's personality, attitudes and behaviors about FGM are mainly shaped by a combination of Islamic teachings, and indigenous customs and belief about FGM (Abdallah D. Raqiya 2006). In such Islamic communities, control of women sexuality in pursuit of purity, cleanliness and religiosity are the main justifications of FGM.

Although some religious leaders have been reached (see Lethome Ibrahim 2008) through sensitization and workshops, to help in the inspiration of behavioral changes (delinking FGM from Islam); however majority Islamic scholars (e.g. Imams), who believe that Islamic traditions and principles are under attack by the western world – have continued to sabotaged activism against FGM – hence the contestation.

Finally, **lack of monitoring and evaluation** of interventions – limits the documentation of progressive strategies – appropriate for FGM eradication. Without proper evaluations, activists can never know which strategy is best suitable for what community, under what circumstances, or which strategy works where, which strategy does not, and why.

11.3.3 Institutions

Alongside the strategies, various institutions that are engaged with FGM abandonment at various levels have several challenges they face and roles they play towards hindrances of change or sustainability.

For example, many local based grassroots organizations (NGOs) in the field **heavily rely on financial help from donors** (government, development agencies and individuals). Despite donations pushing project strategies and goals ahead – nevertheless, limitations of donations include string budgets, time limits and other conditions that may affect periods of activities and organizations' field of maneuver. This limits project implementation frameworks, monitoring and evaluations – thereby leaving FGM projects unaccomplished as expected or half way done.

Given the fact that FGM is a generation problem, **working on time limitations and sting budgets** make FGM projects a non-starter especially in rigid communities. Short periods may be contemplation stages of whether to abandon FGM or not; which periods may therefore be sufficient for communicating awareness but not necessarily instigating behavior changes. Projects of alike - half way done - fail to achieve organization's set objectives—behavioral changes. This is likely to leave communities in a state of disorganization, disappointment, and confusion. Impacts such as communities falling back into their past behaviors (FGM practices) or being rebels to future projects are likely to result.

Thus, **lack of steady continuation of FGM abandonment projects** (due to various challenges) is likely to cause a decline in behavioral changes and attitude towards readiness to change. Here, the impact is, the next organization focusing on same projects is most likely to begin afresh (from Zero) to convince people to change attitudes and behaviors (depending on periods community spend without abandonment projects in place). Now, implementing projects afresh, that once existed, is not only time costly, but also a financially restraining – for one may never know what success might have been achieved – if projects had steadily continued without interruption.

As recommendations; donors ought to take in mind that communities react differently during project implementations. Project innovations and implementation may sometimes require flexibility and revisions according to given challenges – before they (projects) penetrate community and trigger changes. Therefore sufficient patient is required.

Where time frame works are strict, it is also advisable that organizations coordinate amongst themselves and identify which particular institution can take over, supervise or monitor FGM projects that have already been established or implemented within a particular community. That way, project interruptions or discontinuation will be checked upon. Likewise, the same coordination is recommendable within donor communities – in order to minimize time and fund wastage – without impact on behavioral changes.

Besides, organizations engaged towards FGM abandonment ought to be innovative in raising financial support (e.g. engage in auctions, make concerts or shows, photo exhibitions) and check on expenditures (e.g. by use of volunteers or interns instead of only very qualified and expensive man power, reduce on financial benefits under particular conditions, negotiate salaries, employ part time workers depending on need, introduce home office to reduce on vastness or space of operational offices and rent expenditures, etc.), in order to minimize their

dependability on donor institutions and be able to operate within financial limits – in order to sustain abandonment projects – until behavioral changes are reliable.

Further still, sometimes **bad experiences** (e.g. financial misuse or plundering, lack of transparency and accountability) from the past (with particular organizations) may cause community mistrust, hence leading to (a) boycotting future activities tended towards FGM abandonment, (b) vulnerability of activists due to violent attitudes from communities, etc. – which all hinder strategy implementation and eventually behavioral changes. This follows the fact that some institutions (especially grassroots based) may use community genuine problems for ill motives (i.e. to get funds, which they finally divert into private use or swell their accounts) and eventually break off contacts with funding institutions and communities, leaving a kind of wrath behind. There is thus need for a practical law to counteract such behaviors.

Morten Kjaerum (1993) notes the danger of NGOs being drawn by market economy and transformed into profit making organizations once they get pre-occupied with providing and selling services to their members and the public. Whereas NGO 'real' objectives are difficult to tell, some are business oriented with no genuine target of solving community problems, while others are 'briefcase NGOs' that do not exist. This at times justifies deadlines/time limits and pressure set forth by donors – as a means of uprooting such institutions.

Finally, **lack of transparency and accountability** may also undermine FGM abandonment. Questions such as whom NGOs represent? To whom are they accountable? To what extent are their activities transparent? (Peter R. Baehr 2009:13), obscures NGO activities and commitments. Such questions are not easy to answer, because many NGOs do not necessarily have democratic structures and may not represent beyond membership, as Baehr (2009) notes. However, Sophie van Bijsterveld as seen in Peter R.Baehr (2009) suggests that rather than representation of membership or persons, NGOs should focus on representing values and interests. They should shine as beacons of legitimacy and accountability (Hugo Slim 2002) towards their stakeholders – who include victims of violations, donors, members, workers and the public. This helps increase organization support, confidence and trust – especially at local levels, which may later influence steady behavioral changes.

11.4 New Insights

Below I recommend a health working relationship among different institutions sharing FGM abandonment interests, mainly in countries where the practice is prevalently high. This

relationship should also be extended towards community alliances or working together with local people. The kind of network introduced below, reveals a combination of creating and strengthening working relationships between all kinds of institutions working towards FGM abandonment on one hand, and community involvement on the other hand. The aim is to improve measures, accelerate abandonment and guarantee behavioral changes and sustainability: Thereby working towards 'zero tolerance' against FGM practices within fewer generations as highlighted in the UN resolutions against FGM — (A/RES/67/146) — adopted on 20th December 2012[52] and observed on the 6th February each year – raising campaigns and reminding governments about their commitments.

11.4.1 A network-alliance of organizations against FGM, working with and for community – to promote sustainability: Introduction

Network in this sense implies an extended group of people with similar interests or concerns that interact and remain in contact for mutual assistance or support.[53] This network in mind has little to do with the digital age of information computing; rather it argues the traditional way of constituting a link between people while creating a social environment that has less to do with creating space between individuals as provided by digital computing. Whereas social networks as a concept interactions is used to link individual behavior to the larger social system, integrationist also conceive a network as a set of relationships which people imbue with meaning and use for personal or collective purposes (Gary Alan Fine, Sherryl Kleinman 2011). Clarifications made by Susan D.Phillips (1991) show social movements being conceived of as networks that provide structures within which organizations negotiate meaning through the construction of collective identities.

Diverging in purpose, objective and membership; **the interconnected group alliances (networks)** meant – for the purpose of FGM abandonment – are **first and foremost** those various institutions (at local-, regional-, and international levels, public or private) with the common objective of accelerating FGM abandonment at a country level (in geographical boundaries). Examples of institutions in this kind of framework among others are; Government sectors, INGOs, local NGOs, women organizations, development agencies, donors and research organizations; sharing the objective of bringing to an end— FGM

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[52] UN Resolution against FGM http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/67/146 Reviewed on 11.11.2014

[53] Meaning of 'Network' http://www.thefreedictionary.com/network. Viewed on 11/11/2014

practices – once and for all. This kind of network must allow information exchange and sharing to flow freely between and among institutions and individuals in a decentralized manner.

Secondly, the same network should as well entail a healthy and *"equal"* working relationship and cooperation with grassroots communities. Involving local people (as equal partners) at grassroots levels will support accommodating local opinion and views alongside participation, thereby facilitating familiarity in knowledge and understanding about community politics. Winning community trust and cooperation requires (a) showing interest in working with community locals, (b) being taught instead of teaching, (c) being able to de-learn and re-learn about a community's behaviors without judging. This encourages and supports community engagements in decision-making, project -formations/innovation and –implementation, hence working towards mutual solutions to social issues affecting communities – thereby promoting social and cultural transformations from within (Community empowerment approach).

With and for community – phrase – as used in the subtitle above: "**With**" implies here active involvement and participation of community members at grassroots *(Using participatory approach to achieve community empowerment model)*. "**For**" here means institutions or organizations support for community members *(Institutional supporting model towards community empowerment)*. Community members in this case are project beneficiaries or recipients or addressee. Therefore, project innovation and implementation within prevalent communities should aim at supporting cultural, social, economic and political transformations for the betterment of community (projects for communities), while regarding community participation as central. Achieving the **self-help** concept (of community empowerment) towards behavioral changes entails more than working for or about communities (a paradigm for inquiry and action) – to include active community participation (working with communities/participatory action).

Participatory actions allow collaborative dialogues and not dominant discourses. They allow communities to define their own ground rules and mission, rather than be given these by external authorities (e.g. institutions, politicians or service providers). (Grassroots) community participatory actions should allow community members to (a) identify problems, (b) agree on the nature of problem, (c) how the problem affects them and (d) finally finding common solutions. Here, external authority or representatives of organizations or political institutions must act as a facilitator with a role of managing discussions, so that participants feel comfortable and safe in saying their minds.

Community participation engages the idea of involving local people and entails the collaboration of people pursuing the objectives that they themselves have defined (Henry Sanoff, AIA 2000). Participation thus, reduces the feeling of anonymity and communicates to the user a greater degree of concern in development processes. It also instills a greater public spirit and encourages significant changes. As recent as the idea of community participation is, it earlier encompassed the ideals of self-help and self-sufficiency, mobilizing the poor and oppressed to promote social and economic progress. In the current global context however, community participation and empowerment have become more vital and yet distorted in meaning, hence being problematic than ever (Gary Craig, Marjorie Mayo 1995).

11.4.2 Background scenario

The perceived poor performance of the public sector in developing countries has led to a search for more effective organizational forms for the delivery of goods and services by none-government agencies like domestic NGOs, international government agencies and aid donors (P, McMichael 1996 & R, Sandbrook, 1993). INGOs are increasingly regarded as important in their capacity to influence global policy on development matters such as human rights, poverty alleviation and sustainable development (S.Madon, 1995). NGO sectors on the other hand, have often been characterized as providing alternative approaches of participation, emancipation and empowerment of the grassroots people (Henry Sanoff, AIA, 2000).

In the face of deepening poverty for instance, international agencies and local organizations demonstrate increasing interests in strategies encouraging community participation as a means of enhancing empowerment and development – with increasing emphasis on alternatives grassroots approaches (Gary Craig, Marjorie Mayo, 1995). Also, in the public health framework to pursue goals related to community health and development; community partnerships have attempted to reduce risk and enhance protection of say substance abuse, cardiovascular disease, injuries, adolescent pregnancy, mental disorders, violence and childhood diseases (Fawcett et al 1995).

11.4.3 Problem description

Less active community participation (as empowerment model): Whereas such efforts are underway, community participation theorists (Henry Sanoff, AIA 2000) reveal that politicians and bureaucrats have exploited ordinary people and excluded them from community development processes. Governments for example have been accused of consisting of self-

serving politicians, whose interests may not necessarily capture public-, community-, or women- wellbeing (Peter R. Baehr 2009:6). Whereas participation is contextual and varies in type, level of intensity, extent and frequency, genuine participation is mapped as partnership, delegation of power and citizen empowerment (Henry Sanoff, AIA 2000). The opposite is Pseudo-participation – which involves people listening to what is being planned for them, everything having to be checked with everyone before any decision is made, attending public hearings and meetings – hence participation being distorted in meaning.

Community participation can be effective when thought in terms of what to be accomplished and acknowledging the power of community members being actively engaged. Thus in order to design participatory approaches, which are contextual specific, important questions need to be asked. Such questions include; when is participation needed? Who must be involved? How should people be involved or engaged or through what means? What do we need to achieve or where do we hope to lead? Goals for participation may range from generating ideas and awareness, communicating emotions, identifying attitude, to finding solutions to pending social problems or conflicts, etc. Here, organizers or facilitators have to be very certain about their goals.

More participants (in number) – community engagement, may allow stronger input and better possibilities of allowing the community to learn more about itself. Such participation is likely to be followed by a diversity of expressions, hence requiring a design and planning solution that is as transparent as possible. Transparency in this sense encourages people to freely express their opinions, reach compromises and finally come up with acceptable decisions. That way, as Henry Sanoff, AIA (2000) argues, impacts of the decisions are made clear to the people who formulate them.

Under participation, four main steps are categorized (Burns 1979), the first step is awareness. It involves discovering or rediscovering the realities of a given situation or environment to allow proper participation in the field where change is desirable. The second step is perception, which allows the situation (e.g. FGM) and its implications to be properly understood. Knowledge acquired out of perception becomes then a resource for planning the third step, which is decision-making.

Under decision making, actual designs are formulated based on priorities, for professionals to use as resources to synthesize alternative and final plans. *"This combination of collective decision making together with individual responsibility demands an atmosphere of trust. Trust*

is developed through interpersonal interactions that provide the basis for dealing effectively with change (...). Face to face, communication is important in establishing effective interactions and flow of information – the foundation from which cooperation is possible. Out of this cooperation will develop ideas, decisions and strategies, all of which rely on development of consensus. The more group members are involved in decision making process, the more likely they will develop feelings of teamwork and cooperation, thereby increasing their motivation, commitment and contribution to the group" (Henry Sanoff, AIA 2000:32).

The fourth and final step – implementation – requires all participants' responsibilities. Henry Sanoff, AIA (2000:11) suggests that people (in this case community must be engaged throughout the process (step 1 – 4) described above) and take responsibility with professionals (e.g. politicians, NGO personnel, etc.) until the final results (outcomes).

Institution or organization conflicts (hinder 'genuine' networking): On the other hand, minimum efforts of institution or organization alliances (with similar agendas) and lack of combined decision making (within organization-networks) to achieve common objectives or work out common strategies towards development policies or social-economic-political changes – has undermined productive strategies (such as those directed towards FGM abandonment).

Peter R. Baehr (2009:20) aware of the cooperation problem of institutions – yet finding it crucial for their positive impact outcome – quotes a UN official having said "*coordinating NGOs is like herding cats*". Citing an example of Amnesty International's past reputation, "*its independence and unwillingness to associate itself with other HRNGOs for fear of endangering its cherished mandate*" (Peter R. Baehr 2009:20) was seen by other organizations as arrogant, thus eventually leading to its (AI) improvement of cooperation attitudes in the recent years. Meanwhile the 1993 UN world conference on human rights exposed off organizations' differences. Relatively poor less organized 'southern' based NGOs got irritated about large well organized western based NGOs – for assuming that they could speak on behalf of all NGOs with the claim of different cultural approaches and interests (Peter R. Baehr 2009:5). Accordingly, grassroots based NGOs suggest that they were closer to ordinary people than INGOs and therefore offered the more effective approaches.

Similar hassles are witnessed in several organizations today working against FGM. Despite the fact that they are mutually working towards a common interest – eliminating FGM, getting them seated on the same table is genuinely problematic. These squabbles within and

among institutions need to be taken seriously and addressed before project impacts can be genuinely felt. Otherwise more controversies of the nature are likely to affect even the beneficiaries of services (communities with FGM prevalence), hence yielding less impact towards behavioral changes and sustainability.

Also research findings hindering behavioral changes and sustainable point at reasons such as; a) financial burdens, b) selfish motives of actors or activists, c) short leaved abandonment activities, d) wrong strategy application in communities (one size fits it all), e) foreign influence in local matters, f) exerted pressures from the outside, g) top – down abandonment strategies, h) deeply rooted social values that need to be addressed from within communities, i) unstable political environment and political ambitions, etc. As a result, several organizations face a series of critical choices in responding to these fundamental challenges – thereby requiring creative and flexible arrangements; which allow governments, organizations, individuals and communities to work together to address FGM.

It is because of these identified challenges and many more, that the formation of network-alliances between and among various institutions (particularly those sharing a common goal) and community participatory engagement is crucial. This will allow clarifications, communication and information dissemination especially along lines of common interests.

11.4.4 Combined efforts (team work) towards common objectives

Henry Sanoff, AIA (2000) regards the ability to build collaborative relationships as the basis of future community as well as organizational success. The author argues that in an era of organizational complexity and change, maintaining organizational health relies on cooperation and collaboration across and within organizations. Thus, institutions or organizations need to become open learning systems in order to deal with challenges and changing environment or situations, while understanding their environments of operation. Sanoff stresses interpersonal interactions, combined decision-making, and trust as important elements of effective change.

Peter.R Baehr (2009:20) argues that, *"NGOs are well aware of the need to work together to realize common aims."* Using successful examples of coalitions at the European levels, the Human Rights and Democracy Network (HRDN) with now 38 members, was formed to *"influence EU and member state human rights policies and the programming of their funding*

instruments to promote democracy, human rights and sustainable peace" (Peter R. Baehr 2009:21).

Similar **networks of cooperation among organizations/institutions** are suggested in Africa, especially amongst FGM prevalence countries, in order to find common solutions towards abandonment within and across borders. Network alliances between and amongst organizations can help; a) solve project manipulations and duplications, b) better negotiate political reforms and working space that will most likely sustain social and behavioral reforms, c) improve and attract donor involvements, d) attract unlimited or better negotiated time frame works of projects, e) highlight and deal with double financings and fund misuse, f) pave way for better negotiations of cultural reforms at grassroots levels.

While individuals from diverse locations and sectors of activities are interlinked through the network alliance, crucial within such networks are 'round table' discussions (of abandonment strategies, increasing effectiveness, addressing accountability and transparency issues, etc.). The success of such a network alliance (team work) will depend on the working relationship between and within organizations on the one side, and community engagement (participatory actions) on the other hand.

11.4.5 The Network-alliance Model

Research institutions/private researchers & interdisciplinary associations

Private Donors & Donor institutions

INGOs & foreign government representatives

Local based NGOs at country level

Goverment institutions & politicians

FGM abandonment

NGOs ally with community; community gets connected to the network

Government allies with community; community gets connected to the network

Community/ Grassroot level

Male represent-atives

Youth represe-ntatives

Community alliance networks of stakeholders

Religious &cultural leaders

Circum-cisers & ,others'

Women associatio-ns

Professio-al repre…

As we confront day today problems like human rights violation, religious fundamentalism and democracy; there is increasing need of linkage, leverage, correlation and alignment of different perspectives – in order to reach set objectives or goals. A framework—global in vision yet anchored in the minutiae of our daily lives—holding valid perspectives that have something to offer to our individual efforts and collective solution building (towards FGM abandonment and sustainability), is needed. The suggested network-alliance framework therefore, aims at facilitating already existing number of separate paradigms into a network of approaches that are mutually enriching. The model recommends involvement of multiple stakeholders or actors at different levels.

Basically **at the roots (community level)**, lies the firmness/foundation of this model and the pavement towards genuine fulfillment of the set objectives (FGM abandonment). This implies that community stakeholders MUST be engaged and play an active role as equal partners in finding common solutions to social problems and drawing remarkable plans for future behavioral changes. This **bottom - up approach** contributes highly towards sustainability, due to self-help (empowerment) problem solving attitudes exhibited. Exploring, understanding and personalizing cultural and political knowledge through community engagement develops culturally relevant methodologies appropriate for FGM abandonment. Therefore the value of leveraging the unique learning, thinking and knowledge remediates daily resistances against FGM by negotiating the demands of culturally charged context. Thus actively indulging communities in this network model will open dialogue between inside and outside perspectives; which will eventually develop ways of bringing new evidences, tools and ideas into the community.

Different organizations (on the top of the drawing) illustrate various institutional-supports towards FGM abandonment. Enabling or support organizations (such as technical assistance and evaluation teams, etc.) collaborate with and engage leaders and community members (partnerships) within their programmes or project activities, to enhance local capacities that are critical in influencing conditions that affect local people. Enabling organizations thus give and receive support, thereby contributing to the capacity of community partnerships engagement while learning from each other (community and organisations). In this perspective, the work of organizations thus originates the moment (social, economic, political) grassroots problems/loopholes hindering development, human rights and health are identified and sought to be addressed through possibly promising-alternative solutions (offered by different organizations).

Therefore, as Vanberg (1994) says, it is useful to think of institutions as 'tools' or 'mechanisms' that provide solutions to recurring problems in social interaction. William M. Starbuck (1983) asserts that organizations are and ought to be problem solvers, problem solving being the activity that starts with perception of a problem and thus involving various cycles of activities. The author mentions at least two modes that categorizes organization activities; a) problem solving mode (perceived problem motivate search for solutions) and b) action generating mode (action taking motivates the invention of a problem). Taking the problem solving mode-activity into consideration, community problems are central and guarantee organizations' establishment and existence (as alternative institutions/CSOs), in order to get society' problems solved (aims and objectives of organizations).

Local based NGOs and government institutions or government have intentionally been drawn near/next to the community circle as seen in the picture above, to act as bridges between all other institutions and the local based people/communities, thereby making communities easily approachable. Using my own experience and example during field study in Kenya, Ghana and Egypt; being an African/Ugandan by origin, researching in African countries did not guarantee cooperation or openness with the local people (fellow Africans). Having shared at least skin color (Kenya and Ghana) and language (Kiswahili in Kenya) – in common, there were still established (social and cultural) boundaries that excluded me as a foreigner (not belonging to respective local communities). However working with grassroots local based NGOs, government ministries and above all individual community stakeholders (cultural and religious leaders and women groups' leaders) opened doors for an easier interaction, cooperation and openness at grassroots levels, thus allowing easy data collection, participation in implementation strategies against FGM, participation in community life and undertaking research observations and analysis.

Generally, the network alliance encourages a bottom – up model as basis for social and cultural transformation from within communities on one hand; and up-bottom framework as supporting mechanism towards community participatory engagement and empowerment. It further encourages diversity and inclusivity to generate context specific and culturally sensitive combined solutions against FGM to maximize outcome (abandonment and sustainability). This model makes sure that all the bases are touched. Thus the more accurate it is used, the higher the higher the chances of success the model will generate towards effectiveness in addressing behavioral changes and sustainability. A combination of detailed

participatory researches, together with combined agreements on finding solutions to puzzling issues (where need be) will help hold the model firm, once put to use.

11.4.6 Acknowledging research as institution of influence: Mastering the information environment

At this point, I would like to highly recognize the pioneers of knowledge management, who gave access to their progress and problems in the field through scholarly literatures, which is based on today for further researches. I would like to also appreciate various interdisciplinary financial firms for supporting researches financially and those making their sites available for research. Education institutions and the lecturers within these institutions also get special acknowledgement for building on students half-baked ideas. The list is endless but acknowledging each institution and persons, even those not mentioned here is vital.

Numerous books, conferences, journals, individual scholars and institutions have tried to handle this subject (FGM) for the past decades. Many more upcoming young researchers are also still interested in the same subject. This is because the growth of knowledge signals a growing conviction that knowledge is unlimited, yet critical to be known for success in whichever field.

Considering the alteration processes that FGM has undergone, yet proving hard to be eliminated; many institutions including government and private are still struggling to get a better understanding of what they know, what more they need to know and what to do about that knowledge. Therefore, my applause goes to research institutions, scientific researches and individuals undertaking scholarly researches; because the shackles of ideology, emotions and passions that 'science' eliminates, are the very objects that research uses to explain the world (Bruno Latour 1998). This process can be seen as a transition from certainty to uncertainty or from uncertainty to certainty.

Scientific research therefore is crucial in studying foreign communities and explaining human behaviors or various questions about society. Scientific research not only resists unproven utterances and minimizes the gap between speculations; but also establishes knowledge not in caution of avoiding errors, but in ruthlessness in eliminating such errors (Imre Lakatos, 1970).

In applying scientific honesty, it is demanded that one asserts nothing that is unproven. Scientific honesty therefore consists of specifying in advance an experiment or theory such that if the results contradict the theory, the theory has to be given up (Imre Lakatos, 1970).

Obviously, research yields several preliminary findings that warrant further studies. This is where individual researches, research institutions and interdisciplinary research associations are vital towards carrying out detailed researches needed in whatever challenging situation in order to address particular problems in compatible ways.

In the case of researches directed towards - abandoning FGM and ways of sustaining behavioral changes: expectations are that knowledge achieved from these researches is shared to the 'public' and those interested organizations and political institutions; with hope of trying out new ways of addressing FGM, increasing effectivities, improving victim support and protection mechanisms for those at risk, and addressing policy measures.

Still, by stressing the need for a network alliance – involving various stakeholders, the flow of such scholarly information, is easily shared and targets the right audiences (e.g. project implementers, donors, governments, etc.). Because empirical research (in particular) involves highly grassroots knowledge, achieved through participation in interviews, qualitative and quantitative questionnaires or observations, it therefore contains remarkable degrees of empirical evidences (guided by practical experiences) and eliminates or reduces biases.

Networking will be advantageous, in that it will allow such knowledge to be easily shared and explained upon (for different audiences) to get a clear picture of the theory, the people/community studied upon, and the working environment. Therefore, working with researchers cannot be underestimated because of their various experiences and contacts in various fields, which can be capitalized upon to alter behavioral changes. Additionally, some researchers being part of the very communities researched about, allying with them to create changes and developments highly paves ways for proper negotiations of cultural transformations with community stakeholders.

Observing the drawing above, it is not accidental that research institutions are placed in the middle and slightly at the top of all other organizations. In my opinion, researches are crucial for generating theoretical information that can be practically transformed to address behavioral changes.

However, just like the saying – "no man is an Island" – the cooperation of all other institutions is vital and recommendable to supplement the just cause of fighting against FGM. For instance, without the existence of local and grassroots NGOs, the implementation of projects based on knowledge attained from researches would possibly be in vain. More so, without governments checking on their policies, political environment, interests and attitudes,

reforms and policies would also probably be non-attainable. Further still, without special monitoring from international institutions, individual governments would be reluctant to react and keep their oaths of conforming to international standards. Besides, without donor/funding support from individual governments or financial institutions, there would be a limitation towards research and implementation of projects aimed towards improvement of social health, development, human rights and empowerment.

I conclude by saying, "together we stand, and divided we fall". Teamwork, inclusivity, active participatory and empowerment methods is a way forward, to eliminate FGM within one generation. That is why in the network diagram above, each stakeholders, have arrows running back and forth supporting and holding the network together. This network is capable of standing amidst challenges and working towards positive result, if only the values of human rights are genuinely stressed and put into consideration while getting rid of any selfish motives of actors/participants. By trying to combine various perspectives in this model, I hope that FGM activists reading this report can amalgamate the expressed knowledge into their activities or FGM projects targeted at grassroots levels.

11.5 Conclusions

This project partly identifies systematically factors perpetuating FGM and those hindering progress. Studied communities less readily reflect upon, question or challenge their cultural traditions, values and customs (FGM); which this study has done. The project has partly helped to reflect on cultural processes less voiced and debated upon at grassroots levels. Results have been represented as expressed by various grassroots participants and institutions. Communities have uniquely identified beliefs, values and codes of conducts that influence FGM. Organizations have also brought to light difficulties they face in abandonment campaigns/strategies.

It should be noted that FGM varies given; a) marital status- most married women are circumcised compared to those still single, b) generational trends – girls of lower ages between 8-14 years are increasingly escaping FGM nowadays c) the higher the education levels, the lower the practice, d) employed women stand better chances of escaping FGM. Points (c) and (d) are highly insignificant in Egypt because FGM is universal. Here, no matter the social-economic status or geographical location, almost every Egyptian woman must undertake FGM for religious and cultural purposes. In contrast; both Ghana and Kenya show

divergences, as FGM performance is commonly driven by ethnicity, hence accounting for countrywide variations. Here, not all women must undertake FGM as is the case in Egypt.

Although FGM prevalence in the countries of intervention ranges from over 90% in Egypt, 27% in Kenya and below 5% in Ghana, Recent evidence suggests that the practices are undergoing declines and major changes. Based on research findings, there is noted progress towards FGM abandonment. For instance younger generations have managed to escape FGM due to changing attitudes especially in Ghana and Kenya. In Ghana for example, all respondents (no matter the age group) supported FGM abandonment, yet almost all female respondents were FGM survivors. There is also a decline of FGM-associated ceremonies within communities (e.g. in Kenya), which can be directly interpreted as improved protection mechanisms towards risk groups or age-sets, and a change in mindset and behavior practices. However, at worst, absence of ceremonies could also imply a shift to underground methods of FGM performance – delinked from ceremonial functions – for purposes of creating impressions of behavior changes, and diverting attentions of activists and other crime preventers.

Furthermore, there are obvious improvements in number of girls in the education system as compared to the past in both Kenya and Ghana, which is likely associated to free universal primary education for all program – although this is coupled with a number of challenges as seen in UNESCO (2012)[54] and UNICEF (2007)[55] country reports. Nevertheless, education has direct impact on early and forced marriages, as well as FGM attitudes. Also, prolonged stay (of girls at risk) in schools may imply that after a particular age, girls are no longer eligible for FGM. Generally, the practice is less prevalent in Kenya, due to the increasing political will to tackle the issue and increase in women empowerment programs. In Ghana, FGM is also diminishing due to eroding traditional values and social-political transformations in the cultural spheres.

However, declines or changes mentioned may not be proportionate to the efforts exerted. Denials among respondents due to criminalization of FGM, threaten accurate measurements of individual status necessary for proper evaluations of intervention studies, hence

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experiencing practical and ethical challenges. Meanwhile, there is an increasing trend of shifts from extreme cutting (type III) towards milder cuts (type II or I) among the Somali communities in Kenya, hence posing a challenge towards total abandonment. Besides, a rise in medicalization of FGM especially in Egypt and the lack of political and religious will and commitment to address FGM undermines abandonment activities.

Despite significant impacts of the sensitization and awareness approach – there are fewer intentions of actual behavioral changes in Egypt in reality. Meanwhile, cross boarder FGM performances particularly among some Kenyan communities seeks a comprehensive cross boarder approach of tackling FGM. Besides, strategies (e.g. alternative incomes for circumcisers and sensitization on health consequences of FGM) that seemed to be promising in the past years seem to have fallen short of results in particular cases, hence yielding important lessons necessary for moving forward.

All in all, safeguarding freedom and equality of women in this often contentious and highly emotional field (FGM), requires enormous investments (time, human and financial resources). At the same time, one should bear in mind that all-important changes finally must come from within a society without being imposed from the outside. **It is also very important to work with communities and not about communities** as the case often is. Therefore including community stakeholders in matters that affect their lives is an opportunity towards capacity building and an empowerment process that will eventually lead to sustainable behavioral changes from within.

Besides, the role played by non-governmental institutions is vital in addressing gender based violence or violence against women (in this case FGM). Human rights and all other goals can only develop through a crucial interplay of government and non-government organizations, thereby complementing one another. Since NGOs have been crucial in the development of Human rights since the Second World War (Peter R. Baehr 2009), they have also continuously pressured government and reminded them of their commitments to the international human rights standards, given the fact that majority individual governments are signatories to such treaties (Mashood A. Baderin & Manisuli Ssenyonjo, 2010). It is thus only fair to say that without NGOs, human rights would have probably drifted to the bottom.

However, it is important to note that though normative standards are universally binding, but the learning processes, which countries have to go through, in order to fully implement various freedoms, in this case, women and children's freedom (from harmful cultural

practices), remains a very different one. Therefore, recommendations concerning various countries should be very specific, although at the same time, based on the universal normative standards. In any case, activists must familiarize themselves with each context in which they work.

On the issue of NGO effectiveness, by distinguishing between 'real' and 'claimed' effectiveness, Welch, as quoted by Peter R. Baehr (2009:123) asks, *"should we be more persuaded by the success that NGOs have claimed, or did they contribute only marginally to changes that would have occurred "naturally"?"* Answered by P.R.Baehr (2009), most NGOs rarely claim major success, and are quite modest in making such claims. However, it is difficult to say if changes would have occurred anyway. Baehr winds by suggesting that the safer way to stay away from such claims is to limit oneself to *"marginal successes"* as little is known about either NGO effectiveness or impact (Peter R. Baehr 2009:123). In other words, the impact of NGO activities is hard to be gauged. Even their expansion, based on activities, does not necessarily indicate increased or decreased effectiveness, though it might suggest an increase and growth of information availability.

Lessons learnt from this study involve, combining contextualized approaches with holistic and integrated approaches, in order to target either the particularities (a few exceptions) or the 'whole' community. This will help 'hit two birds with one stone', for not every approach will work in all communities whereas specific approaches may yield results in particular communities. Besides, social norms are centrality to community behaviors and reactions towards any abandonment activity. They (social norms) therefore, must be thoroughly addressed. Meanwhile, indulging a wide range of actors (from community and various institutions), is likely to improve on the quality/effectiveness of approaches against FGM, in necessary contexts. Moreover, grassroots 'genuine' participation, at all stages of activities is very vital for cultural transformations. Besides, there is need for better evaluation of approaches, in order to know what works and what does not.

Strategies that victimize already cut women ought to be carefully revised, in order to harmonize communities instead of antagonizing them, by capitalizing on community differences. Approaches that foster human rights points of views, yield more success towards behavioral transformations. Therefore, we need those who work on human rights broadly, across the entire spectrum of rights (e.g. human rights watch), but equally important are the contribution of highly specialized organizations with particular expertise of community context, in order to create practical synergies.

While over a decade ago many academics were still convinced that FGM would gradually become a private matter, we have recently witnessed that the topic remains internationally relevant – given its global context and politically hot. FGM is also becoming a common practice and a major concern in the Western countries due to increasing rates of immigration. Global estimates according to UNICEF are 140 million survivors (those already affected). In Europe alone by 2013 estimates of affected women and girls were 500,000 and those at risk at 180,000 among only registered immigrants (EIGE 2013). There is no doubt that the number of those affected increases steadily per year and will continue to increase in the future. The problem is therefore not to be underestimated given its impact on individuals affected, but also on the political, social and economic development of the global world, particularly the most highly affected countries in sub Saharan Africa. Developments of all kinds will continue to be potentially threatened by FGM, if the practice is not addressed in a timely and appropriate manner. Lots of work waits ahead to achieve sustainable behavioural changes and goals. The struggle towards elimination of FGM must continue!

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12.3 Questionnaires

a) Community questionnaires

SELF ADMINISTERED QUESTIONNAIRE

This Questionnaire is made for *only* study purposes. Any information given will be held *strictly* and *highly* confidential.

Topic: A comparative study of Female Genital Cutting (FGC) and "FGC" abandonment strategies in Africa. Case study: "Kenya, Ghana and Egypt"

Name of Researcher: Idah Nabateregga

Purpose of Research: Partial fulfillment of a Doctorate degree

University: Otto-von-Guericke University, Magdeburg.

Respondents Bio-data (please tick box where appropriate)

Names (optional)…

Marital status   a) married   b) single   c) divorced/separated   d) widowed

Age (optional)…

Sex: a) Male   b) Female

Specific Profession: a) Formal…   b) Informal…   c) none

Research Questions (please tick box where appropriate)

1. Which level of education do you have?

a) No education   b) primary   c) Secondary   d) Higher institution   e) don't know

2. Type of resident

a) Urban   b) Rural   c) Semi –rural

3. City of resident (in Egypt)

a) Cairo   b) Assuit   c) Fayoum   d) Benisuef   e) others (mention)...

4. How long have you lived in this areas?

a) All my life   b) Less than 3 years   c) More than 4 years   d) Over 10 years

5. Is FGC still widely practiced in this area?

a)Yes   b) No

6. What type of Circumcision is done?

a) **Clitoridectomy**-partial or total removal of the clitoris.

b) **Excision**-partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora

c) **Infibulation**: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris

7. Have you Undergone FGC?

a) Yes.   b) No

8. If yes, at what age did you undergo FGC?

a) 4-10 years   b) 14-17 years   c) 11-14 years   d) Above 18 years

9. Give reasons why you did undergo FGC?

a) Prevent immorality/promiscuity   b) Rite of passage to womanhood   c) Culture   d) Sexual pleasure   e) Religion   f) Preserve virginity   g) Marriage-ability   h) Cleanliness   i) Family/Girl's honor   j) Others (specify)…

10. Which period of year did (does) FGC take place?

a) First quarter   b) Second quarter   c) Third quarter   d) Fourth quarter

11. Where are girls commonly (did you get) circumcised?

a) Home   b) Hospital   c) Others (specify)…

12. Who performed FGC on you?

a) Traditional specialists   b) Health personnel, e.g. Nurses.   c) Others (specify)…

13. Who made the decision that you get circumcised?

a) Family...   b) Self   c) others (mention)...

14. Are there any social/medical complications related to FGC?

a) Yes.   b) No

15. If yes, what are the complications?

a) Medical examples; - Difficulties at birth, excessive bleeding, Urine retention, infections

b) Social. Examples; - Sexual difficulties   c) Death   e) others (specify)…

16. At what ages does FGC nowadays take place?

 a) 4-10 years b) 14-17 years   c) 11-14 years   d) above 18 years   e) Underage (specify)...

17. What about the girls that have not been circumcised, what prevented them from being circumcised?

a) Government laws   b) Fear of medical complications   c) FGC not a culture   d) Family support

e) Sensitization and awareness exposure   f) others…

18 What kind of difficulties have uncircumcised girls faced (if any)?

a) Family problems (like) …   b) social/community problems (explain)...   e) none

19) are there any organizations working towards FGC abandonment?

 a) Yes   b) No   c) I don't know

20. If yes, mention organizations you know of, working towards FGC abandonment

a) NGOs like...   b) Government organizations like...   c) International organizations like...

f) I don't know

21. What methods do these organizations commonly use towards FGC abandonment?

a) Sensitization and awareness creation   b) Human rights approach   c) Medical approach

d) Religious approach   e) community based approach   f) others...

22. What challenges have these organizations faced if any? Tick and explain your answer

a) Political...

b) Social...

c) Economic...

d) None

23. Do you think there is progress towards FGC abandonment? a) Yes   b) No

24. What kind of progress has been achieved towards FGC abandonment?

a) Poor   b) fair   c) good (Explain ticked answer)……………………………………….

25. Reasons why the practice is reducing?

a) Government laws e.g.... b) High sensitization   c) cultural reasons   d) Health complications
e) others (mention)..............................

26. Any organizations/individual groups that you know of supporting FGC? (Give examples)
a) Individuals   b) Social groups   c) political groups

27. In your opinion, should the practice be abandoned or maintained? (Please give reasons)   a)
a) Abandonment   b) Maintenance   c) Not decided

28. How would you react to a request to circumcise your daughter?

29. How did you get exposure to information about FGC?   a) Media   b) Health workers

c) NGOs activity   d) Government activity/Speeches   e) Family and relatives   f)
School/institutions of learning   g) others (mention)...

30. Any additional remarks?

Thank you for your kind cooperation

b) Addressed categories in community questionnaire

Part I

Bio Data

Marital status, Age, sex, occupation, Education, Type of resident, city of resident, how long have you leaved in this area? (Time spent in area of residence).

Part II

Practice

1.   Is FGC still widely practiced?

2.   What type

3.   Have you undergone FGM?

4.   If yes, at what age did you undergo FGM?

5.   for what reasons?

6.   Which period of year?

7.   Where are girls commonly circumcised?

8.   Who performed FGM on you?

9.   Who made decision that you are circumcised?

10.   Are there any social medical complications?

11.   If yes, what complications?

Part III

Strategies/Methods

12.   Are there any organizations working towards FGM abandonment?

13.   Mention organizations (NGOs, Government, International, I don't know)

14.   What methods do these organizations use in FGM abandonment?

15.   What kind of progress has been achieved towards FGM abandonment?

16.   What challenges have these organizations faced if any?

Part 1V

Progress

17.   What about the girls that have not been circumcised, what prevented them from being circumcised?

18.   What kind of difficulties have uncircumcised girls faced (if any)?

19.   Reasons why the practice is reducing

20.   Progress towards FGM abandonment

Part V

Challenges

21.   Challenges organizations face in the field of activism

22.   Any org or individual groups you know of supporting FGM

Part VI

Check on the future of the practice

23. In your opinion, should practice be abandoned or maintained

24. How would you react to a request to circumcise your daughter?

25. At what age does FGM take place nowadays?

26. Exposure to FGM information

b) Organization questionnaire

This Questionnaire is made for *only* research/study purposes. Therefore, any kind of Information given will be held *strictly* and *highly* confidential.

Topic: A comparative study of Female Genital Mutilation/Cutting (FGM/C) and "FGM/C" abandonment strategies in Africa. Case study: "Kenya, Ghana and Egypt"

Name of Researcher: Idah Nabateregga

Purpose of Research: Partial fulfillment of a Doctorate degree in political sciences

University: Otto-von-Guericke University, Magdeburg, Germany

<u>**Questionnaire:**</u> for Administrators/NGO Personnel

Name: ……………………………………………………………………

Sex…………………………………………………………………………….

Age…………………………………………………………………………

Marital status……………………………………………………………….

Profession: ………………………………………………………………

Organization: ……………………………………………………………

1. For how long have you/ the organization been working in the field of FGM/C abandonment campaigns?

2. Name the particular communities/areas of your focus

3. What is the prevalence of FGM/C in the area/communities of your focus?

    b. Why the above prevalence rates?

    c. How would you rate the prevalence rates?

        o Reducing

        o Increasing

        o Static/not changing

4. What methods/strategies/ have been used to abandon FGM/C?

    a. What particular approach (es) is your organization using to fight FGM/C?

5. What has your organization done to reduce/in the abandonment of FGM/C?

6. How successful have you/ the organization been/what are the achievements?

7. Which/what, challenges are you/the organization facing in the FGM/C abandonment campaigns?

8. Why do you think the practice continues despite the campaigns to abandon FGM/C?

9. What/how are the people's responses to the programmes/strategies set forth to abandon FGM/C?

10. Are there remarkable differences between the way men and women, or boys and girls react to the support of FGM/C abandonment?

11. In your opinion, what can be improved in the FGM/C abandonment campaigns/ and by whom?

12. Who can communities count on to be agents of change in FGM/C abandonment?

13. What would be the obstacles in the fight against FGM/C and who would stand in the way?

What? Who?

14. Is there any foreign/international pressure, to abandon FGM/C in Africa/Kenya/Ghana/Egypt?

Yes…….   No……

b. If yes, what kind of pressure?   ..

c. What/How are the foreign governments, or International organization doing, in a bid to support the FGM/C abandonment campaign programmes in Africa/Kenya/Ghana/Egypt?

15. What are the correlations between education and FGM/C?

b. What about income and FGM/C? Are there any laws in place that you/the organization know(s) of, which forbids the practice?

Yes (mention)……   No…

16. To what extent are such policies/laws enforced? /how are they enforced?

17. What are the likely social sanctions against uncircumcised females in communities where FGM is practiced?

18. How can women in other cultures avoid FGM practices?

19. How can the government help in eradicating the practice of FGM?

20. What would be the best approach against the practice

   o   Human rights approach

   o   Medicalised approach

   o   Behavioral approach

   o   Religious approach

   o   Combined approach

   o   Others, specify…

21. What reasons inform the practice of FGM?

22. By whom and how is FGM done?

23. Do you think FGM practitioners undergo any training? If yes, how adequate is this training?

24. Are there social/medical consequences of FGM? If yes mention such consequences

25. How would you react to a request to circumcise your daughter?

26. Is there anything you would like to add on this topic?

Thank you so much for your kind cooperation!