European Asylum Support Office

EASO COI Meeting Report

Female Genital Mutilation/ Cutting (FGM/C) & COI

25-26 October 2016

Malta

SUPPORT IS OUR MISSION

European Asylum Support Office

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Fatmata, 13, has not been cut. After peer education in her village, Fatmata's parents decided to abandon the practice. And they're not alone - in Burkina Faso the prevalence of FGM/C among girls aged 15-19 has dropped by 31%. Her mum, Asseta says, "I hope my daughter will have good health, and I hope she will do the same for her daughters and avoid cutting."

Neither EASO nor any person acting on its behalf may be held responsible for the use which may be made of the information contained herein.

Acknowledgements

EASO would like to thank the following experts and organisations for their participation at the meeting and the presentations they gave:

UNICEF Sudan

Bettina Shell Duncan (Professor of Anthropology and Adjunct Professor of Global Health at the University of Washington, USA)

Ellen Gruenbaum (Professor of Anthropology, Purdue University, Indiana, USA)

Omar Abdulcadir (University of Florence/ Regional Referral Center for the Treatment and Prevention of FGM)

Idah Nabateregga, Terre des Femmes, Germany

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Disclaimer

The meeting report compiles information presented by key speakers during plenary sessions and subsequent questions and answers related to country of origin information. The different chapters of the report provide a text badsed on transcripts, rather than summaries or syntheses.

Variations in style, terminology, spellings, and choice of language for different terms used by different speakers may appear as a result.

The external speakers validated the information in this report as of April 2017 and have given their consent to be quoted publicly from this report. Information provided by an external speaker in this report should be cited under the name of the speaker and the context in which it was delivered:

> [Name of speaker], EASO, Workshop on FGM/C & COI, held on: 25-26 October 2016, Malta.

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The target users are asylum caseworkers, COI researchers, policymakers, and decision-making authorities.

Glossary and Abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
DHS	Demographic and Health Survey
FGM/C	Female Genital Mutilation/ Cutting
MICS	Multiple Indicator Cluster Survey
WHO	World Health Organisation

Introduction

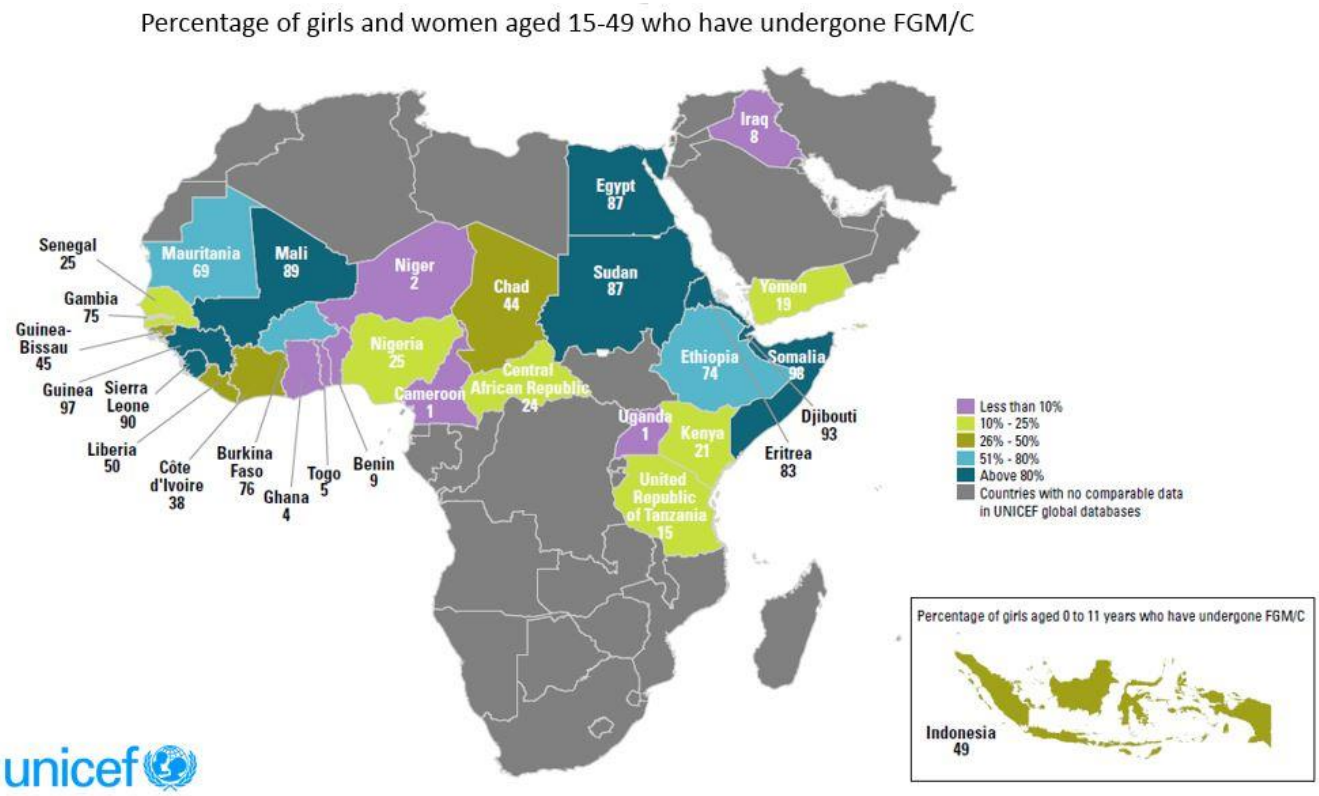
On 25 and 26 October 2016, EASO organised a meeting on Female Genital Mutilation / Cutting (FGM/C) in Malta.

Following the need expressed by EU+ countries for accurate information on FGM/C in specific countries, and in view of a more harmonised approach to Country of Origin Information (COI) and decision practice in the EU+, EASO brought together around 25 participants, including COI specialists, together with UNHCR and civil society organisations.

EASO invited the guest speakers mentioned in the Acknowledgement section of this report, to share their expertise and field knowledge on FGM/C on selected topics and recent developments in selected countries.

This Meeting Report includes transcripts of the presentations and subsequent discussions with the speakers.

Map



© UNICEF[1]

[1] UNICEF, *The prevalence of FGM/C varies greatly across countries with data*, 2016 (https://www.dropbox.com/s/bghaytwx9jdr586/FGM_C%20prevalence%20women%20aged%2015-49_map%20labels.pdf?dl=1), accessed 2 October 2017.

FGM/C: A Global Concern, with a focus on Prevalence in West and East Africa

UNICEF, Sudan

Topics of the presentation: general introduction to FGM/C, definitions, typology, prevalence, impact of the practice on health and factors influencing behavior.

FMG/C, according to the WHO (World Health Organisation) definition, involves altering or injuring the female genitalia for non-medical reasons. The practice of FGM/C is internationally recognised as a human rights violation by all the countries that have signed the CRC-CEDAW until this year. The most recent policy guidance on FGM/C has come from the joint committee of the CRC-CEDAW[2] about two years ago when they issued the general comment/general recommendation that looks at harmful practices including FGM/C, child marriage and others.

FGM/C is historically rooted in gender discrimination and is the result of and contributes to the perpetuation of girls and women having a lower status in society. The World Health Assembly has also recognised the health consequences, including extreme physical and psychological pain, prolonged bleeding, potential for transmission of HIV, infertility and death, and I'll get into it a little bit more of the evidence in a few slides. The global data (we have data on 31 countries today) has historically come from African countries, but most recently we have published data that includes Iraq. For the first time they collected data in 2013, approved by the government. We have also published a dataset from Indonesia Ministry of Health for the first time that measured the practice among girls.

UNICEF as part of the UN system is to provide the technical financial support to the governments to carry out the national household surveys, so every single time one of these surveys is initiated, UNICEF proposes the entire set of questionnaires to the government and says, "These are the different child/women's rights issues we'd like to have information on". Then there is a process of discussion and negotiation of course, budget considerations that come into play. Essentially the reason why we have these data is because the governments have agreed to carry out a survey with and through our advocacy.

In the UN system UNICEF is also responsible for maintaining the global databases on FGM/C, so global estimates come from the UNICEF database. At least since 2013 we've been updating the global number estimate every year with new datasets coming. So this is the primary source of monitoring data for the sustainable development; called Target 5.3 on the elimination of harmful practices including FGM/C and child marriage.

The data I am going to present today is mostly based on 2014 and 2015, the most recent datasets for different countries. Indeed there are some countries that haven't collected the data since 2004 and we're actively working with those governments to update the data, but some are recent, as recently collected as last year. Usually it takes about 9 to 12 months for the data collection to be completed and then for an official report to be issued and approved by the government, so there is a significant timeline. We typically also do not have data more frequently than every 4 years, so this is another key challenge in the monitoring of prevalence in a given country and in a given state or region in that country.

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[2] CRC-CEDAW Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices , 14 November 2014 (https://documents-dds-ny.un.org/doc/UNDOC/GEN/N14/627/78/PDF/N1462778.pdf?OpenElement), accessed 2 October 2017.

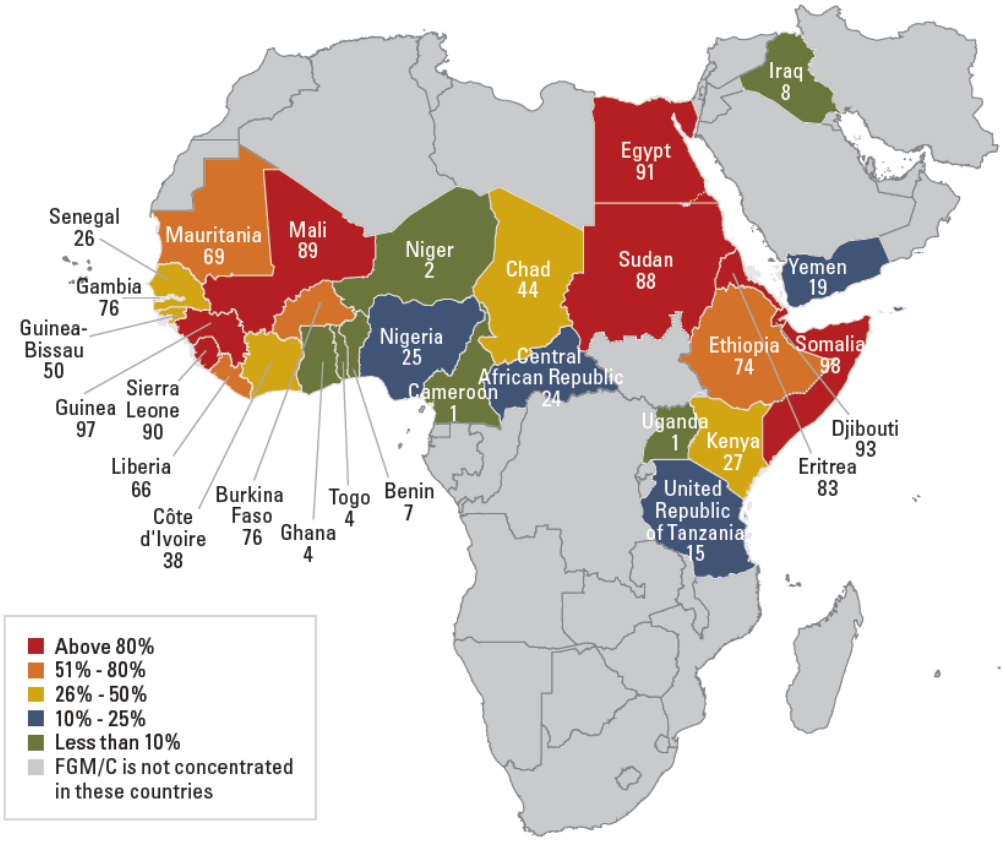
It's important to know that there are *standardised survey instruments*, so we are asking the questions in a standardised way across countries, following the WHO global definitions.

Past work by the Demographic and Health Survey with the organisation MACRO, which was the data collection partner in Washington DC, tested the reliability of *self-reporting*, of women reporting their FGM/C status, when they were cut, who cut them etc., and found that there was validity in this self-reporting method, but essentially it is only one study done in this way so it's still rather low and we still are hoping to increase the reliability.

Typology. I won't get into the types but what is important here is that the UN definition is same as the WHO definition (type 1, type 2, type 3 and type 4 of FGM/C), which represent varying degrees of physical severity of the practice. I look forward to having a discussion about how you operationalise those definitions in contexts where a woman is trying to remember what happened in a distant past. Of course when it's practiced in real life, we don't necessarily follow the exact definition. It's not necessarily the exact definition of the practices according to the WHO. It will happen in different ways with different practitioners and different women.

The main message is: *200 million girls and women* alive today are estimated to have undergone some form of Female Genital Mutilation and Cutting. If you follow this for the past few years you see that the number is higher than before and the reason it's higher this year than last year is because we have included Indonesia. Indonesia brought about 40 million girls, new cases, into the global estimate, so it may look like it's increased, but it's essentially now counting girls that had already been cut and who are not previously counted.

I am going to focus on *East and West Africa* .



This is from our 2013 publication[3], and in at least 2 or 3 of these countries, the prevalence rate has changed a little bit. In the case of Sudan, where I work, it went from 88 to 87 (see also the 2016 Map).

What we see on this map is that it is concentrated in the East and North East (Horn of Africa) as well as in a band across West Africa. I think this is useful when initially encountering the applicant in the process. However, one of the points that I'd like to leave you with is that I think that national borders do not matter that much. It matters more what group they belong to. So this illustrates that the concentrations of the practice tend to go across borders, especially in the case of West Africa where you have people belonging to different social and ethnic groups that exist in multiple countries across borders. In the case of Senegal, the overall prevalence for it is about 26% but when you break it down into different ethnic groups there are certain groups that have over 90%, which is a very important consideration indeed. In addition to the country of origin there is the group they belong to.

As for most part of the grey countries, at this point I think we can say they are not practicing or have very very few cases. There are a number of ongoing discussions with governments about including them just to make a verification on them, including the data collection.

The *prevalence* of FGM/C among girls and women aged 15-49 years (see charts in UNICEF report 2013). A lot of people ask why we stop at age of 49 when they are far beyond the age of 49. This is the generally accepted reproductive age definition that DHS/MICS use. We are interested in all women and girls across the entire life span. There have been some attempts to project the estimate beyond the age of 49, which is the overall practice locally, but this is what we have for the time being in terms of the real datasets not just data projections.

The take-away message here is that it does vary incredibly across countries as we saw from the map. It's almost universal in Somalia, Guinea and Djibouti (above 90 per cent), while you have only 1% in places like Uganda, Cameroon, Niger. As I illustrated before this is primarily linked to those practicing populations belonging to an ethnic group where there are more people across the border in the neighbouring country that are also practicing. For instance, northern Uganda bordering in part of Kenya that has a shared group practicing across the border.

So, as I said, we're also interested in zero aged girls because actually this is the most important indicator - the 0 to 14 age group - because this is when the girls are at risk. If you look at the 15 to 49 age group, all of these women were potentially cut between 15 years ago or more, 15 years ago, 30 years ago... So once they are cut they're always cut and so they will always show up in the datasets as women who've been cut.

So if we want to detect change, if we want to see how things are evolving, possibly thanks to our policies and programs over the past two decades, we will want to look to this 0-14 age group. Current prevalence data for girls aged 0 to 14 is significantly lower than that for older age groups.

You can see the variation is still there across countries. There are some countries where the current 0-14 prevalence is quite lower than their 15-49 prevalence, but that's where we caution everyone not to use this as the final number. This is a snapshot in time. 0-14 is the time of the risk of cutting, so the issue is that some of these girls that are currently recorded as not cut may be cut sometime in the near future, in the next 5 or 6 years, potentially 10 years. So there are statistical adjustments that have been tested to look at the next age

[3] UNICEF, *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change,* UNICEF, New York, July 2013 (https://data.unicef.org/wp-content/uploads/2015/12/FGMC_Lo_res_Final_26.pdf), accessed 2 October 2017.

cohort, that is an older group, to see if one can project the final statistic about the cutting for that age group and measure some progress, but it's not been universally applied in the global estimates at the moment. So this gives an indication of where we're going with the 0-14 age group but we need to be careful not to take it as the final statement on the cutting status of these girls.

What has happened in the past thirty years? There has been an *overall decline* in the FGM/C prevalence since 1985 but, as with the previous statement, not all countries have evenly made progress. Some have made great progress, very strong progress, and some have stayed still. There are no cases where it's gone up significantly. There are some which have gone up the statistical limits a little bit, but we haven't seen an enormous number of countries that are declining rapidly and this is some cause for concern. The overall picture, of all countries put together, wher prevalence decreased from 51% in 1985 to 37% today.

Forecast. By 2030, slightly more than 1 in 3 of all girls worldwide will be born in the 30 countries with national data on FGM/C prevalence. This is a concern because by 2030 we want to have the elimination of all harmful practices, but if we take into account the pace of demographic growth, the decline in prevalence, the percentage of girls that have been cut may not translate into an absolute decline in the numbers of girls that are being cut and that is because of the demographic growth i.e. the growth in population.

So we can't say that we're really on track for the goal at the moment because we still see enormous additional programmatic policies that need to be made in order to accelerate the changes that are taking place, but not fast enough to keep up with the demographic growth.

The surveys also measure *attitudes*. I think the demography community does not like asking questions about attitudes because your attitudes can change from one day to another, but they have been consistent over the different datasets. I think we are increasingly seeing that the agreement that FGM/C should continue has declined. So more girls and more women in the countries that practice FGM/C where we have data think that FGM/C should end. So there is a discrepancy between the personal attitude that a woman/girl has, and the actual prevalence, the actual practice that is taking place. In countires like Guinea and Somalia, where the practice is almost universal, the agreement on ending the practice is quite low, 20 to 30%.

The influence of *education*. If you have higher education levels among the mothers, generally speaking that translates into a lower risk of being cut. As you can see, we are trying to construct a kind of a pattern of different risk factors. We can mention the ethnicity of the family, the age of the girl, whether or not the mother is educated, the wealth status, the urban and rural setting, which I didn't show here but rural families tend to practice at a higher level than urban families.

Another question is on why do you or the family practice FGM/C, what are the *benefits*. The headline here is that girls and women most commonly reported as 'gaining social acceptance'. Actually 'no benefits' is also highly sided, and so maybe they don't see any benefit whatsoever, but if they do see a benefit it is typically a social benefit to their family and to the girl.

Compendium containing extensive data and analysis [4]. This is the longer piece that Bettina[Shell-Duncan] has very much drafted and contributed to. It goes into some more of the analyses on the social factors, on the correlation to wealth, education household status... I think that one of the most exciting things about that publication is that it has detailed tables

[4] UNICEF, *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, 22 July 2013 (http://data.unicef.org/wp-content/uploads/2015/12/FGMC_Lo_res_Final_26.pdf), accessed 2 October 2017.

for every country and every question that was answered. It will give you the data points where you can see for yourself the answers to some of the questions about the characteristics of the families that are making applications. This publication is from 2013. There are two years-2014-2015 - that are not reflected in there, but the analysis around the practice, the social issues and the consequences are still valid. Some of the individual numbers may have shifted a little bit depending on the country. We have also updated brochures on the www.unicef.org website with the updated tables with all those specific numbers.

Just a quick note on *ethnicity*. This is such a key factor, but not every country does collect that information. For example, Sudan has refused to collect that specific information on ethnic origin, while it is such a diverse place with peoples coming from all over the Middle East and Africa that it does make interpretation and programming in a certain communities very difficult, because we don't have the precise information.

Beyond the scope of that dataset, there were some additional questions that we wanted to have answers to about the data. One is *administrative data*. We do have health information systems and education systems in many countries that have FGM/C practice, but FGM/C has been a neglected issue in those systems, so I would say it's generally unavailable through government data systems and administrative data systems. We do have NGO monitoring in many countries that tend to focus on the activities. There are efforts under way to integrate FGM/C verifications and these are typically self-reported verifications, not physical examinations, into health information management systems. I am aware of Mauritania, Djibouti, Sudan and Gambia. These also include school health programs. Since a lot of children do not have access to health facilities, they bring the health program to them in the schools. Child protection systems are increasingly being strengthened across African countries and the information management system for those child protection systems will of course also integrate FGM/C monitoring into it.

The *health impacts of the practice*. As for the health complications, there are the immediate complications and the potential long-term complications. As regards the immediate one, there are the complications of bleeding, delayed or incomplete healing or infections. As regards the longer-term ones, these have been established by a WHO multi-country study, but they are more difficult to attribute to the event of FGM/C specifically. These may include damage to the adjacent organs or reproductive organs, sterility, recurring urinary tract infections, the formation of dermatoid cysts and potentially in extreme cases even death. And then once the woman who has undergone FGM/C is giving birth there are additional risks of complications that may arise.

As regards the *psychological and social consequences*, there are short-term and long-term traumas that are experienced by girls from the act of the cutting. If you see any one of these videos that are produced, it's not a pleasant experience for the girl. One of the immediate social consequences is often marriage. The cutting is done as a preparation for marriage in many groups, not all groups, but one tends to follow the other, which is then followed by the subsequent integration in the husband's family which oftentimes means physically moving to a different place and to a different house.

The flip side of girls that are left uncut is that there is a higher risk of being socially excluded, of men not accepting them as the right woman or the right kind of woman. Given the coexistence in many societies of the practice of child marriage, FGM/C as a precursor to marriage as a child then leads to early child-bearing, because once married there is an expectation of immediate childbirth, otherwise other social consequences will come down to bear on the girl.

To put it in more stark terms, cut girls are generally accepted as part of the community, as normal women, normal members of this group while the uncut girls, if their status is known

(sometimes they keep it hidden), they'll often be referred to in the local language using some kind of profane term, sometimes, oftentimes meaning the word "dirty" or "unclean" or something even worse in some places.

There was a question about *who decides to perform the practice*. My colleagues will get into a lot of these issues in more depth, but what we've seen from the data is that generally girls are not consulted about the practice. Sometimes it's a complete surprise that this would be happening on a given day, and they don't understand what is being done to them.

In a lot of the national surveys that I was talking about earlier, there is a question about a *mothers' intention* to cut: Do you intend to cut your daughter in the future? But that is a very limited data point, because mothers are not the sole decision-makers so we don't really know. An intention to cut may not be actualised in practice because of the multiple influences on the mother. Grandmothers, aunts and other older women in the family or in the community are often more influential on the decision being taken, sometimes without the knowledge of the mothers. Fathers and religious leaders may exercise a certain indirect influence. Many interviews you read from fathers say this is a woman's affair, that this is not their business, but they tacitly support it because they think it's the right thing to do for the family, for the family honour, and to belong to that community. So we can summarise by saying that social pressures do play an important factor in the decision.

Social and non-social factors influencing behaviour. I wanted to expand on the framework that we use in our global program on promoting the abandonment of FGM/C, to understand FGM/C as a social norm. Earlier we said there are personal preferences and personal ideas about the continuation of the practice, but that there are a lot of social influences and social expectations that will ultimately lead to whether or not the family carries out the practice on the girl. As regards the actual behaviour or active performing of the FGM/C, we think this is determined by three factors: *knowledge, attitude and social expectations*. *Knowledge* is the beliefs about the physical world, the facts, what I know to be true about the world. Most respondents in questionnaires will say "Yes, I know what FGM/C is" so there is a high knowledge about FGM/C as a practice. I showed the data about attitudes, personal preference, and personal belief. We have seen that *attitude* to stop the practice scores very high. Respondents would prefer not to continue the practice, but we see a disconnection between their personal preference and the behaviour when it comes to the social influence, the social expectation about cutting, and generally speaking when battling between their personal preference and social expectations.

We have broken down into three components what *social expectations* are: one is my [taken as an example] belief about how other people act. That it's essentially what I see other people doing. If I see it, I believe it. I see other people have cut their daughters, so I believe that it is a practice that they expect me to adhere to.

The second is the belief about how other people *expect* me to act, so it's what I think others want me to do. If I think others expect me to cut my daughter otherwise I won't be a part of this group and I won't adhere to the group's norm, then I am more likely to conform to it and go ahead with the practice even if my personal belief is in opposition to that. This may be further enforced by the fact that there is a social reward or punishment, which can take many forms, but it often takes the form of disappearing marriage prospects if the girl is not cut, active social exclusion, name calling, saying that the girl is dirty, refusing to accept food that has been prepared by her… The list can go on unfortunately…

Positive forces: you can have legislation in place. You can have access to quality service. You can have economic benefits and costs associated to it. Those can be positive forces. These can enable the abandonment of FGM/C. Most of our programs have focused on the knowledge and attitudes to try to increase people's knowledge about the health consequences, that

nothing harmful happens if you don't practice, to try to change the attitudes but we also need to pay attention to how we influence the social expectations and create a different narrative about what people are doing, showing that there are fewer people practicing, especially that young people don't want this practice anymore on girls, and to change the narrative about what mothers and family members believe, that is, that people want them to do to it be an accepted part of this social group.

The issue about *social norms* is one of the key drivers of how UNICEF has evolved, and it has been included in our programming in the past seven years. We are trying to address that more explicitly in all the work that we do so that we can overcome that social expectation issue.

Discussion

[Question]: Regarding the interviews, is it taken into account that many women might answer that they haven't undergone FGM/C because it's being outlawed in their country?

UNICEF: So this is the question of *self-reporting bias*. It is a concern that potentially, the introduction of a law or a step-up in enforcement where people are seeing families being arrested might result in an under-reporting of the practice, so there has definitely been that discussion among the technical assistants from UNICEF for the governments to keep an eye on this. So far, from the analysis that we have done, we haven't seen a major decline in reported prevalence since the introduction of a law, but I would say it is still early days because there is most likely a time lag between the introduction of a law and changing the self-reporting in a questionnaire.

[Question]: I have a question on the intervention side. How do you work with the health workers, I mean midwives and nurses, because mothers and girls are in contact with the health system? How do you work within all the knowledge, attitudes and practices of health workers?

UNICEF: The practitioner, the one who performs FGM/C, varies by country of course. In some countries it's a traditional cutter that has been in the area for decades. In Egypt it is mostly medical doctors who are practicing it at this point, and in Sudan the largest group is trained midwives. So we are seeing that the ones that are supposed to protect and care for the girls are actually carrying out the practice. It hasn't been a very strong analysis, but some anecdotal analysis about the motivation behind that is that primarily there is an economic incentive. Doctors and midwives are paid very little in those countries so this is an additional source of revenue for them. It is very confusing because you have a doctor in Niger who performs the practice on other people's daughters but not on his own daughters. It is this kind of anecdotal stories that cloud the picture. I'll give you the case of Sudan. We are working with WHO and the Ministry of Health. We are working with midwives training programs. They have pre-service training and they have in-service training and they're integrating FGM/C information curriculum into these training packages. The Ministry of Health also took the step of asking every midwife at the end of the training to sign a declaration saying that they will never practice FGM/C as part of their midwife practice. So that's being ruled out in different states but it is relatively an innovation. We haven't been able to test it or evaluate it at the moment, but I think what I have learned over the past few years is that it is remarkable how little this information is reflected in the medical curriculum of these countries. So you have doctors learning about the practice of medicine in a country where the majority of women have been cut and now they're learning what that cutting has resulted in and what kind of care practices may be needed. Therefore, strengthening of the training and then the monitoring of doctors and midwifes as a community of practice is very important.

[Question]: Do you have access to the raw data from the DHS and MICS? Because we see that some country reports do not include important variables, for instance the Egyptian

report doesn't say anything about religion. Many countries tend to group results on regional level and do not split up in states, like it should be in Nigeria. Is it possible to access these data?

UNICEF: The data at www.unicef.org are public. Your institution or you, as an individual researcher, can register to access the MICS and DHS datasets. They are all there, so if you have WITS or SPSS you can run some of the tables with the raw data and the questions. We would love to receive all sorts of feedback on the template, on how the country reports are drawn up, because these are standardised templates. They are generally done by the statistical departments without a lot of in-depth analysis or secondary analysis on this particular issue, which is why the Global Joint Programme and all these countries encourage the UN Officers to commission a secondary analysis on those factors. For certain countries, as I said, religion or ethnicity may not be collected because they're sensitive, so it will just depend on what's available within that dataset, so check www.data.unicef.org.

[Question] You mention the religious leaders; we know they are the ones who control the practices and the attitudes. Do you concretely work with them or with faith-based organisations in order to eliminate the practice? For example in Nigeria, the data differ a lot depending on the states. There the role of faith-based organisations may be crucial.

UNICEF: Religious leaders are core stakeholders and programs work at community level with the local religious leader on engaging with them and winning them over on the subject. Many times the religious leader was never asked the question on the practice and so hadn't really given a thought about it, and was quite open to discussing it. But then there is also the question of engaging the religious leaders at the national society level to give out positive messages. In the case of Islam, there are a lot of different views and a lot of different interpretations, so people will use religion as the justification for it, and they will find the religious leaders that support that particular stance. Even along the same line of thinking, there are different religious leaders who have made a different interpretation that is against FGM/C and who will stand firmly, saying that religion has nothing to do with it. So we have a wide variety of different views.

We engage with everyone in the country programs on these views: some are very actively helpful in dispelling the myth that it is linked to religion, and some are continuing to perpetuate it. UNFPA has worked on establishing religious leader networks. Our Joint Programme has supported scholars from Al Azhar University in Cairo to travel to different regions and work with the local religious leaders to issue *fatwas* that explain in very clear language the relevant references in the Quran, say what their interpretation is and why they are against FGM/C. However, sometimes it really comes down to which religious leader these populations listen to. It might be ultra localised, so a fatwa may be helpful in the way that Allah is helpful and the enabling environment, but it may not convince everyone. That is a really challenging issue because of the diversity and the different views.

[Question]: Is state protection available and accessible for women against FGM/C?

[UNICEF]: I wanted to make a general point about the law and offering protection. In fact, it's the family testifying against family, or community members turning in another family and community. They often resort to traditional mechanisms for mediation and problem-solving, so it may never go to the formal system. It will stay within the non-formal community-based system, whatever is common practice in that community, so we may never hear of the case. We may never see it. I think there are a number of initiatives trying to build on those kind of community-based protection mechanisms and make them more linked to the formal system, but it is definitely not a reliable system at the moment.

I have seen some good practice regarding shelters for girls in *Kenya*, particularly by World Vision. I have always been suspicious of a runaway centre because I feared the girls would then become stigmatised in their family and in their community and would not be able to go back and to repair the rupture of social relations because of the running away. However, the project by World Vision also linked to the issue of a vacation cutting during holidays, when the practice peaks in some ways, wherein girls that are living potentially in the town in order to attend school or living in Europe and then returning home, to their home country in Africa for vacations, they often take advantage of the fact that they are not in school to conduct the practice. What World Vision did was, they did have a place for the girls to go, but they called it the Summer Camp. It was a Summer Camp program, and they would negotiate in advance with the families to have these girls enrolled in the summer camp program, but effectively they were protecting the girls in a supervised place with social workers and others during the peak season of cutting for these girls in Kenya. I thought it was very sensible in a way because they were doing it in a way that the families were not taking a risk to protect their girls; they were actually enrolling them in an educational setting for the summer vacation, and at the same time there was protection.

So I think that protection is still very much underdeveloped, and we have to ask a lot of questions about different methods of protection if they are not creating a bad situation for the girl, potentially jeopardising her affiliation with the family and creating an additional stigma.

Female Genital Cutting/Mutilation in Senegal and The Gambia

Bettina Shell Duncan, Professor of Anthropology and Adjunct Professor of Global Health at the University of Washington

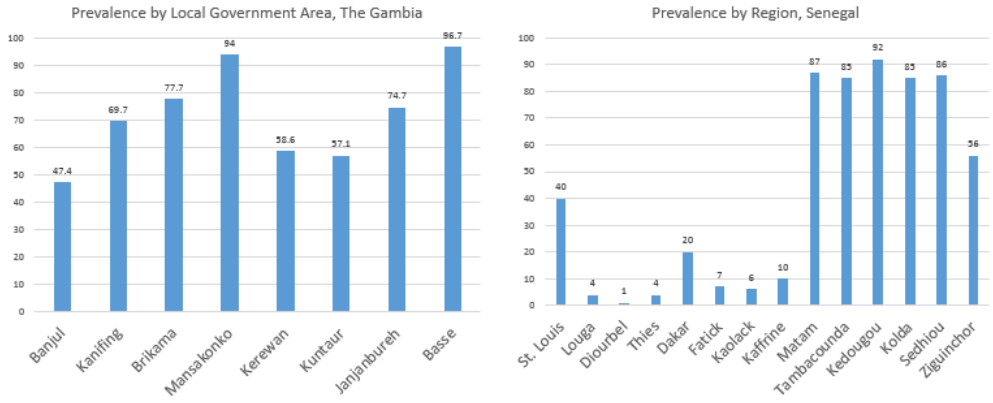
I am a biomedical anthropologist and I have been doing research on FGM/C since the late 1990s. I was the principal investigator for a World Health Organisation-supported study on dynamics of behaviour change, so in that research we collected both quantitative and qualitative data on decision-making. In the presentation that I put together, I have the most recent national level survey data from Senegal and the Gambia, which is from the demographic and health surveys from last year and the year before. I'll have data that are more recent than this report as these data keep coming out. My latest publication is a 2016 report which gives the most recent numbers on prevalence and other issues like the practice support, current state of legislation etc., and it's accurate as of August of last year, and is available online [5]. [..] I have also included numbers from the research that I have done, but I wanted to be real clear that where it is quantitative and qualitative, it is done in certain study sites which are not nationally representative but were meant to give me a window into understanding how decision-making is done and what's involved in these two countries.

Senegal and Gambia. Senegal is the westernmost country in Africa bordering the Atlantic Ocean, and the Gambia is completely enclosed on three sides by Senegal. These borders are the effect of colonial rule. Senegal was a French colony whereas the Gambia was a British colony; the British were controlling this river at first with slave trade and later on trying to stop slave trade. These borders do not reflect what is culturally going on in these regions and divide the ethnic groups that straddle both borders. There is a tremendous amount of similarities in people who live on either side, the economic mode of production, although on national level there are some important differences: Senegal is a much better-off country than the Gambia, also with regard to *FGM/C policy*, the ways that the practices have been approached are extremely different in the two countries. One of the things that is complicated and interesting to us is that these borders are very porous: people can go back and forth, and one of the things we wanted to understand is: If families are actively going across these borders, how do different contexts of FGM in the two countries influence it when people can so easily transfer across these settings?

How widespread is the practice of FGM/C. For 2014, the prevalence is now 25% in Senegal. In 2013, the prevalence in the Gambia saw 75%, so much higher than in Senegal, although Gambia is a tiny country. […] But figures at the national level mask a lot of variations that happens at regional levels in both countries, but especially in Senegal.

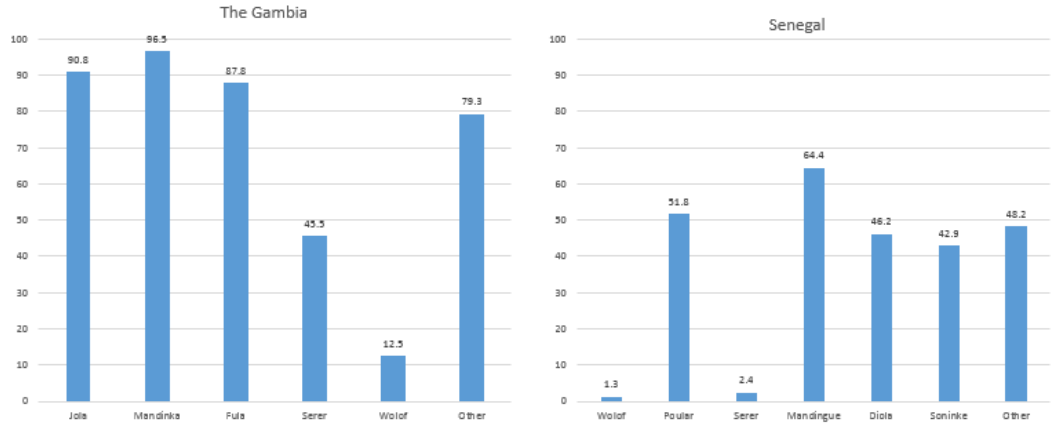
[5] Shell-Duncan, B., Naik, R., Feldman-Jacobs, C., *A State-of-the-Art Synthesis on Female Genital Cutting/ Mutilation: What do we know now? FGM/C Research Programme Report,* 2016. New York: Population Council, http://www.popcouncil.org/uploads/pdfs/SOTA_Synthesis_2016_FINAL.pdf

There is regional variation in the prevalence of FGM/C in both The Gambia and Senegal



On the left hand side of this graph is The Gambia. It is broken up into local government areas and it shows that the prevalence changes anywhere from as low as 47% in the capital city of Banjul to being near universal in the far eastern area of Basse. In Senegal the variation is even greater: in Fatick and Kaolack the prevalence is only 7 and 6%. In Kolda, the prevalence is 85%.

The prevalence of FGM/C varies along lines of ethnicity



Of any of the socio-demographic variables that we can extract from the datasets, *ethnicity* gives us the most information about the likelihood that a woman or her daughter is cut or going to be cut. In the Gambia, the ethnic majority are Mandinka and the prevalence among Mandinga is 96.5 %. In Senegal they are called *Mandingue* with a prevalence of 64.4 %. In Senegal the Wolof are the ethnic majority, and they are said by and far not to practice FGM/C, but the prevalence is 1.3 %. This is not a statistical error. Ethnicity is complicated; there are also issues of inter-ethnic marriages, and ethnicity tends to be traced through the line of the father but not 100%... so this is not a statistical flaw. Among the Wolof in Gambia, it's 12.5 % - there has been a longer history of inter-ethnic marriages. In the Gambia marriages used to be arranged where people were marrying cousins. Now it has been replaced by what people are calling "love marriages", where people are selecting their own spouse and inter-ethnic marriage happens. Also, if marriage happens between a family that practices FGM/C and one

that doesn't practice FMG/C, this is increasingly being negotiated. It's not obvious, it's not automatic whether FGM/C will be practiced. This was part of the complexity that I did research on, with regard to behaviour change.

The national prevalence data broken up into '*urban' and 'rural*' does not capture as much of a variation in practice as ethnicity and region do. It is found both in urban and rural areas, and one of the things that I have been asked in the context of doing experts statements for asylum is, 'Couldn't they just move to the capital city and be ok? It is not the case that the practice does not exist in cities, at least in these two countries, or in any at all.

Is there variation along the line of *religion*? There is a perception that FGM is a Muslim practice, which is way too simple. In Senegal and the Gambia, the vast majority of people are Muslim. In Senegal, the prevalence among Muslim women is 25% so that means there are 75% of Muslim women who are not being cut. So it is not just a Muslim/not-Muslim issue. The prevalence among Muslims in Gambia and Senegal actually mirrors the national prevalence very accurately. The number of Christian people in each country is absolutely tiny and the prevalence among Christians also mirrors the national prevalence, so it's not the case that it does not exist among Christians, it is not the case that all Christians do, so religion doesn't tell us in any deterministic way that a family does or does not practice FGM/C.

Prevalence among girls 0-14 yrs. In the national surveys, we used to ask questions about *one* daughter, usually the most recently cut girl. With that you do not get the denominator and you cannot talk about prevalence. Now in the UNICEF MICS survey and the DHS they ask about *all* girls between birth and age 14. This is because there is a strong interest in the question: Are there signs of the practice going down? It is not possible to give trends in decline by looking at the prevalence in girls 0 to 14, because it tells you about the current cutting status of a girl, not the final cutting status. In some countries, the age of cutting is pretty late, around the age of 10 in Kenya and in Egypt. So if they ask this survey question to a mom of a 9-year old girl, she might say, 'The girl is not cut' but the full answer is, 'She is not cut... *yet'*. The girl might be cut next year, maybe the family has decided against it… In Senegal and Gambia, the age of cutting is a lot lower; the vast majority of girls in both of these countries are cut before the age of five. The *prevalence among girls 0 to 14* includes girls who have reached their final status, girls who are not cut, who might be cut in the future, and girls who are not cut but might never be cut, maybe because they don't come from a family that does the cutting, or maybe the family has changed their mind. So looking at the daughter data is really complicated and there are better ways to get a trend in a quick way, which I will show in just a minute.

Mother's education level. We also have socio-demographic data on *household wealth and education.* We like to look at these variables in relationship to the prevalence among girls, rather than among women's own self-report, because a woman might be saying what the wealth is now, but if she was 35 years old and was cut 30 years ago, what does her current household wealth has to do with the fact that she was cut 30 years ago? So household wealth gives us a bit more of an idea about how wealth or education might influence cutting practices for decisions made on girls in the family. So we divide up the data this way. There are trends in both countries that prevalence is higher among the daughters, among the mothers who have no education and it *goes down steadily with increased education.* Girls of more educated women have a lower risk of being cut. But it does not go down to zero, especially in the Gambia *[no education: 59%, primary education: 51 %, secondary/higher: 42%]*.

Breaking up the data by *wealth quintiles*, this is comparing the lowest wealth quintile to the highest wealth quintile. *Girls of wealthier women have a lower risk of being cut.* In Senegal women who are from economically better-off families have a drastically lower rate of cutting than women who are from less well-off families. The same is true in the Gambia but not near

as big of a differential. Talking about wealth in Gambia is also really complicated: the vast majority of people are very poor. Anybody who is in the highest wealth quintile is a small select group of people.

Who is at risk? Girls of mothers who themselves have undergone FGM/C. As I said, out of all available socio-demographic variables, the factor that tells us the most about potential risk of being cut is ethnicity. But the greatest variable whether or not a girl is potentially at risk of being cut is *whether the mother herself was cut*. This is because the practice of FGM/C is not randomly distributed in the country but handed down from one generation to the next. Families either practice it or don't, and of course they can make the decision to abandon it. There are a few instances of places where not practicing families started doing it. It usually happens in the case of inter-ethnic marriage where a woman will marry into a family that practices it and may be cut later, but in the vast majority of cases, what happened to the mum is a really good indication of what could potentially happen to the girl. People do not just suddenly decide, "Oh, shouldn't we practice circumcision?" It is definitely a traditional practice that is carried down from one generation to the next but not in a blinding unquestioning way. There is a lot of dialogue and deliberation which has been the focus of our research and decision-making.

The age of cutting. More than half of all women who have been cut in both of these countries were cut before the age of 5. The chances of a woman being cut after the age of 15 are extremely small - but is not unheard of. In the qualitative work that I did, I had conversations with one woman who was cut after she was married, after she had given birth to five children. She was married into a family where all of her co-wives were cut and the social pressure and torment that she experienced was so bad that she decided "this is it, I am so sick of this treatment" and she went to the circumciser on her own and requested to be cut.

I have heard anecdotes about women who marry into a family where co-wives are cut, and are being cut during labour and delivery without consenting to it, because the women don't believe that a baby should be born to an uncircumcised mother. The numbers are small, but to say that it is impossible for somebody over the age of 15 to be at risk of being cut is not true. That is something that I had to write about in the statements that I have given in particular about Gambia, that you are not at a zero risk just because you are past a particular age, so you need to look very carefully at the story, at what is happening in the family and why a woman who is older than 15 might be claiming that she is still at risk.

The type of cutting. UNICEF showed you the WHO typology and one of the things to understand is that they do not ask the question to women: 'Did you experience type 1? Did you experience type 2?', because women have no idea what these typologies mean. When it is graded in a typology, it is done by a trained physician or a trained nurse who knows the typology and the human anatomy, so you can get that in a clinical report but surveys are self-report on women. It is one thing to ask, 'Are you cut or not?' When you start getting into the typology you need to use terminology that people are going to understand. So the people who wrote this survey questionnaire had to figure out what can possibly be meaningful to ask in different countries. They made questions about 'being cut and no flesh was removed', 'being cut and having some flesh removed', and 'being cut and then stitched closed'. Instead of using the WHO terminology they use this to try to get at the severity of it.

You can impute that to 'be cut but no flesh removed' in general sounds like nicking which would be a type 4, and that doesn't exist in Gambia. 'Cut and flesh removed', could be either type 1 or type 2, and that is what exists most commonly in both of these countries. When you talk about 'being closed', these questions get tricky because when they talk about 'closed' and 'being stitched', they do not do stitching in these countries, they do something called 'sealing' where they leave the cut tissues to adhere and so they actually *do* become closed. This is a

question that I just wonder how it comes out on the ground, but sealing *does* exist in both of these countries and others.

Is the practice of FGM/C declining? As I said, looking at the daughter data would be lovely if we knew that it was the final status. But we don't. We look at the survey data from women and their self-reported status, women between the ages of 15 and 49. There is a better way of looking at the data than by looking at national prevalence in repeat survey data: take the most recent survey data and break it down into age cohorts, so the youngest age cohort is 15 to 49, and we then can make graphs of the prevalence at each 5-year age cohort, going from 15 to 19, up to women aged 45 to 49, and get a really nice idea of trends. You have to remember though that we are still talking about something that happened sometime in the past. In Senegal and Gambia, this is at least ten years ago that most of these women were cut, so if we want to know what has happened in the last ten years we are going to need to look at the girls' data, but this gives us an idea of these trajectories.

What we see with statistical controls is that in Gambia there is absolutely no significant decline in the practice among women of the age groups 15 to 49. In Senegal, we do not find a statistically significant decline either. If we do a really complicated analysis on the daughter data we get a more promising picture that looks like change is beginning in Senegal. You have to remember that these women, 15 to 19, were cut ten years ago, so a lot of the activities with law and NGOs, are beginning to take hold on generations younger than this.

There are questions in the survey, 'Do you *support the continuation of FGM/C*?', 'Are you unsure about it?' or 'Do you oppose continuation of the practice?' You have to remember that these women were given a questionnaire, somebody was sitting there with a piece of paper asking them… For example, if you came to my house and asked me if I support child vaccination, my answer would be 'yes', and then I would want to give a caveat, 'but, you know, there are people who have religious rules…' The surveys do not include all of these different caveats, and with FGM/C there are a lot of caveats - which is why as scientists we get a bit wary about how much weight to put on it.

They asked this question of support to all women. The percentage of women who support the continuation in Senegal is 16% and in Gambia it is 65%, but as I mentioned, the biggest risk for a girl being cut is for a woman who herself was cut. What is more interesting in these data is to pull out the women who are themselves circumcised. What is really interesting is that support for the continuation is not universal among cut women. We can say that in both of these countries there is a lot of dialogue. There are lots of debates about what is the right thing to do even amongst people from families who have traditionally practiced.

Prevalence and support of continuation. The other thing that is interesting in these data is to see the relation between the prevalence in the country and the percentage of women who say they support the continuation. In all countries support is lower than the prevalence. It includes both cut and uncut women, but it tells us that something is at least under discussion. In some countries they also collect information from men. One of the things I am going to show you in a minute is that we also did our research on the *men* who do the decision-making.

Sometimes *men are involved in the decision-making*. People told us again and again and again that FGM/C is women's business, but when they were saying that this is women's business what they were meaning is *older women*. They prepare the food, they set the timing, they pick the cutter, they do the training, but men are involved in the sense that they are asked to contribute with money for the training. There are costs: even if they do not do big celebrations and rituals, they are still paying the cutter and oftentimes the girls are given new clothes or presents depending on the country. If the man in the family has an opinion, he can say what his opinion is about it and in certain cases it holds weight. In Senegal and Gambia we found that it particularly holds weight if he convinces his own mother about what should happen.

So looking at what men have to say, men's support, it is not irrelevant by any means. We see in almost all countries that support for the continuation is lower among men than it is among women, and this is an important finding.

Cultural norms and meanings of FGM/C. So another thing I am always asked is, 'Why do people do this?' 'What are the meanings of this? As an anthropologist, I find it really hard to distil something down quick and simple, but I will. I am talking about the study communities that I worked with in Senegal and Gambia. We worked in peri-urban communities around the capital city Banjul. We worked along the north bank in Gambia and then right across the border in Senegal. There were some communities that were literally bisected by the border but with people flowing back and forth. I am generalising about these regions; you could go to the far north in Senegal and they might talk about it differently, but this is coming from the areas where I have done research.

There is a whole range of *reasons* that people give to describe the importance of the practice and why it is done. The thing that people talk about most readily, the thing that comes to the tip of their tongue most quickly is, 'It is our tradition'. That is not a brush-off answer; it is actually a deeply meaningful response. They use this phrase again and again, 'We found it from our grandmothers'. We heard this over and over and over again as people were talking about it, that this is actually a tradition that is passed down from one generation and shifting to the next. It is about inculcating into girls the concept of womanhood and solidarity of women in their extended family. Girls were traditionally initiated at later ages than what we see in the data now. It used to be at around 10-11, right before entering into adolescence. They were taken into the bush, into seclusion, where cutting happened, and then they were secluded during a healing period, where there was also a lot of life training. The training was on a wide range of things, but one of the things they talked about was the way that women show respect to their elders. They talked about knowing the eye. The way to display deference to men and women who are older than them. When women marry, they move into their husband's home and need to have the solidarity of other women in their marital home, and they need to know how to understand the social hierarchy, how to display their subservience to those who are older than them.

So cutting physically transforms them. It is also part of making them moral and showing respect. It is also described in terms of having the cleanliness for proper prayer, although as I said, there are lots of Muslims, in Senegal in particular, who do not cut, but for the people who do perform cutting, they are viewed as having the cleanliness that is required for proper prayer. One of the biggest things that came out in the Senegal-Gambia data was displaying respect to those who are older than you and respect to ancestors. Ancestors wouldn't have handed down a practice that was not in your best interest and in the best interest of girls. So the idea of even questioning it is something that has taken a long time to do, because it was very much seen as taboo. So many years ago campaigns began in the 80s and ramped up in the 90s in both countries. Just the idea of raising this topic was considered very sensitive. Now you walk around in the peri-urban communities in Banjul and people talk about this. There is a buzz out there. And I didn't need to know families for 8 months before anybody would talk to me about this. It is something that is discussed much more actively. But the context of bringing it up was part of 'What do you think of these campaigns?', because the knowledge of the campaigns was universal in all of the study communities that we were in. The way that they practice is not just one thing.

I already mentioned that it is now happening at younger ages, and it is also more and more common to not take girls in groups into the bush. That is considered something that is more old-fashioned, that's what the grandmothers or the past generation did. Now it is often done in the home of the girl or home of the circumciser. Sometimes in small groups, sometimes alone, sometimes the circumciser would come to the house and do just one girl. So there is

constant discussion about what is the right way to do this, how should we be doing this and anymore, if at all. So in some cases it is about, 'Should we be doing this at all?' There were families that I talked to that had decided to abandon it, but most of the debates were, 'What should we be doing?' 'When we do it, how should this be carried out?' But there *is* abandonment.

One of the things I wanted to say is that just because somebody comes from a family that once practiced it, even though they point out the importance of upholding tradition, it does not mean that it is practiced from time immemorial exactly in the same way. That is a big myth about the practice. There are always active discussions about which of these previous customs fit in these modern circumstances, because what is happening today is different than when our grandmothers were cut. Do we still take girls to the bush? Was it hard to get them to the hospital? Now that these girls are in school, can they really stay out in the bush for 3 months? It costs a lot of money to stay out in the bush for 3 months. Do people spend money on this anymore? So my colleague Ylva Hernlund used this title 'Winnowing Culture', talking about a winnowing basket, sifting out what to keep and what goes. She talked about that as a process with culture.

None of us do things exactly the way that things were done in our families in our grandmothers' generation. We might still carry on traditions that happened in our families eons ago, but are they being done exactly the same way? And FGM/C is one of these that is constantly up for reappraisal.

The other thing that UNICEF mentioned was the *pressure to conform*. Ellen [Gruenbaum] is going to talk more about a campaign in Sudan called the *Saleema* Campaign. And I just say *Solama* is the word that is used in Senegal and Gambia that is different than the Sudanese word *Saleema*; *'solama'* is a word that I heard a lot in Senegal and Gambia. It literally means uncircumcised. But it is a powerful invective, a huge insult. It means not only uncut, but ignorant, rude, that you don't know yourself. Telling somebody that their mother is a *'solama'* is like the worst insult according to the people that I work with. So I just wanted to point out those two. The degree of pressure on girls who are uncut from their peers, the degree of pressure on parents who decide to not cut - are you properly parenting your girl? Is she just going to run amok and be *'solama'*? - The pressure is enormous, not just on the girl, not just on the mum, but on the extended family. Sometimes, this is where fathers become involved in conversations, in really important ways as well.

> *"Changes in the practice are vital. For example, girls should be taken at a very early stage and not in groups, neither stay in the bush as was the case during our time. We stayed for almost two months in the bush but came home every evening after sunset and went back before sunrise, in very unhealthy conditions".*

This is just a simple quote from one of the interviews that I did, but the big first sentence in this is '*Changes in the practice are vital*'. I heard this over and over again from women. Even though FGM/C is being carried on and passed down to younger generations, there is nothing static about it. What is constantly being argued is 'How do we do it?' This woman was saying for example, 'Girls should be taken at a very early stage and not in groups'. They told me over and over again that if you do cutting on a baby, she will heal easier than an older girl. I have no idea why babies would heal faster than a 10-year old, but they told me over and over again. We don't stay in the bush as was the case in our time, we stayed for almost 2 months in the bush and came back home every evening after sunset and went back before sunrise in very unhealthy conditions. So health has become a really important part of the conversation in Senegal and Gambia. One of the things that one of my own research showed is that the health message has taken hold in a really, really important way, that I will show in this.

We did research on *decision-making*. We talked to families for whom circumcision had been discussed in the past 3 years. We divided it up for whether the girl was still uncircumcised or whether the girl was recently circumcised. We asked who participated in this conversation - this is a direct conversation about whether or not a girl should be cut. The number on mothers is very low. We were talking with the mothers and we realized they didn't mention themselves because they thought it was obvious – 'We are talking to you' - but mothers are not the most powerful persons in this decision-making. They told us that by and far the most powerful people in this decision-making were the *grandmothers*. If a woman's mother-in-law says, 'Now it is the time for circumcision', the younger women in the family have to defer. They can send messages and say what their opinions are, but they are not the most powerful people in the conversations, but rather elder women in the families.

We did find that when *fathers* were brought in to the conversation, it was much more common that these girls remained uncut. What our research was showing was that, if a family was deciding to not cut a girl, oftentimes it was important to have the father onboard. He might sometimes be leading the conversation, it might be the grandmother leading the conversation, but the men needed to know because it has a bearing on the whole family. It influences the status, the position of the entire family, and just not doing it without bringing him into the conversation for some people was not seen as practical. We talked with men, and they told us over and over again that they do talk about the practice, that they do have opinions. If they support the continuation, they end up just saying, 'Well, that is women's business; they are going to go and do it'. But especially younger men became increasingly opposed to the continuation.

Repercussions of refusing FGM/C. A little bit of this depends on who is doing the refusal. A young girl often is not brought into the conversation about whether or not she is going to be cut. As you can imagine, if it is a baby, nobody is consulting a baby; if it is a 10-year old girl, she might catch word of what is going on, and if she's decided none of her friends are cut, she doesn't want to be cut, she might say something. Authority is with older people in the study communities that we were working in. Who is doing the refusing is an important question in the communities that we worked with in Senegal and Gambia. If a grandmother and extended family members are refusing that any girls in their family are cut, there are repercussions. People will look at them and say, 'What on earth are they doing?', 'Are their girls going to be moral?', 'Are their girls going to know how to behave in a respectful way?' But it is possible for families, if they pull together, to refuse, particularly if there are other families in the community who are also refusing. If the refusal is coming from a mother who has a newborn, and she is saying, 'I don't want this baby to be cut', that is a much different situation if the extended family is not backing her up. In the communities that I was working in, it is possible for a grandmother or an aunt to take a girl to be cut. They don't need to get the mother to come along, it is okay. And until a law - and I will talk about law in just a second – A law was just passed in Gambia; they have no idea what on earth this law means yet, if anything.

I will explain why. The blithesome responsibilities for the girls are held by the entire extended family. So if a mom was saying, 'We are not going to cut this girl', and then the mum is at the market and an aunt comes, or the grandmother, and takes the girl to the circumciser, there was nothing in terms of common law or written law about this. That was not a police matter: that is their right to do so. It is one thing if an entire extended family wasn't onboard with a no-cutting decision. For a mom to be able to enforce that -this was something that I had to talk about in asylum statements that I have done for Gambian women - she would have to be with that young girl 24 hours a day, holding the baby, never handing the baby over to anybody else. The idea that she would be able to protect that girl indefinitely and if that girl were to marry into a family that cuts would still be risk-free, just wasn't feasible. But if a young woman refuses without the consent of the family, I have seen that that sparks violence, especially in

Gambian communities. How can a young mother go against the will of the elders? It is such an unthinkable thing. It influences the entire standing of the family to have somebody behaving out of line. So a big question is: *who is doing the refusing*? I have just never seen a 10-year old girl say, 'I don't want to be cut' and that carried weight, unless the entire extended family had anything to do. In fact, everybody would say. 'Look at this girl, she is talking back to her elders. Probably it is time to take her to be cut.'

Consequences of not having undergone the practice is something that I am asked to say in statements. There has been a lot of talk about whether a woman who has not been cut finds a husband. In Senegal, in Gambia, it is not the case that somebody is not marriageable if they are not cut. What they told me over and over again is, 'Any woman who wants a husband is going to find a husband'. This is not true in other places; I worked in Northern Kenia and it was unthinkable for an uncut woman to be married. But in Senegal and Gambia, they can be married. Any woman, they will be able to marry. But if a woman speaks out and goes against the wishes of the family, people will say, 'Was she properly trained?' That makes a difference. For a young girl not being cut in an area where others are cut, she is going to be mocked and teased. I have seen girls come back home crying about this. People will criticize the family saying, 'How can you leave this girl "solama"?' Pressure is made on the family. If a young mother, as I said, is trying to not have a young girl cut against the wishes of everybody else and her family, there are huge consequences. It is considered as inappropriate as it can possibly be.

Another thing I am asked to comment about in asylum statements is the *possibility of relocating to another part of the country*. I think UNICEF actually knows the Senegal situation better than I do. But in Gambia it is not the case that nobody cuts in Banjul, so just moving to the capital city is no protection. It is a tiny country, a little over a million people. Everybody knows everybody. The idea of somebody moving and then nobody would know where you would go is not possible. It is a place where you talk to people for 10 minutes, for instance, we would be going down to any field community and my research assistant would introduce what we were doing and they would go, 'Oh, you know, my extended cousins are over here, I have family'. There was not one village that we went to in any part of the country where they would not come back and go, 'Oh, we have family, they are inviting us to stay here'. Everybody knows everybody. There are no secrets, and until this law was passed it was not illegal for extended family members to take a girl. So, in Gambia, the idea of relocating discreetly, it just doesn't exist. You [UNICEF] know better whether this is true in Senegal.

[UNICEF]: I think it is the same case in Senegal. Dakar is all of Senegal in one place. You know somebody's cousin or aunt, so the information would easily spread.

[Shell-Duncan]: When we did our research on behavior change, one of the things that we talked about was this idea of readiness to change. This just reiterates what UNICEF was saying. Individuals don't make the decision for a girl to be cut all by themselves. In the vast majority of cases there are groups of people who weigh in on it. So on the left-hand side, I have *Behaviour,* that is, either they practice, they are undecided or they have abandoned it. In the other axis, I have *Preference*, that is, they support FGC, they are ambivalent or they oppose. Somebody can be a reluctant practitioner, when a girl is being cut even though they don't want it to happen, because it is not one person who is deciding all by themselves.

The idea that people can act upon their intention is not like I have decided to go on a diet, so I am not going to eat cheese. I can decide that all by myself. This is a group decision in many cases. In the work that we were doing, we found people who were in all these different groups. The majority of people in our study communities were willing supporters, but we found people who had reluctantly abandoned and people who had willingly abandoned FGC as well.

Explicit positive and negative associations and stage of change. We made a questionnaire that asked people about the advantages. This was based on our ethnographic research, we made a scale from all of these different questions. We would say, 'Do you agree that circumcision shows respect to grandmothers?' They would agree or disagree with it. All of these became agree/disagree questions. We came from our ethnographic research with this list of disadvantages. Most of the disadvantages were health questions. One of the things that became a big deal is that one of the perceived newest threats in Senegal and Gambia is the threat of getting HIV from circumcision, especially if you use the same cutting instrument on each girl.

One of the things they said was, 'Yes, we inherited this tradition from our grandmothers, but HIV didn't exist back then. Our grandmothers would never give us bad information, but this was something that just didn't exist'. One of the things that we found is that people are considering what customs to give and take, but this information that there are new health risks played a lot into the decisions of the people who decided to abandon the practice because it is a new threat, even though the prevalence of HIV is pretty low in Senegal and Gambia. It is scary and a risk that can be averted either by getting a new blade for each girl, which some people did, or by not cutting at all.

Are there organizations working towards the abandonment of FGM/C. The answer is yes. Both countries have a large number of organizations that are working towards this. I have listed only the biggest organizations: Gambia: APGWA, GAMCOTRAP, BAFROW. Senegal: Tostan. I don't think BAFROW exists anymore, but they were a big deal before. Also, under Senegal, I have listed TOSTAN, and now TOSTAN also works in Gambia. But GAMCOTRAP is a big organization that has been in Gambia for a large number of years. There has been a wide variety of different strategies towards it. GAMCOTRAP led efforts, tried to get the Gambian government to pass legislation, and this became a very tricky issue. While I was doing my field work in Gambia, some leaders from GAMCOTRAP who had been talking about the idea of introducing a law ended up in prison, and no charges were filed for a long time. Eventually there were charges against them later on, but they were released. But the Gambian government does not have a stellar human rights record. The President of the Gambia comes from a family that practices FGC. His own mother was an outspoken supporter of the practice.

Legal Protection

Senegal: 1999 criminal law that prohibits the violation of "the integrity of the genital organs of a female person: penalty 6mo-5y in prison, or, where cutting results in death, hard labor for life.

Gambia: 2016 law that stipulates that a person who engages in FGM can be sentenced to up to 3 years in jail or 50,000 Dalasis ($1,200), or jail for life in the case of death.

For many, many years, the Gambian president said, 'We will never have a law here'. Then last year, to my shock, he put out a statement saying, 'I hereby ban FGC'. And then earlier this year the Gambian parliament passed *a law banning FGM/C*. After having him on the radio and television saying, 'We won't do this', he also left messages in the media that showed that he was upset about the number of Gambian girls and women who were getting asylum in other countries. So on the ground, Gambian people are speculating that he passed this ban simply to stop the number of claims. I have worked in Senegal, Gambia and Kenya. I have done expert statements for many women and the vast majority of them have been from Gambia, because it was a place where there was no place that women could turn if they didn't want their girls to be cut.

What that means on the ground now that this law has been passed, I have no idea. I really have no idea what it means anymore. In Senegal, the human rights situation is very different.

TOSTAN has been a successful NGO for a long period of time. Senegal passed a law after initial successes of TOSTAN by holding public declarations where they got members of the community to come together after a long 2-year program, and pledge in public that they would not cut their daughters. After the first series of declarations, Senegal passed a law banning FGM. There have been some instances of the law being implemented. In the areas where I was working, people knew that FGM was illegal. They knew that there was a law, but they knew nothing of the details of the law. They didn't know if you could walk to Gambia - if that would be legal or not. As regards the people who were continuing the practice in our study communities, they were cutting girls at younger and younger ages, because little girls cannot go and tell their friends what happened to them. A newborn baby cannot tell anybody. I worked in one village where a 7-year old girl had been taken with her family to Gambia, and her grandmother cut her while she was in Gambia. And when she came back, she ran around and told all of her friends about had happened, and was mocking the other girls and the community for not being cut. And the community became extremely anxious because they knew it was illegal.

Of course, the Senegal law does not have an extra-territoriality clause. In fact, what they did was illegal, but nobody there knew what was legal or not, so they were very anxious, and this caused a big row in this particular village. In the communities where I worked this was not a conversation starter, but after we had been there for 2 years, we started asking people about their responses to the law. They believed that the law was enforceable, they knew of no cases in Senegal of the law being enforced. So they didn't have to have detailed knowledge of the law to believe it was enforceable. They said they had heard of people going to jail in France, and I said, 'But what about in Senegal?', and they said, 'Oh, we have no idea.'

They were still afraid of the law, and there were different camps of responses to that. Some people said, 'We don't care, the government can come and get us, we are going to do what we want.' Some people said, 'We are going to do what we want but we are going to do it secretly, and that is why we are doing it among babies.' Most of them would talk about the people over there, in that compound, and say they are doing it. They would talk about an abstract other, so it has gone underground among the people who are supporting it. Big anxiety about the fact that, if something goes wrong during the cutting, you can't just show up at the clinic. They are afraid to go to the clinics if there is a complication from FGM/C. A lot of the local circumcisers stopped cutting because they are afraid of it, and they have this thing that they now call *travelling circumcisers* coming through. They are people who go from one community to another and perform cutting.

Since they don't know these people, they wonder if this is somebody who really knows what they are doing or not. There has been a response in that a lot of the locals have stopped doing it. So they are afraid. Did this person really get trained on how to do it, or is this just somebody coming through and this is just a money-making scheme for them? They have no trust in these people, they didn't know if they were going to just move out of town after they do their cutting there. So it has had very complicated responses but, even without direct knowledge of cases of arrest and conviction, the law made people afraid; it either caused abandonment or, as in most cases, it drove the practice underground.

Discussion

[Question]: When people discussed FGM among themselves, do they use people from all the ethnic groups with different practices as examples? When they discuss, for instance, Mandinka, talk about it, 'but we know the Wolof they are doing it, their girls still behave properly'….

[Shell-Duncan] Yes, people do that, especially in Senegal, where the Wolof are the ethnic majority, and they are also better-off. There is this concept that people talk about becoming like the Wolof, sort of a 'Wolofisation', so some people think that is a good thing. People are adopting the dress of the Wolof and other customs, and say that their girls are doing fine, while other people are resentful of it. They are saying, 'Oh, everybody wants us to become like the Wolofs. We don't want them to take away our culture.' So they do look and say that these girls are okay, but other people say, 'No, they are trying to take away our culture.'

[Question]: In families where there are several daughters, and you say that there is this on-going discussion, would parents or mothers have these discussions on a daughter-by-daughter case, or is there a tendency that once the older daughter is cut, the other daughters will also be cut, or are there variations?

[Shell-Duncan] If they have more than one daughter they will sometimes have girls cut in groups. But there is this idea that the girl has to be old enough, and what that age is, is different in different ethnic groups. So for example with the Mandinka, they didn't traditionally practice this in infancy. So if they have really young girls, they might only cut the six year old and the seven year old girl, and the baby might not. I did meet families that say that they've left this tradition of FGM/C behind, where their eldest girl was cut but subsequent daughters were not. So it's not uniform in families.

[Question]: Among the people you met, especially in Senegal, those who change their minds, what kind of arguments are relevant? Is it mostly health as you said, or maybe religion too?

[Shell-Duncan] Well, there has been work with religious leaders in the far north of the country. I didn't do my research in that area. Where I was working, women talked about religion indirectly, saying you have to be clean to pray. But men talked about the religious significance more than the women. It wasn't the first thing that anybody was talking about in the study communities where I was in. Senegal was big and culturally varied, so I am sure that is different in the far north, where people were tipping towards contemplating abandoning FGC or had already decided to.

In a lot of cases it had to do with 3 things. One is having an *adverse health reaction*. If anybody had been a direct witness to a girl who died from the procedure, that had a ripple effect through the communities. That, combined with this message about HIV coming from FGM/C, had a big influence. So people were worrying about the health repercussions. Years ago, NGOs started talking about health, but they talked about it mostly in terms of obstructed labour, and problems with childbirth. And then the women looked around and just said, 'You know, we have got 10 kids, she has got 9 kids and our grandmothers, they had all these kids - how can this possibly be?' And they really rejected that. But the idea of HIV, it has hit. The law has made a big difference and then also this NGO, TOSTAN, that has done these public declarations and bringing together... everybody knows about this NGO there. Just because a village participates in a public declaration doesn't mean hundred percent of the people in the village have abandoned it, but for those who decide to abandon it, they know they are not the only ones. Ostracisation is not as extreme. So it's these things combined.

[Question]: Is state protection available and accessible for women against FGM/C?

[Shell-Duncan]: In terms of protection, as I mentioned, in *Gambia* a law was just passed a few months ago. I have not been there since it was passed, but obviously implementation will take a while if it is implemented at all. It was not only not illegal but it was also celebrated by the President of the country until late last year, so any kind of protection was utterly unthinkable and non-existent in Gambia. My guess is that it is going to take quite some time for anything to change. Senegal, it is a really mixed bag. In *Senegal*, human rights protection is much better

and the prevalence is much lower, and there are some organisations working in earnest. Tostan has achieved international notoriety for what they are doing, and in general, work on international human rights campaigns, including violence against women, has a lot of very well known Senegalese activists involved in it. However, the idea of a mother going to some place for substantial protection - there is a law in Senegal - in theory one could go to legal authorities, but it is an extremely rare phenomenon in cases that I have followed. The idea of actually getting witnesses, because it's actually family testifying against family, is extremely complicated, so Senegal is a mixed bag.

I have also worked in *Kenya*. I refer to the presentation by Terre des Femmes about the rescue centre in Sierra Leone. Kenya actually has a bunch of rescue centres now, churches that offer protection and who are very active in Kenya. That's actually the only place where I have personally done work, where I have seen visible protection. People on the ground knew where to turn if they don't have families onboard.

[Question] Is your research on decision-making publicly available online?

[Shell-Duncan] yes. Some of it has been published. There is a 2010 report that I wrote with my colleagues on this that is available on-line [6], that describes in detail this dynamic of individuals having a very difficult time making decisions without consensus amongst others in their family and even in their social networks. There is ethnographic data as well as quantitative, so it is useful to see quotes from informants either in Gambia or in Senegal. It is filled with that.

[6] Shell-Duncan, B., Hernlund, Y., Wander, K., Moreau, *A. Contingency and Change in the Practice of Female Genital Cutting: Dynamics of Decision Making in Senegambia. Summary Report on the WHO/NSF Multicountry Study on Behavior Change*, 2010 (https://csde.washington.edu/~bsd/FGC/Contingency%20and%20Change%20in%20the%20Practice%20of%20Female%20Genital%20Cutting.pdf), accessed 2 October 2017.

FGM/C Trends and Issues in Sudan

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I am an anthropologist and I have been working in Sudan since 1974. It is very exciting for me, after all these years, to see how far we have come in comparative data and our ability to look critically at so many aspects. Before, it was mostly narrative kinds of anthropological work that was reported. There were a couple of early surveys but they were not done with anything like the rigor that has been applied in the more recent ones. I think we have a lot to thank these academic, intellectual, international NGO organizations for pulling so much together that we can use in practical ways.

I will look at the prevalence and some evidence of change, but I also wanted to talk a little bit about the kind of research that I and some other anthropologists do, what we call qualitative research on social context in the process of change. We never have the degree of quantitative precision – but sometimes we are able to offer something in terms of longitudinal perspective that might be useful for understanding the dynamics of decision making, which I hope will be helpful to some of you. I will be talking a little bit about these community case studies. I won't go into great depth – I have written about them elsewhere. I also wanted to talk about the career of a midwife that I have worked closely with, as well as a couple of others I have known, and I want to mention this Saleema Initiative and legislation, etc.

On the UNICEF map of prevalence (see UNICEF presentation): just let me draw your attention to Sudan, prevalence is 86.6 now.

When I first wrote a book about the topic back in 2001, I called it the *Female Circumcision Controversy*. I was trying to look at why it was controversial in the different places, and one of the things that I was able to copy from another source at that time was a map that was attempting to estimate severity – not only high prevalence, but also what type of cutting was done where. There was a period of time when you saw all the intense ones were in Sudan, Somalia, Eritrea and Djibouti. These were the places where you had the most serious type of cutting, one that is referred to now by the World Health Organization as type III. I just didn't choose the country for that reason as a place of research, but that is where I ended up. I was faced with type III and I really wanted to understand it well because I was interested in women's roles.

Reasons people continue the practices in Sudan.

About the reasons for continuing the practices, we talk a lot about *social norms*, but as an anthropologist, I like to really caution people not to think rigidly about tradition or norms. Tradition is something that is respected, it came from the grandmothers, it is something that you feel a strong sense of identity towards sometimes, but it also is always contested, and different people think different things about it. It is not just rigid roles that people follow automatically.

So it is a good thing to ask people about their traditions and about the changes that they have seen in their lifetime, because they do care a lot about things like schooling and health. I have heard a lot of people in Sudan in the last decade - in the times that I have been going - talk a lot about the complications not from the cutting itself, but from new aspects of it, like how much it costs to get a caesarean section in case you need it, or how much it costs to send your daughter for health care if you need it, and how much time is taken away from school, and

that sort of things. So for cultural practices, there is a widespread awareness, the expectation that it will be done, but what exactly is done and under what circumstances varies a lot, in a country like Sudan, from one place to another. Whether it is adhered to by everyone in the community or not is not always clear.

Among a lot of the people that I have interviewed over the years, the issue of *shame* (*'eyb*) *and honour* plays a decisive role. In some of our studies, "shame" was an overriding emotion expressed by adults. If a girl is not circumcised she may be called "*ghalfa*" (unclean, open, perhaps a "slut"), Even as people begin to see advantages to not cutting, they are still worried about whether people are going to make fun of their daughters if they don't. So the shame issue comes into it in a way that could play a role in this family decision-making.

Also, I think that a really interesting point about it is that decision-making doesn't happen once. It happens every day until the girl is out of the danger zone of high risk for circumcision or for cutting. And as you can see, there are still some that get caught later in life. So maybe they are never completely finished deciding in some ways. I think for adult women in Sudan it is not such a risk, unless they are in a circumstance of being a second wife or across different ethnic groups, where it is very common that people might question the traditions of one wife when looking at the other wife. So, I just wanted to reinforce that very valid point. I don't have statistics to show you, but I have heard many stories like that.

There are the other reasons: *health* – many assumed it was good for the girl, helped prevent childhood diseases etc. Years of trying to focus on health risks and the activism work were not always effective, just as years of focusing on rights objections were not always effective. But the fact is that people have heard different arguments now. There is a buzz about it, it is how Shell-Duncan mentioned it. I think that is the case in most of the parts of Sudan where I have worked. The far north not so much, although maybe that is changing.

There was also a very strong element of *morality* where it might not be seen as exactly part of Islam or Christianity or other religious teachings, but rather those religions preach morality very strongly, for example, if you think it is going to contribute to the likelihood that your daughter will better be able to be a virgin at marriage, or that your wife will be faithful, etc. – those things come into play. And then there are those assumptions about *religious expectations*. I must say that the religious expectations were really something that I thought UNICEF and other organizations have been challenging pretty effectively in the last decade including, as I have seen, through training sessions with local village sheikhs, being taught by a sheikh who is being sponsored by UNICEF to run a workshop out in eastern Sudan.

The teaching techniques that were used by some religious leaders have been very amusing: 'What is the matter? Who created us? God created us. Did he make some mistakes?' You know, getting people to talk about this among religious teachers has been very interesting. Some of the religious groups, such as the Sufists tended to be very responsive to this. In my experience in Kordofan area before, there were a lot of Sufist religious leaders who were really willing to embrace change, at least to go away from the pharaonic circumcision, the type 3, but then in recent years the other sects have been somewhat more resistant, such as the Salafists. And we will talk about that in a moment I think.

So *religious expectations very often play in with morality expectations*. I think a lot of the families have had to discuss whether it is possible to preserve good morality in their daughters even if they don't have this, because there are other ways, through teaching and so on. Although there has been a lot of efforts to identify percentages of people who hold on to their reasons, I think it is quite common that almost all of the reasons are present to one degree or another in a community, and therefore can be assumed to be a bit active, and I don't think that efforts to change can sort of target the most likely one and only work on that.

The *human rights issue* was an important one. I am trying to get my head around how we deal with this going into the future, because I am a strong believer that we want to promote human rights, and yet sometimes I saw people memorizing the clauses of SIDA in a village, without having any real way to implement them. I think it is really a starting point, but it needs to have a lot more mobilization of religious leaders talking about religious expectations because people are more motivated by that than they are by international agreements on human rights that can be perceived to be Western or external, and that is often thrown back at activists as a way of preventing them from being effective.

I think the health consequences do require a very reasonable presentation, and involve key personnel. I think we have mentioned there is a lot of medicalization of the practices that has gone on in many countries. In Sudan, it is very interesting because it used to be very heavily in the hands of 3 categories: untrained or traditional midwives; trained midwives who, since the 1920s, are supposedly being taught not to do it at the schools of midwifery but many of them said they just had to learn it on their own afterwards, because of course midwives have to do this work; and the 3rd category was medical doctors. After the 1979 conference in Khartoum, a lot of the professional associations declared doctors shouldn't do it, but they continued to do it. Now there is one doctor in Sudan, Sit el Banat, she has actually been publishing a lot on this, and I noticed some of the African-American Muslims have been picking up on this writing and advocating circumcision as being a good thing for Muslims if they do it in Sit el Banat's way. So I think this Sudanese doctor has really entered the international dialogue in an interesting way.

In Eastern Sudan in 2004 I was doing a project for UNICEF. There had been a study that was being done at that time – an epidemiological study that was trying to follow cohorts of girls and return and visit them every year to see if they were circumcised, to monitor their circumcision status as it changed.

Now, as an anthropologist I would be thinking, if you come in and ask the same question every year to the same families, you are actually engaging in change, you are telling them, it is not a neutral thing, this was a village where there was a health education program being put on by the Ministry's and UNICEF funding, and they were really doing a great job of bringing out health personnel, religious people, political leaders and actors and people putting on plays. They were trying to do a multi-faceted approach to convince people that it was time to change.

Is there *evidence of change*? Country rates can be compared over time. […] The 2013 dataset showed these tables comparing the 2 age cohorts of the 15 to 19 and the 45 to 49. I have been one of the people who have been somewhat critical of trying to do the 0 to 14 percentages – since you can't compare them across countries, since practices are different according to ages. Now they have been trying to do some more advanced ways of dealing with that to make them more useable. But I still find that looking at 15 as a good age by which most of the societies will have finished doing them, but not all, is useful. So if you look at the 15 to 19 and the 45 to 49, you see that 30-year gap. So the only thing that I found in that 2013 dataset that really gave me hope that there was dramatic change happening was this cohort comparison. A dramatic change, I say. But look at Sudan. It went from 89 to 84 % – that is not a huge percentage decline in 30 years. But if you look at some of the others, you see some more dramatic changes, like Kenya that went from 49 to 15 & %. Liberia went from 85 to 44 %.

So it kind of suggests that we can see a lot of differences among countries in their momentum for change, in the circumstances of change. I think that is quite important. When you are looking at things like country totals and trends - I also made this argument in one of the cases that I worked on - you have to also keep in mind not only what the current overall statistic is, but what its change freight has been by doing comparisons like this. So for example, in Kenya

you can see that their overall rate of 27% doesn't really represent what the future may look like, because you can see a dramatic decline in the younger age groups. And yet Sudan shows that it doesn't make that much difference. The country estimate is pretty good for the younger age groups as well.

I think that is an important table and I would like to see more of that work with cohorts as Shell-Duncan was describing. Sudan's overall rate is high and is changing slowly. Most women all over the country are familiar with it and the MICS survey showed that too. The marginal differences and the things that are covered in this new report which I have referred to here at the bottom are based on that 2014 mixed analysis. I think it also suggests that different regions should be treated differently. However, we have the problem in Sudan, as was mentioned earlier, that it is a very mixed country. There have been lots and lots of population movements up and down the Nile Valley and across the Sahara and the savannah towards Mecca, back and forth. We have West Africans, we have Nile Valley Sudanese who have been moving about, and in the last couple of.. well, we've had a civil war before the South Sudan split-off. The country was at war from 1955 to '73 and again in the '80s and the '90s, and it wasn't until the peace agreement in the early 2000s, so during that period of time we had massive internal displacement of people, of ethnic groups from the south and many of them tried to stay even after the peace agreement. I think Sudan is very complicated, and it is not that easy to identify by ethnicity either because, as UNICEF mentioned, the government hasn't chosen to keep the data that way. But even regionally the data is very misleading because you don't necessarily know exactly who is there or how long they have been there. But you can see some important differences.

Prevalence among women aged 15-49 by state in 2014 varies a lot from 45 % in the areas of Darfur, which has been subject to a lot of violence and population movement in recent decades, up to a very high percentage in North Kordofan. The way West Kordofan has been divided has changed overtime, so it is a little harder for me to track data in that area, but that is one of the places we did a community study back in 2004. I think this map is very indicative of how various it is by region. I had never seen this map until this 2014 MICS data came out. I had never seen quite what that disparity is.

The *prevalence by age group* is decreasing by 25% from age group 30-34 to age group 0-14 and by 21% from age group 15-29 to age group 0-14. We need more information on and understanding of the huge variations across states, also represented here. It is declining more rapidly in some states than others. So this is based on the percent prevalence between these two age groups by state. FGM/C is also declining within the 0-14 year old group.

[UNICEF] One thing that was very interesting about this chart is that we are trying to compare, across three different surveys, if 0 to 14 has changed per age of the girl. Usually between 7 and 9 was the average age of cutting across all groups together averaged out. I felt what was interesting was while the MICS 2014 is lower, lower, lower, lower, lower up until about age 9-10, it kind of evens back out with the 2010 data. So looking at it this way, you are not really convinced that there is a major change happening in the 0 to 14 age group, whereas if you do the complicated statistical adjustment, you have greater grounds for hope.

[Gruenbaum] the age at which a girl is cut could be significant. I would like to make a different argument now, not based on statistics, but some of the things that were happening in places where people heard it was going to be made illegal. I ran across this in a short study I did in Sierra Leone, but that was a while ago so I am not sure how that has played out. But in Sudan too, whenever a rumour would get started that it was about to be made illegal, or that the midwives were going to be punished if they did them anymore, it would spark people's fears and they would say, 'We'd better get it done now.' So there were periods of time when there were rumours of really large scale numbers of people being done earlier than they had been,

but in a lot of those places when I asked about them, I felt like it wasn't entirely rumour. It was really going on that people were in their families making decisions to get it done earlier. Maybe justifying that in terms of 'Well, they heal faster'. I heard medical personnel saying that about boys, and so I think they were applying it to girls as well. They were also, I think, just feeling like 'We have got to get a man under the deadline'. The net outcome at age 14 will be the same. But the net outcome might be different in the meantime in terms of the ability of girls and girls' knowledge to influence the outcome. I will have a case here in a minute where I will show you where I think that girls play a really important role in this themselves.

So this is another one of these – the distribution of circumcised women aged 15 to 49 by age of cutting. So 5 to 9 – I have always used the term the ages 5 to 7, or 5 to 8, in my writing about the places that I have worked in Sudan, but the last circumcision that I witnessed was on a 10-year old.

The *type of circumcision* is something that we could not ask about for a long time. There were some decisions made. People didn't know for sure what type they had had. Some of the surveys that were done earlier and some of the research techniques didn't really try to get at that. So it is really delightful to see that there are now some more unified ways of phrasing the question so that we can get at that information.

77.0% have their genital area sewn closed and 90% have their flesh removed. There were some people, some of the activists and some of the smaller organizations in Sudan who said, 'Look, a girl is violated even if she is pricked. Don't ask what type. It is enough to know if she has been cut or not cut'. So there was a kind of political pressure away from knowing the type, but now I think the pendulum may be swinging back a little bit more in this direction.

Just over half of the women are for *FGM/C abandonment*. It appears that urban dwellers favor abandonment of circumcision more than the rural. This supports the kind of things we saw for Gambia and Senegal as well.

I want to talk a little bit more about the *qualitative type of research*. I have been researching several parts of Sudan over the period of 74 to 16 – I did get to go to South Sudan back in the 70's. We were talking about that at the break. Most of my experience in the south was that people were not following circumcision practices of any sort. Except in cases where there was intermarriage by a husband who is from the north and who lived in the south as a merchant or a government worker who might marry someone from a local ethnic group. In that case, as his wife, she would be cut, or as his second wife, she would be cut. I did talk to a couple of Dinka women when I was in the south who had been cut.

But because there is a lot of population movement and all the displacement from the years of civil war, many women from the southern ethnic groups, like the Dinka, the Azandi and so on, lived in northern Sudan for over a decade. So there are some people who might be coming from Sudan, who might be originally from an ethnic group of South Sudan, who have adopted general cutting because they lived in the north for so long and were trying to fit in. That is something that I haven't really known how to pull out of the data that exists, but it is a really important consideration if you have refugees or asylum seekers from South Sudan. You might say, 'Oh, South Sudan doesn't have circumcision', and yet they may have been living in the north for a long time, and their families and their communities may have changed their practice. So as far as I know, there has not been new research in South Sudan since its independence, they had so much war and I don't know what is going on with female general cutting there now. We don't know.

And yet those might be people who are seeking asylum. I wanted to look at all of these issues. How do activists do their work and how do norms change and shift within a community? I have done some community case studies that were complicated by many of these variations

across the countries. I am going to try to tell you about a couple of them. I found there was a lot of variation in family decision-making even within the same community.

One of the communities where I did a lot of work was Abdul-Jalil in central Sudan. The first time I went there in the 1970s everyone on the west side of the village was doing pharaonic infibulations, or pharaonic circumcision they called it at the time; it was the common practice. The midwife who was serving that part of the community was doing very severe forms of circumcisions, and I watched her do them and I watched childbirths and so on, so I knew exactly what she was doing and how she was talking about it. Then I followed her over the years. Her name is Besaina. She is someone who has really made tremendous changes, and you can kind of see how a community's change happens, and understand how different elements of a community might influence things by looking at a place like this.

This is in the Gezera Scheme, which is in one of the more highly developed areas of the country in terms of more schools and clinics and so on. She went for government midwifery training back in the 1970s and then she began to be more and more religious over the years. I went back and interviewed her in 89, in the 90s, in 2004. We spent a lot of time together and I have spent time with her each of the last 2 years. One day when I was there in 2004, she was called to do a circumcision one morning and so she invited me to go with her. This is her 'shanta', or her box of equipment, and that is essentially your licence. When the midwifery training colleges start asking a midwife to take an oath never to do circumcisions anymore as UNICEF reported – that's what they are doing now in the midwifery schools run by the government - the threat is that they will take your shanta away, they will take your equipment away or revoke your licence basically, and you won't be able to practice.

[Picture of midwife] She is wearing an inner scarf on her head, which shows you something. She didn't do that in the early days when I knew her, but she had gotten more religious, she had gone in a Hajj, the pilgrimage to Mecca, so she was praying regularly, she was really trying to do the right things in terms of religion and also in terms of her growing awareness of medical issues. She thought her medical issues were excellent in the past, and she was using antibiotic powder, really good equipment and good techniques back in the 70's. So I knew she was a really conscientious medical provider. And yet she is one of those that we talk about in terms of medicalization. It is being done by someone who has medical training. She is not a doctor, but she is, you know... Anyways... She was a mother of five, and she was also a farmer. We talked about motivations for midwifery. In all the times I've talked to her, her main motivation has been service to her community, but it was also initially a secondary source of income in addition to being a farmer. In 2004, the day that you saw the picture just now, we had been called over. She was called over to the home of this young woman. I am not going to show you anything else, but this one picture. I wanted to show you this girl, I had a lovely interview with her before, she was 10 years old at the time, but she was someone who resisted being cut when she was 8 years old, when the family wanted to do it. Her girlfriends were all getting cut at the age of 8, and she said she didn't really want to do it, she was scared. So she talked to her mother and her father about it. She got her father involved, and her father said, 'No, she doesn't have to do it'. The mother, the grandmother, the aunts, these are aunts you see here. They were all pressuring her to get done, but the father said, 'Don't. She doesn't have to, it is not required', and so she was left alone. By that time there had been a lot more activity among the school teachers in the community, and it turned out that one of the school teachers who I had known back in the 70s, had secretly taken her daughters to a different midwife who did a less severe kind of cutting, and not told anybody.

So I saw the beginnings of the kind of a decline in support for the severity. A few people sneaked in their daughters through, and then 10 years later being more out about it and saying, 'Well, we only did sunna for her', or then a decade after that, some of them saying, 'Well, we don't think we really need to do anything'. So at the time in 2004 when I was there,

this girl had changed her mind. This is why I say girls are so important. She changed her mind through social pressure and thinking about it. She decided she was ready, and so she initiated it with her mother. Her mother was more than happy to comply. The father was out of town, so she was able to get herself circumcised as it were, and obviously as a child, she is not responsible for the decision. Her parents are. But still, you could see how she, had she not felt that social pressure, she might have escaped it until getting older. I have argued a lot with some of the women I have talked to as an anthropologist, I tried to listen more than persuade, but one of the things I have sometimes talked with women about is, they want to know what I think is the right thing to do. So I would say, 'Well, I think you should do what you think is right, but I think if you don't know for sure...', if they are vacillating at all, I would say 'Why don't you wait and learn some more about it, try to figure out this and that?' I have tried to argue that delaying might be a useful thing for people who are vacillating. If you just convince people to delay you might get into situations where the girl becomes old enough to speak up for herself, and is not persuaded or bullied by others.

Still they are using henna, you can see she has got a hypodermic needle, she is sterilizing the equipment, this on the left is the hand of the midwife. But the aunts are still putting on the henna, they are going to put on their traditional protective gear, I mean spiritually protective gear. In this picture, this is last year when I went back again, I interviewed her again and I found out that she has through the course of all this – if I can just summarize her career – she went from, in the 1970's, full, severe, totally belief in it, proud of it, wanting to bring the foreign anthropologists in to see every last thing she did – to a decade or 2 later, she was saying, 'Well, I am not sure that I should do pharaonic, I think I should do sunna, because I think that is what religion requires of me'. Then at this time in 2004, for this circumcision, she only wanted to do a type 1.

And on top of that, she asked the mother, 'How much should I take?' So it has become an individual act with no so much 'We have to do it the way our grandmothers did', but 'How shall we do it now? What is the right thing to do now?' That day I had a further conversation with other women in the village who said, 'Well, since we are only doing the lesser form now, do you think we really need to do anything?' They were talking about it in a way that made all the difference, I think, to the community's transition. I learned that the community made a transition in about 1994 to doing only the less severe type.

By 2004, she was asking 'How much do you want to take?' and then, this was last year in 2015 when I interviewed her, and she said she had given it up completely. Again, another policy. This was the government who called the midwives in. The Ministry of Health took the initiative to bring existing midwives, not just the new trainees, but the old ones like her, and brought them all in and gave them – I think she said it was - 3 days of workshops, where they were intensively re-trained. They talked about religion, health, rights. They did the whole gamut of arguments, and she took the oath. She said, 'I am never going to do it again'. And she stuck to it. Well, it just turned out after she took the oath there were still some families that still wanted it done because it wasn't an entire community deciding, although the community had moved tremendously.

There was another midwife in a neighbouring village who was brought in in the dead of night, a little bit like these roving midwives you would hear about before. But there was a midwife who was being brought in under cover of darkness in the evenings to do individual circumcisions in the families who wanted them. The medical assistant at the clinic found out about it and he came in, and he caught one of them, and he said, 'If you ever set foot in my village again, I will report you to the Ministry of Health'. So here we have a combination of factors between religion, health, rights, change over time, secular change, education.

[Picture of two girls] It turned out that these 2 girls, they told me they were the last 2 girls that had been done. They were in that group of 8 that was done one year by a midwife from outside the village. After that, no one has been done in this whole community.

I also felt like it was important to understand the dynamics of change. I have been looking at midwives and interviewing religious leaders. There was an Inter-African Committee Against Harmful Traditional Practices that was very active in a lot of the countries in question over the last couple of decades. They have kind of been supplanted by some of the other organizations like TOSTAN and by the work of international organizations like UNICEF, UNFPA and DFID funding and so on.

Now I want to come to the *Saleema initiative*. This was something that we talked about a lot over several years. One of the things that we talked about in 2004 was that there wasn't a good word for the uncircumcised state. As UNICEF mentioned, often it's a word like dirty or slut or something like that – that is a very pejorative word. Some of the leaders of the movement in Sudan, the Sudanese intellectuals and Samira Amin, who was working with UNICEF at the time in the Child Protection Unit, they all determined that we needed a good word for it. We had long conversations about this, ideas of who could come up with better terminologies, who could come up with better posters? I reviewed a lot of posters too in the old days. Some of them were scary. But they came up with this idea of bringing together media, religious leaders, artists, poets and others into a conference, where they reviewed all of the communication materials and talked about how could we talk about the uncircumcised girl in a positive way. They came up with the term *'saleema'*, which you can tell is rooted in the same word that they are using in West Africa, but it has very different connotations in Sudan. It means healthy and whole and happy – it is a really lovely word.

So we have to continue to pronounce it very differently. I think it was a very positive term. This also went hand in hand with some thinking of some of the activists, like Rogaia Abu Sharaf who is an academic person, and Nahid Toubia who is an activist doctor, who were talking about the need for success stories so that families could feel that they could think about being willing to give it up and actually act on it. They had to know that they would not be incurring all of the social consequences that they had thought would be so negative to actually changing their practice. (Would you give me a notice if you think I am running out of time? Because I tend to talk too much. It is fine, okay. We will leave it to the chairs then)

The shocking and shaming and scaring and all of those kinds of techniques that were often used in the early anti-circumcision work, particularly during the colonial periods of many of the countries that we are talking about, those could have a very negative backlash against the idea of change. So the idea of trying to find a way to make people feel inspired by change, or feel it was doing a good thing – not just because doctors told you to or because human rights agreements from Europe told you to, but rather because it was something that people like yourself were doing and having good luck with, and having good success with. Back when I was there in 2004 I did a lot of interviewing for success stories. I found some really interesting ones, some real doozies too, like one of the people I interviewed said that he was a biologist and he didn't want to see his daughter circumcised. But he needed to go out of the country for a year for a fellowship or something, so he wanted to make sure his daughter didn't get circumcised while he was gone. He said he went and threatened his whole family and he threatened his wife, and he said, 'If I come back and the daughter has been circumcised, I will get a gun and I will shoot you, and I will shoot myself'. He was very dramatic about this, but he made it into a funny story, in which he succeeded, but his success story was really not about how he threatened, but rather that his daughter grew up, she got an education, she got married, she became a mother, she had a professional career, so he could tell a success story that could be soothing and reassuring to others who were considering change.

These success stories could be a way to encourage people once they are ready to make a change and go ahead and make the change. So I think the *Saleema* idea – trying to have an image of a success story, and an image of a girl who has not been cut can be encouraging to others.

I just learned that the use of the word *saleema* for an uncircumcised girl has been something that is being promoted in these educational campaigns and it is much more common than I realized. 14% of women or 1 woman out of 7– and that is for the whole country – use the term *saleema,* and 1 out of 3 in Blue Nile. When I was in the Gezera area with the midwife that I was telling you about, that area had not been a particular target of any of this, and yet they had all adopted the term *saleema*. I was really surprised how this has spread linguistically really quickly. I think it meets a need that people had about how to talk about the uncircumcised other than saying 'not circumcised' or using the pejorative term. To be able to have a positive name for it seems to have been a really good idea. And it is more common in urban than rural; not surprisingly they are more likely to have televisions. This isn't a comprehensive study yet, but it suggests that the use of the word *saleema* and having a more favourable attitude toward FGMC abandonment may go together.

I wanted to move ahead to talk about *signing declarations and making statements*. That was a technique that was used a lot by TOSTAN in Senegal. People thought, because so many declarations had been made, perhaps that was a goal and they were trying to have the declarations as a goal. I did a study in 2004 again for CARE because there had been a village where they worked and tried to get a declaration. They got a declaration and they thought it might spread. I went back 2 years later with a research team and we tried to see what the effect of the declaration had been 2 years down the line. We found out that lots of people didn't even know about it. It really didn't have a big effect on them. It hadn't really fully mobilized the community. It is very clear you can't just say, 'Oh, there is this declaration against it, that means it's been finished'.

Sudan was trying another technique, using *banners* like this, that they would take to special events and try to get people to sign their names. And there was a lovely video that was made a couple of years ago of people doing testimonials, so you could have it playing on a video screen in waiting rooms at hospitals and so on. That was just ordinary people talking and saying, 'I am taking the pledge (and show them signing their names) because I don't want my granddaughter to be cut', or 'I don't want my grandson to marry a cut woman', or whatever. So those kinds of things may be another way to mobilize people, and I think the future research, that shows how successful each of these has been, is going to be very valuable to us.

I want to take a few minutes to speak on *legislation* as well. Sudan is a country that had a law back in 1946 but it only banned the pharaonic type. I found this very interesting because the labels 'pharaonic' and 'sunna' were very much contested over the decades. When I was there in 2004 I was having a meeting with a group of activists. They got very angry about this, even though I was using it as folk terminology, they said, 'We should never use the word *sunna*, because it just makes it associated with religion too much'. The act of trying to de-link circumcision from religion was how they were talking about it 10 and 5 years ago. *De-linking* was a really very popular word in Sudan for a while.

As I mentioned before, there has been training of sheikhs, discussions, and publications to try to say that this was not religious. That is basically what the British were trying to do. They got a bunch of religious leaders back in the 1940s to sign a *fatwa*, saying that doing the pharaonic form was against Islam. But they didn't go all the way and say that doing all forms was against Islam, so that is the law we had been working with. People rebelled against this law, and a legal researcher who I worked with back in the early 2000s again had done extensive search

for any cases where that had ever been brought to court under this law, and couldn't find any. So it was obviously an ineffective law. In recent decades, the activists wanted to get a law that would outlaw all forms. Down there, I talk about Article 13. This was supposed to be a clause in the Child Right Act of 2010, and at the last minute it was pulled. I heard activists, several of them told me the same story very vividly. The Council of Ministers was all ready to put this up for a vote, and at the last minute, the door cracked open and someone said, 'The President won't sign it if you leave in Article 13'. They were under pressure, and the President would not approve it. So they pulled that Article 13. The President was making statements – it was a little bit like you described for Gambia – it is that you get the State not having a unified position, which is interesting.

So you have people working for a law, the Minister of Youth and Sports, or the Minister of Welfare, or the Minister of Health might all be in favour of it, but the President could pull the plug. They tried to find out what caused the President to pull the plug, and it seems that he was also very strongly influenced by one of the religious groups, the Islamists, the Salafists were particularly concerned about that being in there because they wanted to allow a loophole that would allow the so-called sunna type which they were trying to advocate as being Islamic.

A lot of the communities of Sudan are dissatisfied with the fact that they don't have unity among the religious leaders, and yet a whole bunch of the religious leaders are now supporting abandonment or are supporting a legal change. I went to an event three years ago where we had the Minister of Religion and the leaders of several sects, including Sadiq al-Mahdi, the historic political figure as well, all sitting in the front row at an anti-circumcision event, being video-taped, being filmed, speaking about it, being on television. There is a tremendous amount of change happening and yet it is not unified. So it does help, but it doesn't help enough because people do tend to listen to their local religious leader, and have a lot of loyalties towards local religious leaders. After Article 13 failed, the strategy was to put regional laws in five states. So that is still under debate. The Norwegian Christian Medical Institute in Bergen had a little article recently, in which they said that the two strategies that were being pursued were included in the amendments of the criminal law. That seems to be the one that is closest to maybe being passed. So we may have a law before too long.

Finally I'd like to add, I was studying two communities in central Sudan longitudinally. Each of them had two ethnic groups. The ethnic groups influenced each other, so that circumcision was spreading. The practice was spreading into groups that were not doing it in several areas of Sudan. And yet, in other places, activism was having an effect. So I think I have seen it going in both directions, and that is why it is so important to know the details of the family situation and the religious group that they are in.

Here is my summary:

- Sudan has a high rate of FGM/C. The rates are declining slowly.
- It is uneven by region, ethnicity, sect, education level and residence, and those things are not always easy to tease out.
- The State commitment to outlawing it has vacillated, but it has never been fully illegal. Even if it were, I don't think enforcement is easy, because even the enforcement of the 1946 law was not possible.
- If a complaint is filed, it is usually withdrawn under social pressure. As a country with high rates of internal migration and displacement, living out of reach of one's entire extended family is not realistic.
- For asylum, I think the analysis of life circumstances is key. A unified family commitment against circumcision can be effective, but mother, father or both are not enough because of the role of other extended family members.

- Given that middle class families living in urban areas have a very protected life, you would think that they would be able to enforce that, but one of my dear friends, they had their daughter basically removed by the grandmother one day. She was baby-sitting, she knew that they didn't want circumcision, and yet she decided the time had come and drove her back to the village or had their driver drive them back to the village where they came from. But the mother was able to act on it on time. She called up and said, 'Don't you dare touch my daughter, etc. etc.' So a very active set of parents can defend their daughter, but it is not enough if you don't feel like the whole family has had enough. Now this may change in the coming years, as more and more of these activist mothers and fathers become grandparents in their own right. But at the moment I think it is still a very serious issue for asylum.

Discussion

[Question]: Do you know of Darfur peoples in the west not practicing FGM/C? Do you know of them not practicing and then adopting it recently? We saw older women aged 40 and above who basically were not cut, and women 40 and below from the same population were being cut.

[Gruenbaum] I think that there was some historical data that I read when I was writing my book a decade ago, so I can't remember all of it precisely, but some historians had found that the practices of cutting were class-aggregated too in some of the west groups in Darfur area. So the elite families were circumcising and the ordinary people weren't. In some of the areas where they were heavily nomadic, if you were circumcised you could give birth more safely in cities than you could if you were a nomad. There were some arguments about that. There was another study by a cultural geographer some years ago – Higgs - who was looking at those issues in relation to nomadism in an urban settlement. It may partly be a rural urban thing, but it also was an elite thing to have it done in some groups.

[UNICEF] One thing that you raised which UNICEF also found as a challenge in interpreting the MICS 2014 data was migration flows. So we don't have a question in any of the surveys about 'how long have you resided in your current residence?'. So we don't know if the central Darfur or the west Darfur residents being surveyed in the 2014 are necessarily the same people or what percentage samples constitute the same people, how long they have been there, or if they were counted last time in Gezira or somewhere else.

[Question]: I was struck by the data on the drop in West-Darfur. Is that due to the ongoing conflict over there? Not enough social rest, social balance to perform FGM.

[Gruenbaum] It is quite possible. I can't say from first-hand experience. I haven't been working with Darfur but that would be something that one would anticipate. The incredible disruption that has happened in Sudan. It is amazing we have any statistics at all, I think. The reliability is always something at issue. Now that we have the MICS and the DHS doing repeat surveys, there are certain areas, like South Sudan, where we don't have that information. So they have been able to get some information from a lot of people in Darfur who are settled and protected now, and they may be very much in refugee camps and so on, or in displaced persons camps. So they may be under a lot of influence for positive changes.

[UNICEF] Yes. When we had this finding and analysis, we did debate it back and forth a lot in trying to understand why you would see this pretty massive difference in West and Central Darfur. I think the Government Statistics Office and the National Council on Child Welfare, plus the UN agencies, we came to the conclusion that we don't have enough information to really say why. Why would it be like this in West and Central Darfur but not as stark in North Darfur, in East Darfur, in South Darfur and all of that? Basically the intersection of all those Darfurs is an area called Jebel Marra, and Jebel Marra is where there is a lot of ongoing conflict

and displacement, so why would you find that in those two but not the others? There may have been some kind of recent adoption or change because of migration. But I think it would be several leaps forward to conclude it was due to the conflict. In terms of programming, we are actually very active in the Darfur states. The five Darfur states have functional governments with national councils on child welfare, who are carrying out *saleema* initiative activities. We have at least 100 active communities in those areas, and some of the best reporting on activities comes from Darfur, simply because there is a lot of NGO presence. There is a lot of capacity in the Darfur states in terms of humanitarian interventions. Sometimes we would get a report from Darfur that is superior to that of a more peaceful part of the country, like the northern state, where there isn't a lot going on in terms of NGO activities. So it is all counter-intuitive.

[Gruenbaum] It is also surprising that Blue Nile, which is another area down in the east, also had a lot of conflict, and yet it seems to be doing better than some other regions.

[Question] Cutting and sexual honour. The parents who don't cut their daughters, are they seen as parents who are failing to raise them as moral adults?

[Gruenbaum] Yes, that was one of the responses that... in 2004 when I was working with Samira, we did two communities out in western Sudan, and that was something that I remember so vividly. There was one community we went to where the religious sheikh had come to the decision that he was going to tell his community that from now on they should stop doing circumcisions at all. They were a very, very strongly unified community of Sufists. We did interviews with dozens of the families in the community. Most of them said they had not done a circumcision in two years because the sheikh had banned it, but they weren't convinced in their hearts that it was the right thing to do. I remember so vividly some of them saying, 'You know, I am really worried about people shaming me or being ashamed of my daughter, or that anybody would make fun of her'. They were really worried about that peer pressure, about people calling her a slut. They were just afraid that that might happen. There were some of them who said, 'If we stand up for this, how can we be sure we won't be made fun of when our girls are growing up?'

So it was a very palpable kind of feeling that they had. The *Saleema* campaign is very good for addressing this. This initiative is trying to arrive at a point that people can feel it is not shameful, and instead embrace a different form of honour. Do honour to your family by caring for your daughters, by sending them to school, by bringing them up with a moral attitude and education. Moral upbringing rather than circumcision might be a way to replace that. That honour and shame thing is very powerful, as you know. It is a really powerful emotion and it really needs to be addressed. It is not enough to know that there is a human rights agreement or a medical concern. You've got to deal with those emotional gut feelings that people have.

[Question]: Is state protection available and accessible for women against FGM/C?

[Gruenbaum] So, my answer to the question, I think it is been very clear that laws are generally not effective in that way, but the legal structure is part of the change effort of course. So I think in many of the countries that we are talking about, we have been talking about official government legal structures, whereas the informal types of traditional law, I mean we used to call it traditional law and it used to be part of the Sudanese constitution way back when, the traditional law had precedence in certain ways and only certain things went to Sharia courts for the Muslims, certain things went to government courts. And I think in practice that is how it works in a lot of countries still, that people will go for dispute settlement, as UNICEF pointed out, to traditional mediation or traditional problem solving. In the country of Sudan I have not come across anything analogous to the shelters that you mentioned, nor do I think it would be feasible for the same reason that it has been very hard for there to be any prosecution of cases, because as I mentioned yesterday, one of the scholars who did some

very thorough research on courts, she interviewed a lot of judges in Sharia courts, and other courts in the country, and found that most of them really didn't know the status of the law, and they really had never had a case brought to them about it. If they did, and there were some cases of police having been called, or a case taken forward, but it was quickly dismissed within a few days because of the whole issue of this honour-shame thing and the family. You can't bring dishonour on your family by bringing a court case or running away to a shelter or something like that. There may be parts of Sudan, particularly the areas impacted by conflict, where all bets are off on how this would work, but in the central parts of the country the shame issue involved in that would be very strong. I think the issue of going to religious leaders and, in some cases I found like in eastern Sudan with some of the groups in eastern Sudan they had such a firm structure on the sheikh who was in charge of your lineage or ethnic group, being in an urban area and actually being a source of appeal if you are having disputes in the family you might go to the sheikh in the city, and that might be analogous in a way to seeking shelter or protection from some other sort of consequence in your family. But it all has to be in that structure, in my experience.

[Question] Consequences for girls or families refusing FGM/C

[Gruenbaum] In several parts of Sudan, there has been very strong ability of a family who wants to either protect a girl or to cut a girl to do what their preference is without interference from others in the society. So therefore I think the family is really important. The ultimate decision making, the issue of how many relatives are brought into the process is the tricky part – because I think if the parents agree, they can effectively protect for the most part, but I know of exceptions to grandmothers or senior aunts being able to go ahead and conduct the circumcision if the parents aren't present. If that is the case, then there is no recourse because who is going to take your mother to court? That would be really shameful to the family, for you to prosecute your mother or take the midwife for that matter. So you really have to know the family's circumstances to be able to make a judgement on it.

Prevalence and practices of FGM/C in Somalia

Omar Abdulcadir (University of Florence/ Regional Referral Center for the Treatment and Prevention of FGM)

My presentation is divided in 2 parts: The situation in Somalia where FGM/C is performed, and the Somali community who lives in Europe. I will also talk on how the Somali community living in Europe can help to change the mentality of the Somali women in Somalia, and how I can help the Somali community who lives in Europe.

In Somalia, we say *'gudniin'*, this is the term that we use for FGM/C. As you know, everywhere in the world, the word 'mutilation' is not used in the country where it is performed. The terms that are used locally may mean 'cleanliness', 'beautiful', and so on. In Somalia, in all 18 regions, they don't follow the classification of the many types of FGM/C. In Somalia we only have 2 types: the 'sunna' and the 'pharaonic' (Type 3). Why did I put there the term 'sunna'? This is because the people still used the term 'sunna' related to the religion. It is very, very hard to change that word.

Sunna is of two types: '*Diijin'* is the Somali term, you inject with a needle in order to only draw some drops of blood. The second is when the clitoral prepuce is cut off and you stitch it after. The pharaonic type (*Fircooni*) is the harmful one that we see in the hospital in Florence. In the classification of WHO: Type I and Type III respectively. Type III is subdivide into:

- Type III-A: Removal and apposition of the labia minora
- Type III-B: Removal and apposition of the labia majora.

The *Pharaonic* is practiced in every region of Somalia and it includes the 90% of all FGM/C. As the name suggests, it has been practiced since the old Egyptians. The Sunna is more recent and started during the 60's. It is very common in big cities like Mogadishu, Hargeysa, Baydabo, Jowhar, Bosaso; and it is used by particular people only

The role of family, ethnicity, religion and culture in the practice: When they perform infibulation, the decision today is taken by the mother or grandmother or the family. Sometimes they close everything. It is very, very hard to pass urine, and sometimes the incision begins to reopen the scar. When girls are being undergone FGM the size of the hole in the scar of infibulation is decided by the girl's mother, grandmother, aunt and by the exciser. If the girl can not urinate until the next day, the exciser expands the size of the urine hole.

What is the *context* of this practice? It is to purify, the term in Arabic is *Halaaleyn*, *Halaal*. All the women, neighbours come; the family in the village are invited. They celebrate with food, sing, dance, and give a gift for the baby. Usually it is not only one girl who has undergone the cutting, but the village tries to have many girls on the same day – 7, 10 or more.

Who performs this? Not only the practitioners, the older women, or the midwives or whatever, but in Somalia there are even male excisers (barbers, nurses). In the urban area, we have the hospitals; it is the doctors or nurses who perform FGM/C in a hygienic environment. But in rural areas is the women who exercise it, and they have no anesthesia or gloves. There are no sterilised materials.

Who is the group at risk in Somalia? About eleven million of people live in Somalia, and about 2.5 millions or over are girls under 15 years waiting to undergo female genital cutting. According to UNICEF, 98% had undergone FGM/C: that's the highest level in the world to have undergone female genital cutting.

What are the *repercussions if somebody refuses the cutting*? The community and the family consider the girl as impure. She cannot read or touch the holy Quran, she must purify to remove the dirty part of her body (*haram*). In the rural area, if the family does not perform this practice, they are covered with shame and are isolated. Their animals cannot mix with animals from other people to graze or drink from wells. So female genital cutting is a question of respect. The family cannot refuse to do this. A mutilated girl is considered more beautiful, cleaner, more honorable, and can have a husband in the future.

What are the protection measures in Somalia? We have a law, since 15 April 2016. We have international laws, the Sharia (Islamic law), but the important ones are traditional tribal rules (*xeer*) that are very important in the context of the community. As you see, the Minister of Women Affairs and Human Rights, they made this law in April 2016, but many people do not believe yet that female genital cutting is a crime. In addition, our government is very, very weak and they do not control every part of the country.

What are some of the *preventive measures and activities* or organisations of Somalia? A Somali organization that works for improvement of young people (SOYDEN) reports that thanks to the work of activists, medical staff and religious leaders who give information and education, a reduction in prevalence and a change of the practice (from type III to type I or alternative rituals) are noticed, specially in urban areas.

What *can I do here in Europe for these women*? We have a Regional Referral Centre of Florence. We care for immigrant women, who come every day. In one year we see about 800 women in the hospital. They not only come from Italy; they come from the UK, from Norway, from Finland, from Sweden.

The most important work that we do is *deinfibulation*, especially Type 3. According to the WHO guidelines (May, 2016) on the management of health complications from FGM, *deinfibulation* is recommended for preventing and treating obstetrics complications in women living with type III FGM. Antepartum and intrapartum defibulation is recommended to facilitate childbirth in women living with type III FGM. Deinfibulation is also recommended for treating urological problems, infertility, retention and so on.

We began our work with deinfibulation in 2003. We did about 250 deinfibulations since then. We never do deinfibulation without the presence of the husband or the partner. How we open or close the scar, we decide about this with the woman and the husband, to avoid problems with the family. Our goal is that of all the women who were deinfibulated, their daughters will never be cut. Now we have many, many girls, about 10 or 16 years, some of whom live in Italy, others in Europe, and never were these babies or girls/daughters mutilated. Because we have information, health education, and particularly we have given them every treatment that they need.

The result of our approach are: reduction of unnecessary caesarean sections in FGM women; solution of infertility and sexual dysfunction; solution of gynecological problems.

Our work in clinical care – what do we do? The first thing is *welcoming* people; it is very important. In welcoming, you should know the tradition, the culture, the respect – these are three things that we adopt every day in our work. *Confidentiality*, Multidisciplinary care. We have with us psychologists, anthropologists, sexuologists. When the women come to us, they should know what the *anatomy* of a woman is. We show a picture of the natural anatomy of the genitalia, because they saw their mother, grandmother, and they saw only female genital cutting of the genitals. So before the welcoming, before we do the treatment, we show how is the normal anatomy of a woman. After that, we decide.

One very important thing that we do is *work with the men*. Today I heard that the person who performed female mutilation is usually the woman. In my research in Italy, I met many

communities, not only Somali, but from Nigeria, Burkina Faso, Eritrea, Ethiopia and Egypt. I made a research for 3 or 6 months. The Somali and the Ethiopian and Eritrean men had a good undertstanding to eliminate the female genital cutting. But the Nigerian men and the Egyptian men are very, very hard to give some information to them. In Egypt, it is the doctors who perform the female genital mutilation. When the baby is 1 or 2 years old, they are visited by a pediatrician. He says if it is necessary to perform this operation or not. The men from Nigeria told me that they don't want to eliminate this practice because it is very necessary, because the context is that we stop the sexuality of the woman. This is a real situation that we have to work with.

In Somalia, infibulation Type 3, is decreasing. People try to use Type 1. If I ask; 'Do you want to eliminate this practice?' They don't say 'No'. But what I see in my work is that many people who live in Italy and in Europe say 'yes'. So we try to give education to the people who live with us, and they can give information and education to those who live in Africa or in Somalia.

Before, many people went to Somalia, Europe, all the world to do the cutting. Now there is the law: you cannot perform female genital mutilation in Europe. During summertime people go to Africa to perform it. But now the law says that if you come back after two months, in the airport or wherever, the family will check– if the daughter was infibulated, that means prison for the family. So what do they do now? They leave the daughter for three or four years in Africa. After that, they come back in Europe, so they have time to do what they want.

Another thing that I tell you is that in my view we have a new problematic vision of female genital mutilation, which is not only how to eliminate it; there is a new frontier of female genital mutilation. We had in these years the first immigration in Europe, especially in Italy. We had people, women with strong identity. They had female genital mutilation or they had infibulation, but they have identity. They come in the hospital only for complications, or when they feel ill. And when they come into hospital, they cannot connect their infibulation with their situation. We try to help to them eliminate female genital mutilation. But we have a great problem with the new generation. The new generation doesn't have any identity. They don't belong neither to their original family, Africa, nor to their new country, where they live. They are inside two cultures. Their mental mutilation is worse than female genital mutilation. The new vision that we have now is that many of these girls come to us now to ask us to restore their clitoris. They tell us, 'I want back what I lost before', but the problem is not this. The problem is mental problems.

The other problem that we have is *international adoption*. Many people, many girls of 4-5 years, come from countries of female genital cutting, and the family is usually a European family. We have had an example where a couple, a family, an Italian woman, accepted to adopt one baby from Ethiopia. When they knew that that girl was mutilated, they refused to do any adoption for her. I and Dr. Catania went over to them, we met this husband and wife and said, 'Why don't you want to do this adoption?' We gave them one example: 'If I do the echography, the ultra-sound, and I see a little malformation for the future baby, what do you do? You make an abortion or you have your baby?' She told me, 'If the malformation is very little, I would have my baby'. I said, 'So it is the same case with that baby that you want to adopt – she has a little malformation'. The baby came to Italy, to Florence, to us. We met the family, we made the visit, and fortunately the little baby was not mutilated. So this is also a problem that we will affront in the future.

The last is the problem of *mixed babies*. For example, the young girls that had an Italian father and a mother from Somalia. Many of them were mutilated in the country of the mother or the father when they were babies. Now they live in Europe, especially in Italy, and they discover that they were mutilated. We now have six of these cases and we are trying to help them. They want to have the reconstruction of the clitoris.

Our problem now is what can we do to *reduce the female genital cutting*? Some time ago we proposed a *ritual* to reduce and in Somalia they do this. Many of these daughters or babies don't have any complication and they don't cut anything. But the problem is how to introduce. In our world, we have religious leaders, community leaders – they are very important and without them we cannot work. They have a strong influence on the community here in Europe and also in Africa.

In Malaysia, for example, they continue to perpetuate female genital cutting. I saw gynecologists who were in the conference in Florence who told us that it is a normal duty; every morning they go to the hospital to perform Type 1 of female genital cutting.

The last point is *re-infibulation*. In our hospital, when we have a delivery, the husband asks to close. But we always say that it is not possible, it is illegal in Europe for example, but my colleagues in the United States told me that it is legal – they do. Is it right? So we cannot close anything, but we restore what is possible.

Discussion

[Question] After you perform the deinfibulation, and you restore the clitoris for a woman, is she at risk for being re-circumcised if she goes back to her country?

[Abdulcadir] No. When we make the deinfibulation, we cannot restore the clitoris. We can only open the scar. Then, sometimes, in 50% of the deinfibulations we have done, the clitoris was intact, because in the last 20 years, for example in Somalia, the men who performed this type of mutilation discovered that there were a lot of consequences. When a family asked to do type 3, they wanted to not cut anything, only to stitch and when we operate, we discover that the clitoris was intact. Now many girls, 80% of the girls that I see in Italy, have their clitoris. If they go back to Africa or Somalia, no, because if the girl had a family with a high identity and they decide to not perform any female genital mutilation, they don't accept. But many times they have a risk, because 90% had infibulation. I had one 18-year old girl who went back to Somalia and returned with a Type 3 because she said, 'Now I can decide by myself and I want to do what my tradition says.' And they went there.

[Question]. You talked about certain ethnic groups that traditionally perform Type 1 and not the pharaonic. Do you know which ethnic groups are these?

[Abdulcadir] Type 1 is performed by the Arabic people who live in the urban area, in the coast. The rural people, or the ethnic group in these rural areas, perform Type 3. Nowadays they all choose what they want, but before only the Arabic people performed Type 1, and the people who live in the coast. Usually they come from other places with influences from Portuguese or Arabic, these are the Rer Hamar or Benadiris.

[Question]: Can you also elaborate on who is doing now more type 1 which is the lighter type. Which groups are at the moment still sticking to type 3, and which ethnic groups are moving towards the lighter ones - type 1? Is it an ethnic difference or it is a difference in urban/rural or something else?

[Abdulcadir]: No, no. In the past the difference was ethnic indeed. But now many people (mostly educated, urban) choose not to do the harmful one, type 3. They try to change and do type 1 only, because they know that type 3 is dangerous. Some of them don't do anything, they don't touch the genitals.

[Question]: Is state protection available and accessible for women against FGM/C?

[Abdulcadir] The protection of authorities in Somalia? I was in Somalia this year, but there is no prosecution in Somalia. I don't think that this will be done in real time. We will have to wait many, many years for that. People continue to perform FGM/C, but what is necessary to do is

education, information, sensibilisation. Information about campaign and awareness-raising. What is very important: economic resources for the poor people. For example, if we have the a project for the poor families, to give a sheep or goat, they have the possibility to gain economic resources and give education for the daughter, and this is the possibility to eliminate female genital mutilation. So for the elimination of FGM/C, the presence of religious leaders, community leaders, and the participation of international organizations and UN agencies that we have in Somalia at this moment are also important.

Prevalence, social and religious context, risks, reaction authorities in Sierra Leone and Burkina Faso

Idah Nabateregga, Terre des Femmes, Germany

Terre des Femmes is a human rights organisation and we work with gender-based violence topics including FGM/C. I will speak today about the regions where we have projects in Sierra Leone and Burkina Faso.

FGM/C has lifelong consequences. As UNICEF states, about 200 million girls have been affected. It is practiced everywhere; it is not just an African problem, we have it also in Europe as well as in Germany. At least 48,000 girls have been affected in Germany and 9,300 are at risk.

I focus on FGM in **Sierra Leone** where we support a project, in Lunsar. The population is 6.6 million; the male population is 48%, female is 51%. As for religious affiliation, most of them are Muslims, but there are also Christians and traditionalists. The literacy rate for adult males is higher compared to that of women, but also the youth education literacy is also a bit higher.

According to the demographic survey of 2013, 90 % of the total population of women is affected. More than 16 ethnic groups live there, of whom Mende and Temne are the largest, and most of all these ethnic groups practice FGM. Except one, the Krio who do not practice FGM at all; they live in the western region of Sierra Leone. The highest rate of FGM depends on the region. In the Northern region prevalence is about 96%.

Generation differences: Like all my colleagues have already shown, we see a difference among the girls that are 15-19 (74.3%), 20-24 years (87.5 %) but also 24 years and above, who are the highest affected (95%). The lower the age, the lower the risk as well.

Religious belief: There is also a variation in this country. 93% of the Muslim population is affected and 77% of the Christian population affected. Nevertheless it is a practice that is practiced by by all religious beliefs including the animists, it's not just a Muslim belief.

Residence: in urban areas the prevalence is a bit lower than in rural areas by a difference of about 6%. It also differs by region, with the western region having the least prevalence rate (75.6 %) compared to the northern region (91 %).

Education: Those who have a secondary or higher education are less affected (prevalence 77%) compared to those without any kind of education. 96%.

Given the *wealth quintile*, the ones with the highest wealth percentages are lowly affected, by 77%, and those with the lowest wealth quintile are highly affected.

General characteristics of FGM in Sierra Leone

Type II excision is very common. There are also about 3% of infibulation (type III) cases. Circumcisers belong to the Bondo secret women societies. I don't know if you've heard about this society; it has much effect on the FGM cases within Sierra Leone. It is a decisive factor because most of the people, almost all of the women, belong to the Bondo. Their children, their women and female daughters have to belong to the society as well at one point of time. There are approximately 50,000 circumcisers within this society, and FGM is basically an initiation ritual and a first stage required to become a woman or to become even part of the society. FGM is therefore is a rite of passage to womanhood. By the age of 14, one has to have undergone FGM already to become a full woman, and it is also part of the social acceptance to be part of the secret society.

Most people still adhere to their practice, and till now the country has no law against FGM although it has several legal frameworks in place. Sierra Leone has signed CEDAW and CRC, Maputo Protocol, the African Charter on the rights and welfare of the child, but nevertheless there is no law against FGM/C within the country. When in 2007 a clause against FGM/C (in the 2007 Child Rights Act) happened to come up, it was massively resisted and scrubbed off the agenda.

In our organisation we work with AIM that is Amazonian Initiative Movement, located in Lunsar. The focus areas of AIM are FGM, forced marriages and sexual violences because they're all at a high rate in Sierra Leone. The target groups for the organisation to work with are girls threatened by FGM or other violences. Circumcisers are also target groups, as are teachers, parents, health personnel, political and traditional rulers - these are very important to be onboard, and also as the community as a whole.

One of the AIM's projects is providing *alternative sources of income for circumcisers*. They try to provide adult educational agriculture courses for them. There is a group of women circumcisers in Sierra Leone with whom Terre des Femmes is working to change the behaviours. They have a very big impact, they belong to the *soweys* or the Bondo society, so if we work with some of them, we have a degree of influence on the practice.

There is also a *safe house*, opened in 2011. It was meant for about 15 to 20 girls, but because of a high need it accommodates over 25 girls. There are social workers on site who are working with the girls, caretakers during the day and a night watchman, at least for the girls to be safe or not to be taken out by force by their parents.

Education of girls: We also take care of the education of girls and the resumption of school. For example, some girls that have escaped to come to the centre are massively frightened by female circumcision. Female circumcision of course is followed by early marriages or forced marriages, so the girl has to escape and break out of school even before female genital mutilation takes place. So if they run to this centre, and their education is re-assumed.

There is also *conflict resolution and mediation* with parents: since they are just children, they need their parents. At the end, there is conflict, they have run from FGM, but still they need that parental care and guide. They can't be fully under control of foreign hands I would say, they need their families, so the organisation works upon that. They talk with the parents, they give them sensitisation and awareness raising, they give them time so in this centre the parents are given time to rethink their actions.

There is also *awareness raising of children and youth*, because children are important actors of change. They are our future generations and they are target groups. If they are safe from FGM, we know that is actually a whole future, a whole new generation that is saved from FGM. Most of the parents, almost of the old generation, have gone through FGM, so this is our most important target group. There are human rights that have been introduced within two schools in Lunsar and meanwhile they have also been introduced in 15 other schools. There are human rights clubs that are raising awareness around that topic. There are theatre projects and radio broadcasting about female circumcision within the region and in different parts of the country.

Other projects include *sensitisation and awareness-raising of FGM* but also other gender-based violences, focus on circumcisers by providing them with alternative sources of income. However that does not guarantee the sustainability of the projects, because at one time they may decide to fall back into that practice. It doesn't matter if they have gotten small credits or not. So it's a gradual process.

<u>General challenges within the region</u>:

Resistance from the Bondo societies; they have a very big influence even on the politicians, but also the communities at large. To penetrate them is a really hard thing.

FGM is a source of income for circumcisers. Even though they get alternative sources of income or they are taught a small agricultural business, adult education, even if they are given small credits, it's never a guarantee that they will hold onto these projects. Some of them end up falling back but nevertheless, the sources of income are provided. They are still sensitised and awareness-raising still takes place and so on, it's a gradual process. Abandonment is a gradual process.

There is *lack of political backup and government support*. The mere fact that even the FGM law that was to be included in the Child Rights Act was actually pulled down means there is no will, and in such a country there are no protection measures.

Circumcisers have also a strong community influence, especially on the communities like the Bondo society. The fact that they belong to the Bondo societies, most of them have influence on the politicians. The politicians usually worry about their votes. If it is campaigning time also on, they won't do anything that will distort their votes or they won't come at loggerhead with cultures. At the end of it all they belong to these cultures.

There have been also *open threats, and verbal and physical attacks*. For example, four journalists who were openly criticizing FGM were stripped naked and frogmarched through the streets, so that is one type of extreme violence. The Bondo societies want to maintain the practices at all means. So there tends to be a threat out there towards activists.

The *intimidation* of anyone daring to break the taboo and the role that *religion* plays and gives meaning to the life of those opposing the challenge impacts on behaviour changes.

The biggest challenge is *lack of funding of organisations*, sustainable funding and also the time frameworks within which this project takes place. For example if a project on FGM will last for two or three years, that is a very minimal framework for a community that has practiced FGM for generations and generations.

Burkina Faso. The population is 18 million. The Mossi are the largest ethnic group, the Fulanis second, but also others. The percentage under 15 is 45%, 16 to 64 years 51% and people aged 65 and above is just 2%. The literacy rate is 36% in total: adult men are 43%. The women are less educated (29%). Regarding religion, 61% is Muslim, 23% Christians and 15% are indigenous or other religions.

The *prevalence of FGM/C in Burkina Faso* is 76%. It varies from one ethnic group to the other. For example, the Senoufo have 87% prevalence, the Fulani 84% and Bissi 83%, whereas the Tuaregs 22%. By region, it ranges from 54% in the central west to 89% in the central east. By residence, the rural population is more affected than the urban populations. Given the religious variation, the Muslims are also higher affected than any other religions, but prevalence is still high with all religions.

Common characteristics of FGM/C in Burkina Faso. Type II is commonly done in Sierra Leone. The practice is part of the social acceptance, it gives a sense of community, it gives belongingness to the community. It is seen as an initiation ritual from childhood to adulthood, and that it is why it is practiced within the age of 4 to 14 years so that a child can become a full adult. It also has other reasons like cleanliness and hygiene, fidelity and virginity which is expected of females and then a prerequisite to marriage. FGM/C is usually performed by traditional circumcisers and affects ages 4 to 12 years. It is usually practiced from May to December, most especially in holiday seasons because then afterwards the girl has to be married, so there is enough time to prepare the ceremonies.

The *legal framework*. Burkina Faso has signed international and regional treaties, but it is also interesting to see that at least the country has strong *laws against FGM since 1996*. There also exists a national telephone hotline where parents or whoever thinks that there is a threat of FGM/C can call for help. In the national budget there is a part for FGM-funding activities which is rarely found in most African countries. In 2005 a reproductive health law against harmful traditional practices was passed, and since 2013 a national action plan against FGM was adopted. The government is also partner of UNFPA and UNICEF Joint Programme to eradicate FGM by 2015 (we are in 2016) so the programmes are going on!

Our concrete partner in Burkina Faso is the *Association Bangr Nooma*, meaning 'There is nothing better than knowledge'. Target groups of the association are villages leaders, religious leaders, police, traditional birth attendants but also circumcisers, teachers, affected females, but also communities. The regions of intervention are: the Mossi kingdom, Ouagadougou, and the nearby villages.

Among the activities are *sensitization* and *awareness-raising activities*. Potentially threatened girls are identified within the villages. When these sensitization and awareness-raising activities take place, potentially threatened girls are identified because of the door-to-door activities within the communities and these community-to-community projects. The outreach impact is that 800,000 people in Burkina Faso have been targeted, over 33,000 children have been protected, and the existence of committees in more than 820 villages.

About 300 circumcisers have been provided with small credits and 180 ex-circumcisers campaign with ABN against FGM. To bring these circumcisers onboard, they also provide extra incomes for circumcisers. When Ebola was in the region, it was emphasised that circumcisers come on board to fight Ebola and this was an opportunity that was used to put circumcisers onboard so as to fight against FGM for our future projects.

The activities: There are three *sensitisation phases* - one is winning of village chiefs, whereby one man and one woman is chosen and trained by ABN to be facilitators. If that phase is finished then they go on through a second phase which has to do with sensitisation of local influential people. Here we mean teachers, police, TBAs and circumcisers. Phase 3 is the sensitization of the general population or the grassroots people. So there is a focus on key persons within the community and if these persons are reached, then the message can come down.

After these three phases of sensitization, there comes another stage of protection, whereby a selection of members of the *village committees* is done and then they act as watchdogs in different communities. The selected village committees are also responsible for *village monitoring visits*, and identifying girls at risk and newborn babies, whose sexes do they belong. If they are girls, they are escorted for a particular period of time to see to it that they are not affected by FGM. Because the laws are tight on everything, now there is a risk that newborn babies are cut. So to avoid that, they have to monitor the girls and keep on having the monitoring visits until a particular age.

The committees also hold *behaviour change activities* within the communities. They also organise the *official ceremonies against FGM*, that is when the communities are ready, because these visits usually occur more frequently within the communities, so they make communities ready for these ceremonies. It should also be mentioned that the ceremonies do not lead to abandonment. There is some resistance. People will say, 'We have abandoned' openly, but then the activities will go on underground. So it's not a guarantee, but it's one measure.

They also mobilise influential people to be *change agents* and also hold speeches against FGM. It's not only influential people but also people that have had experiences about FGM, that

have been cut and that maybe had health problems with FGM, who have lost someone. These convincing stories are usually shared with the populations and these are more convincing than someone coming from outside the community without any problems and sharing abandonment strategies. It is more reliable when the information comes from within and from those affected.

When all this process is done, there is *a new social norm* that usually begins after the activities and the abandonment ceremonies are organised. That means it is openly declared. No families stand alone and say, 'I'm not circumcising because it's dangerous'. If the others are not with you, you can't do it alone, you can't decide it. There is stigmatisation associated with it, ostracism, all kinds of that name that have been called and so on. There is no family that dares to abandon it on an individual basis. Only underground.

General strategies: the *legal approach* is having an influence on all the other approaches. The fact that the laws are there means that it is a step forward. The *alternative rites of passage*: is not just FGM, but it has also other positive cultural context. Other information can be given out to girls, that is, that there are alternative rites of passage whereby the cut is excluded, and other information on becoming a woman, how to behave sexually, how to breastfeed, how to be clean and so on. They still remain intact, so if we say we are eliminating FGM, that will always be a problem with communities because for them it's not just a practice, there is also a social norm surrounding the practice.

There are *community dialogues* - active male involvement – between religious leaders and traditional leaders. They are also brought onboard as facilitators. There are also education activities, *alternative sources of income for circumcisers* and *change of social norms*. Media is also put on board so that they can air out the problems or they can reach a particular kind of community that may not be reached with particular strategies.

Who is at risk? Girls that are below 14 are at risk. Pregnant women are also at risk. If they are pregnant, maybe they have succeeded to be protected from FGM. If they get married, they become pregnant and then the traditional birth attendant finds they have not been mutilated, they will have to cut them before they give birth, pre-child. So they are also part of the decision-making process.

Who decides to perform? Parents: that means it could be their father, it could be their mother, but it also could be their extended families. Generally for the brides, *the decision-makers are the co-wives*. For example, if a woman goes into a polygamous family and has escaped FGM from her family, it could be that the husband is also not too much into FGM, but the pressure from the co-wives will force that person to undergo FGM willingly. Sometimes the *husbands* may also require FGM to their newly wedded brides, so they are also decision-makers in this process, together with the *mothers-in-law*.

Again, who is at risk? Those contesting for marriage. *FGM is a prerequisite for marriage*, without FGM there is no marriage. That means the husbands are decision-makers in this process as well, as husbands. We can also see here parents playing a role. For example, a girl that is not circumcised is worth less bride price in some communities. We have a *bride price* culture in most African societies, so she is worth less bride price. It doesn't matter how educated she is. For parents that is already a great loss. Maybe the girls are looked at as sources of income, sources of incoming quotes I would say, because for the bride price they expect some kind of exchange. They get cows, they get money, they get clothes, they get various animals. If FGM is not done, there is less bride price or they risk not having bride price at all.

Positive changes:

Generation differences. Younger generations are more often spared and gruadually they are not being cut.

FGM is no longer a taboo and is openly talked about.

An increasing number of people supporting abandonment and we have religious leaders, traditional leaders and circumcisers onboard which was very hard in the past to bring onboard to fight against FGM.

Awareness about FGM is increasing. If we go into communities, the activities, and the awareness are there. People know about FGM. They are open to talk about it. They are open to discuss it. That means there is already an impact. For girls that are running away from FGM that means the message has come to them, and that is why they run to safe havens, to get security there. That is where communities are also thinking hard: How do we modify the practice? By cutting girls that are less aged, for example 0 to 4 years. That means the message is there. The changes are there, the communities are realising the changes.

There are *community abandonment ceremonies*, open ceremonies where at least there is a justification that the communities are not alone in this changing process or behaviour changes, but at least in the communities, several people are standing with them. Earlier it was a problem to get one family to decide not to circumcise when the adults have already done it or are doing it. So at least there is that a guarantee that not all the adults are doing it. At least there is flexibility either I do it or I don't.

Under the **negative trends**, there is *medicalisation of FGM* which means that instead of the traditional ways of doing FGM with crude instruments, in the environment and so on, they are deciding to go for a medicalised FGM, including health personnel in the FGM. That is for me a negative change. It is supposed to be abandoned, it's not supposed to be modified.

Lower ages of girls that are affected by FGM: instead of 4-14 years or 9-14 years, now the *newborn babies are being cut* because the sensitisation and awareness has not yet reached them. So they are helpless, and in this process they can be victims of FGM and no one will know about it. The parents are safe. In some countries like in Burkina Faso there have already been cases against FGM where the parents have been imprisoned, circumcisers have been imprisoned. In cases where the babies are affected, no such legal cases are known.

There is *cross-border FGM* for countries that have ineffective laws against FGM, so we find that where the laws are stronger the communities will cross over to nearby communities where FGM laws not too much in enforcement and they will let their girls be cut there, come back, once that it is good.

There is also a *modification from extreme cuts to simple cuts or to just a pricking* which is also a modification. The question is: Do we want to go this way towards abandonment? Do we want to take another step to let the communities abandon FGM slowly, or do we want to campaign for total abandonment? Will it be a problem in future that if we take communities through this process and say ok, we relativise the problem, they have come from infibulation and are now doing a clitoridectomy. Is there going to be a problem in future of even eliminating this clitoridectomy? Are we maximising funds? How about the time framework?

FGM is also underground. There is also the problem of self-reporting cases. There is also too much of denials in the countries where the laws are very effective. If researches are made, there is too much self-denial: 'I've not practiced FGM', 'My children have not practiced FGM', so that there are no consequences. Some people have fears of bringing or reporting medical cases which are very severe for the victims.

Repercussions of refusing FGM: that is a moral question. Has this family raised their daughters in a moral way? Are they bad-mannered? So it *is* a moral question, and for families whose

daughters have not undergone FGM, it's not just individual stigmatisation but it's also family stigmatisation sometimes. Families completely, completely, lose their belongingness to their community. They're completely isolated from these communities. They can't attend market meetings, they can't go to markets to buy anything. In these communities, there is a market on a weekday maybe and women are very happy to have such market days. That is the time they go out. Now we also have this public space. They work in the markets, they meet friends there and so on. So if they have not undergone through FGM, if their daughter has not undergone FGM, the mother will not dare come into this market. The children fetching water at boreholes - we have communal water sources – it will truly be a problem for them too. In school I've seen drop-off cases where the child, or the children, are feeling very isolated from their peer groups and they decide to drop off school, so that is how far it can be. There are also risks of not being married, because FGM is a prerequisite to marriage or the low bride price. Therefore, I think men play a very great big role here, although indirectly, but their role is already there as decision-makers, as husbands, as religious leaders, as traditional leader and as gatekeepers of the culture and so on.

Possibility of relocation: In countries where the laws are not effective enough, there is no possibility of relocation, be it in urban areas, be it in your geographical location. You can forget it; you cannot relocate the families. If their countries have a high in prevalence like we've seen, relocation does not matter in this case, because women have to be circumcised everywhere. At the end of it all, you belong to your community; women and girls belong to their communities. They have families, and if they want to be accepted, they have to follow their cultures. And there is the risk of being isolated for the rest of their life. Thank you so much.

Discussion

[Question]: Is state protection available and accessible for women against FGM/C?

{Nabateregga] I think if awareness-raising and sensitisation are taking place in most of these communities where FGM is prevalent or not too much prevalent, we have to take care of how it is going to impact. What are going to be the repercussions? I think in this case the rescue centres offer a very good strategy to catch up the girls that are running away from FGM or early marriages. (…) Usually the families can be talked to, the police is alerted, but at the end of it all they say, 'Ok, that is not too much of our problem; that is a family problem. You should be able to solve that on a family basis, or within a clan basis.' At the end of it all, these authorities are supposed to protect the children. Sometimes they call upon organisations that are in charge of FGM activities to seek protection from them on this. If there are no safe houses, then the organisation has to jump into this community and sensitise the families about protection measures, about the consequences of FGM and so on. It could also take a while, because it needs a community-based organisation to do that.

I should say that generally in most of the African countries where the legislation has been there, nevertheless we don't see much impact on the FGM figures. That means the governments have failed to effectively implement this law. No matter, the fact is that this is a top-down strategy that the communities don't access in most cases. They were not involved in the process, they feel left out, they feel it's a dictated method of implementing, and like I said, in most of these cultures they live a cultural way of life. They look up to their traditional chiefs and religious leaders more than to their government because those are not authorities to them, those are people that they go to in times of conflict. They go to in times of need and so on and so forth. So government may fail to protect common people, a common person on the ground whereas the chiefs, the religious leaders, mediate into that situation immediately and make a move, or solve a problem immediately. That is why most of this [government measures] was ineffective.

Even in most cases where government measures are effective, people find solutions. It is a readiness index – how far is the family ready to accept abandonment? How far is it to live a sustainable life without FGM? There are families who will abandon for quite some time, maybe two-three years, but when a project against FGM/C ends, and there is no further help, no follow-up, then they will go back to their practices. And at the end of it all, they run back to their cultures and they will practice FGM again. So the laws are not effective.

[Question] A woman who claims asylum because she is the daughter of a cutter, a 'sowei', who is in the Bondo society, and she is obliged to succeed her in the function, but she doesn't want to cut women, and that is why she is persecuted by the secret society. What are the consequences? Can you say something about this succession procedure, and if this is really going on?

[Nabateregga] The succession is there, it is true, and girls are mostly trained from the age of 5 to be successors, to be 'soweis' in their communities. So at the age of 18, they are supposed to be already practicing the role slowly within their communities and to be on the steps of their parents. They still practice with parents, they go to the bushes with their parents, they take on practical knowledge learning from their mothers how they do it, how to process is done and so on. If they decide against it, and the parents are for it, that is already something which is very difficult for them. If the mother was also against, or is contemplating, 'Should I leave this practice, should I not?', that is another stage. That is another readiness in the sphere. But if there is no contemplation about it from the past generations, from the mother as well, who has given over this tradition over to her child, then she is in danger. She is not accepted in the community, she doesn't have any family at all, and if she is seeking assistance from this family, that means she doesn't have any social, economic, moral support from the family anymore. Not just the family, but even the relatives. Then that is a failed case in most cases. For the asylum seeking procedures or so on, that will be a very good case to consider. To consider the daughter of a 'soweis' to be part of the asylum, but also to take a look at the family situation – how is it? How are the relatives? Which village, which community does she come from? How are the percentages? How are the reactions or the strategies against FGM? How is the mother? Because these are very big kids, and these are the people who decide – the father and the mother. So how is it there in the families, how far are they to abandon? How far are they to support their girl's decision? If it is not the case, then the girl has no chance.

[Question] Did you ever come across these kinds of situations in Sierra Leone, of girls refusing to succeed their mothers as a 'soweis'?

[Nabateregga] Not really, but the mere fact that girls run away at a very young age to seek safe haven at the centres, that is already one of the boycott methods at this stage. It doesn't matter if the mother is a 'soweis' or not, but that is already a boycott method that the girl is already highlighting at a very early stage. So this time, or this period of time that we keep the girls at the centres, it depends on the organizations have to go within the communities, to within the families, to sensitize, to talk with them, to follow up the process – because that is not the end of it all. At the end of it all you have to consider what is in the best interest of the child, and in most cases the children need their parents as something psychological, as something they need a base.

So that is why this period allows this healing process. Maybe it was a misunderstanding. Maybe there could be a chance of convincing the parents to let the kid take her own foot, her own path. This process allows a mediation, allows that at a later stage the children go back to their families. If they don't have the opportunity, then they still have the centre, but of course that has economic impacts, because they have to be educated, they have to be medically

taken care of, they have to be dressed up, and so on and so forth until the child can have a sustainable life or gets a job, be on her feet and can take care of her life.

Discussion with experts

[Question] Does re-infibulation occur?

[Gruenbaum]: I think *re-infibulation after birth* is automatic. If you look at these medical diagrams, you can see that. You can't just cut a woman open to give birth and then not do anything with the opening. So you either have to reconstruct some sort of labia, which is an expertise that I don't know that many birth attendants would have, or you close the opening again with stitches. So the childbirths that I have seen have done the stitching if there is a cut open, just as an episiotomy that is done elsewhere would be stitched. So it is a matter of just kind of restoring integrity, so it really isn't seen as something damaging. Many women also seek re-infibulations voluntarily in Sudan in order to preserve vaginal tightness. Others of my friends who are activists say, 'Let's try to promote tightness through Kegel exercises and the use of other herbs and things like that', so trying to reduce the demand for re-infibulation.

But the other reason that was mentioned earlier is also very much rumored to be done, which is to give the appearance of *virginity*, and also they have been doing a lot of *hymen repair operations* and that sort of thing. We really need to get a better sense who is doing them and why. I have heard many stories about them but I don't know of a really good study or evidence. Maybe the others will. But that doesn't seem to be something that I have heard of people forcing on others. An adult might choose to do it herself under social pressure or under voluntary desire.

Someone else mentioned late-life *re-circumcisions* of a woman. I have heard of elderly women choosing to do this before they die, so that they will arrive in heaven as an intact person, and they see that as preferable. I have never heard of anyone being forced to do that. I think it is extremely rare to think of an adult woman being forced to be re-infibulated. She would simply do it by the conditions of her anatomy, that this would be a choice of hers. However, I do think we lack all the data we might like on that, unless others have information. And finally the issue about how that fits in with *honour* is an important part not to overlook, because although there is a very strong value on virginity at marriage, the younger generations are very much looking for love marriages more than they did in previous generations. They still want to maintain family honour, but they have been pushing the envelope: not just marrying who the family would like you to marry, your first cousin or whoever might have been indicated for you, but it is almost doubly important then for young women to claim honour if they are going to be choosing a love marriage. And yet, I know very well from talking to people who work at universities that sexuality among unmarried young people has been taking off, and they are trying to still maintain the honour by maintaining these appearances in a way.

[Abdulcadir] In Somalia re-infibulation is not forbidden, especially in north Somalia, where they continue to make the re-infibulation for the adult woman after birth. I saw, for example, in Florence a woman that had 9 re-infibulations in her life. The re-infibulation is made in Somalia really after infibulation, when the family, the mother or the grandmother say that the operation is not good. So the hole is very large and they begin to re-infibulate it. This is a real situation that in this moment we have in Somalia. The real question that I see now in Europe, but also I see in Africa, the female genital cutting and the cosmetic surgery. Why I, an African, cannot do what I want? And in Europe you have to do what they want about my vagina. The re-infibulation of that woman if you decide to close, why do I go to the surgery, privately in a clinic, and I have to reduce the labia minora, I make some surgery that we do if you are going to see an advertisement in the UK in the newspaper, Do you ever think of this? The question that I ask you is: How do I protect this lady to perform, to return female genital mutilation without the influence of cosmetic surgery? What is the limit of the cosmetic surgery and female genital mutilation?

Then the other was the risk that if the parents decide to oppose to perform female genital mutilation. This is a daily thing that we see in Europe, especially in Italy, that we see in Africa, when they return to the country. But it is very important that that family they should have a socio-economic context, that they have money. Or they have a high level in society. In that moment they can have an influence inside, not only the family, but all the ethnic group that belongs. We have one example in Merca, it is one city 100 km from Mogadishu: There was a lady 10 years ago who made a project 'Don't touch my daughter'. She did something; she called in the religious leaders and community leaders, and now, after 10 years, that city and that group don't make nothing. Female genital mutilations, the harmful type 3, has disappeared. This is what I think, but what do you say about female cosmetic surgery? Thank you.

[Nabateregga] I would like to just add on what Abdulcadir has just said. In the case of re-infibulations, every time after a birth a woman has to be re-infibulated. She does not have to, but it is a common culture. They have to be re-infibulated. That is why Abdulcadir said that after 9 births a woman has been re-infibulated 9 times. It is very common in the Somalian communities. If they get divorced, they go back for a re-infibulation. If they are widows, they also most times go back for a re-infibulation again. So there is not too much pressure, but that is what they know. To come back on the EU+ presentation, there are no physical examinations as you said. I would say there are no physical examinations in that the children or the women are not taken to the doctor's to be checked, but there are cultural examinations. That means before a Somali lady goes into marriage, she has to prove she is a virgin. She proves it on the wedding night. That is a night when the vagina has to be broken, and she has to prove it with blood. And the period of this night is usually 7 days. So they give her time to go through the process, because it is a hard process that is re-infibulation. Sometimes they have to use a knife, sometimes it has to just be natural penetration. And this is controlled by the aunties, sometimes the mothers. So there is a cultural examination.

[Gruenbaum] I also have seen many re-infibulations on a woman who has given birth many times. For a traditional birth attendant or an untrained, or a minimally trained midwife, I would think that re-infibulation is a really common thing. This is different when you have the option to construct labia instead of re-infibulating. That might be the situations you are talking about for urban women with access to medical care and medical advice.

[UNICEF] In the Sudan program earlier this year we were looking this issue of re-infibulation, and what kinds of resources should we be investing there. And so our first question, of course is: What do we know about it? And it turns out we know very, very little. Omdurman, one of the largest hospitals in Sudan, has one doctor who has been tracking cases of women who had been opened for the purposes of child birth, and then sewn shut again following the procedure. So it is done as has been alluded to in order to facilitate child birth and then put the genitalia back the way it was in some cases. I think he is only tracking 46 women in Sudan, which is in tens of millions. The second point of evidence we had is the MICS, the multiple indicator cluster survey. In 2014 we did ask a question: 'did you give birth in the last 12 months? If yes, were you re-circumcised at the time of the birth?' We found that 23.6% overall in Sudan of women who had given birth in the last 12 months were re-circumcised.

But the percentage or re-circumcision varied from 50 to 60% in the east, the Red Sea, and to less than 10% in most of the Darfur states. So we were looking at that and thinking, actually this probably has a lot more to do with access to medical care than the desires or the wishes. Darfur is very low coverage. Typically they would be giving birth outside of a facility, maybe with the assistance of a community midwife or a trained midwife. So our conclusion was first and foremost we need more information. Is this an important policy issue to further pursue, and is it to do with culture? A culture or a tradition of re-infibulation that we need to work on winning the hearts and minds of people to not do this, or is it actually more linked to the

medical practice following childbirth? So then we need our target on this is much more the medical community.

[Gruenbaum] So wouldn't we really be concerned to know about the role of choice in this and the reasons why one might feel pressured to do it? If it is simply repair after an episiotomy, the Sudanese corollary of episiotomy for an infibulated woman is a cut. That could be reconstructed as labia by a skilled surgeon, but it is unlikely to be reconstructed in that way by people without that special training. It is much more likely to be re-closed. Is that what we mean by it? Or, do we mean the so-called *'addel'* in Sudan, which is something that women feel they should do to tighten their vaginas for the benefit of husbands' pleasure or something like that? So I think we really do need better data before that can be thought of as being in anyway a forced pressure procedure on adult women. It needs to be understood much better in terms of who is doing the choosing in my view.

[UNICEF] Bettina [Shell-Duncan] raised a good question – Is this re-circumcision question standard in the MICS or DHS? It is not. Sudan tried this one. Usually when that happens, the brain trusts who work on these questions then look at the data – How well was it collected? What was the non-response rate? and all of the things you look at on surveys questions. They will determine the importance of repeating it in future surveys in other places.

[Question] We have many applications from women from Guinea that are already mutilated or cut and they come in fear of re-excision. Does it mean that the first excision was not finished or well done? We have applicants who say that they have type 1 and they say, 'It is not finished, so now I fear a type 2.' This is not re-infibulation, no? They don't talk about infibulation. They have been mutilated type 1 or 2, and they say that it was not well done, and the husband verified and he noticed that it was not done well. So they have to face a new excision.

[Gruenbaum] Yes, it is. I don't know the west African situation, but I do know that sometimes you hear of stories like this, where a dissatisfaction with the first cutting is then remedied by a re-circumcision. So it isn't the same as re-infibulation, which is the one with the closure, but it is removing more. Because the excision, if you look at those types 1 and 2, there is so many different little gradations, so it is just the prepuce, now they want the clitoris, or is it half the clitoris and now they want the whole clitoris. Or did they not take off enough of the labia, and the husband wants you to take off more. In Sudan there have also been cases of husbands being able to divorce their wives under Sharia law without any reasons or recourse. That it is something that women often have a fear that, if the husband isn't satisfied with how their genitals are, he might for any reason divorce them. I heard women talk about that.

So I don't know if that applies in this case but the idea of being acceptable to your community in the type of circumcision you had, that would be something to ask about whether that is an issue or not, because I can see that there could be people afraid of being forced to be re-circumcised.

[Audience] The local sources we contact – doctors, gynecologists – they don't know anything about re-excision because for them it doesn't exist. Excision occurs only one time. It is a ceremony, it is not necessary to make a second excision. But this term is used in the asylum application; that is why we have a lot of problems to find information on this topic. There are no data.

[Shell-Duncan] I have never run across ethnographic descriptions of it happening, and I haven't heard of that being talked about in any of the communities that I have worked in. I haven't worked in Guinea though. That question could be rooted in these decades of debates about what if a girl would still be at risk if the practice wasn't done well enough? But I don't know of any data – qualitative or quantitative – covering this question.

[Question] How are FGM/C practices related to religion?

[Gruenbaum] This is a question about the Beja, the patterns of practice – are they different from the Beja in Egypt? I don't really know much about the Beja in Egypt, but if you look at all the ethnic groups in eastern Sudan, the Hadandawa, the Beni-Amer, and so on, some of them will go across the borders with both Egypt and Eritrea. So these are really important ethnic groups to understand.

My experience in eastern Sudan was that there has been a very strong sense of holding to the ethnic group traditions for infibulation, at the same time as there has been a lot of pressure toward a more cosmopolitan existence through increased travel. One Hadandawa community that I was in, 10 years ago, was very much protected from such influences. The women were incredibly isolated. And in another community, they were very much subject to missionary activities from the Salafist movement, the Salafis were recruiting heavily among the Beni-Amer. I spent several days with one woman who was now wearing a face veil which the Sudanese women had not traditionally done. So whenever she went out, she wore a face veil, and she was in torment because her husband was a labour migrant working in Port Sudan, and she was following this very strict Salafist religious tradition. The Salafists told her that she must do *sunna* circumcision. Her grandmother was saying, 'You must do pharaonic infibulation'. There was a strong government program that was educating against any form and really had put a lot of pressure on some of the people to say, 'You should stop completely'. So it was a lot of stress on her life to try to figure that out.

I think a lot of the women in the east, in those tribes, are experiencing exactly those kinds of conflicts, not knowing who to go with. But the Salafist movement was very strong in east Sudan, which leads into the issue of radicalisation and Islam. it has been very stunning to me to see that some of the most radical Islamists in Sudan were pushing for continuing the type 1 circumcision, the so called *sunna*, which I didn't anticipate, because a lot of the other religious leaders in Sudan were gradually coming out more and more to say, 'No, it is not Islamic, let's abandon it'. I would also like to hear Bettina [Shell-Duncan]'s point of view about what is happening on the radicalisation of Islam and how that is playing out with some of the other ethnic groups in the country she reported on.

[Shell-Duncan] Well, in the study communities that I was working in Gambia, the link to religion did come up. It came up a lot less among women than it did among men. Women talked about being pure and clean in order to pray; men were more interested in what religious leaders had to say and what are the interpretations of Islam, or ways that people live with Islam. I didn't get the sense in the communities where I was, that radicalisation of Islam was making a big influence on the practice, but I did not work in the far north of the country.

[Gruenbaum] Some of the Sudanese in eastern Sudan 10 years ago were also promoting sending missionaries back to Saudi Arabia to get the Saudi Arabians to practice sunna circumcision. I doubt they had much success, however, when I was in Saudi Arabia many years ago, I also talked to some people who said, 'Well, it is actually part of our tradition too'. You hear often: 'We gave it up a long time ago'. My experience both in Sierra Leone and in Sudan is that when people speak from a voice of presumed religious authenticity, like a very convincing preacher or prophet, they often can persuade other people to follow them. So if people are part of a particular religious sect, in addition to being part of a particular ethnic group, those can both be factors, but they aren't unchanging.

[UNICEF] I am going to link into that with a question about – are there countries or ethnic groups where FGM is increasing rather than decreasing? I think the question of radicalization is it somehow leading to an increase? My first response would be – there is a time lag with all of this DHS and MICS data so we don't really know about the very recent trends, 5 years or 10 years – it is harder to make determinations, also because the girls are not yet of an age out of

the risk of cutting. So we don't know that much about this proximate cause. I looked at a recent analysis from our data research and policy division. They basically have 3 categories. They were countries that made significant progress over the last 30 years, there were countries that made some modest progress in the past 30 years, and most of them were either little progress or no progress. But there were no countries in that review that had increased. So that is good news! Sub-nationally, I don't think we have taken a hard enough look at the ethnic de-segregation of the data to say if one particular ethnic group has increased in the last 30 years or 10 years. I recall we looked a little harder at Senegal once and saw that the Mandinka had gone up by 2 percentage points, which was still within the statistical margin of error, so we couldn't really say one way or another.

I think we have a lot more data than we could do in terms of the most recent trends and ethnic disaggregation. My point is that there are historical instances 50 years ago of groups adopting the practice from others. The Diola Foni, in Ziguinchor, the Casamance region of Senegal, one can think of immediately, and the Dinka 50 or 60 years ago, now probably 60 or 70 years ago – they didn't practice it, now they do because they started inter-marrying with groups that did practice as displaced persons. So it is also another argument for: culture can change one way or the other way.

Terminology

[UNICEF] We use the WHO four types of FGMC. The most recent revision also breaks them into subtypes with some further description. So the challenge that we face in collecting evidence on a population-wide scale, through the MICS and DHS National Household Surveys, is how to relate the typology (describing what has been done and the different ways it has been done) with a woman's personal experience. If you ask a woman to relate what has been done to her to a specific type, how accurate is the information we get? As the presentations have pointed out, the way that the questions are operationalized in the DHS and MICS actually collapses 2 types into one question. So we are already at 3 types instead of 4 types.

The further challenge is that when collecting the data, an adaptation of the question into the local language is done, where the practices are rather referred to by its anatomical descriptor, but more of a conceptual description about purity. In Guinea they say 'crossing the river'. It is one way of describing it. We are dealing with a *conceptual barrier*, a *linguistic barrier* as well as potentially the *lack of anatomical knowledge*. I thought it was very interesting actually, that someone said earlier that when they may be looking around into the surroundings to construct a narrative about what happened to them, and then report that in surveys, I think it is a very reasonable thing to be recognizing in terms of limitations in our data collection, especially in cases of countries where the practice is happening before we form memories, before 1 or 2 years old; this may be very difficult.

To summarize the challenge, the way that we conceptualize it in international definitions to what degree does it correspond to how people are reporting it on the ground? To what extent is that a needed understanding from my perspective in order to take a programmatic and policy action in order to promote abandonment?

[Question] Are there local terms in any culture for any type or any part of the continuum of female cutting?

[Gruenbaum] Oh, yes. There are so many varieties. If you speak in Arabic to Sudanese, you have 'sandwich', the 'half', there are many different terminologies, but they boil down to the 'sunna' and the 'pharaonic'. People start adopting the term FGM in Arabic. Ther are terms for 'not cut', '*ma mutahira*'. There was a big debate in Arabic about the difference between '*khitan'* because one of the terminologies echoed the Qur'an and one didn't, so they were trying to argue about making sure that the one that echoed the Qur'an was not used, because

you don't want people to associate it with religion. So you get into some really interesting linguistic difficulties.

[Audience]. In the whole Mande region ithey use the term *'bolokoli'* for excision, and *'bleh-koro'* for the uncircumcised.

[Audience] We discovered in Somalia when we were discussing FGM that people relate FGM only to infibulation. So someone could say, 'No, we stopped FGM', and in our perspective we thought they stopped it completely, but they meant that it was transformed to 'sunna'. That is something to be aware of when you discuss it.

[UNICEF] Certainly, we have had this discussion in Sudan in early this year about to what extent are people saying they have quit *'khitan al'iinath'* [female circumcision] and just moved to *'sunna'* as something else, as something different and new.

[Gruenbaum] I can not give you a vocabulary list of the terminologies from many different cultures, but certainly there are different terms for the different kinds of operations like I was referring to the sandwich: 'Oh, she didn't do much. She just did the sandwich' or 'She just did half'. Words like *purification* are a euphemism for cutting the genitalia.

It would be good to have a list of the kinds of euphemisms, the kind of metaphorical statements, and the range of terminologies that are used in the languages being spoken. I worry about that for translators because I don't know how translators take a statement and have the sophistication to know how to translate it properly to really reflect the way the person is speaking about it.

[Abdulcadir] In my work I never use the terminology of mutilation. Tor example, Egyptian people use '*tahara'* [purification]. The Somali people use *'gudniin'*. Senegalese or Ivory Coast people use 'excision'. In Nigeria they use, 'circumcision'. They don't know the classification of female genital mutilation. They use the terminology of their own community.

doi: