BUREAU FOR GLOBAL HEALTH
UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
(USAID)

BUREAU FOR GLOBAL HEALTH
STRATEGY FOR
FEMALE GENITAL CUTTING (FGC)
(FY 2004 – FY 2006)

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Table of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
DFID	Department of International Development— UK
DHS	Demographic and Health Survey
EGAT	Bureau for Economic Growth, Agriculture and Trade (USAID)
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
GH	Bureau for Global Health (USAID)
HIDN	Office of Health, Infectious Diseases and Nutrition (USAID)
HIV	Human Immunodeficiency Virus
MOH	Ministry of Health
PATH	Program for Appropriate Technology in Health
PRB	Population Reference Bureau
PRH	Office of Population and Reproductive Health (USAID)
PRIME	Primary Providers Training and Education in Reproductive Health
REDSO	Regional Economic Development Support Office
UNFPA	United National Population Fund
UNICEF	United Nations Children's Fund
UDHR	Universal Declaration of Human Rights
USAID	United States Agency for International Development
USG	United States Government
WARP	West Africa Regional Program
WID	Office of Women in Development (USAID)
WHO	World Health Organization

Executive Summary

Female Genital Cutting (FGC) is the name given to traditional practices that involve the partial or total cutting away of the female external genitalia and/or other injury to the female genitals, whether for cultural or non-therapeutic reasons. USAID's policy, effective September 1, 2000, recognizes FGC as a harmful traditional practice that violates the health and human rights of women and hinders development. USAID opposes any practice or support for FGC and works toward the goal of total abandonment. Under no circumstances does USAID support the practice of FGC by medical personnel.

FGC violates a young girl's right to reproductive health, and gravely harms her physical and mental health. The type of genital cutting a woman experiences influences the likelihood that she will have negative complications—the more severe the cut, the more serious the consequences. Above all, FGC is a cultural practice, and efforts toward abandonment require understanding and changing the beliefs and perceptions within the community that have sustained the practice over the centuries. An estimated 135 million women and girls worldwide have undergone FGC, and two million women and girls a year are at risk of being cut—nearly 6,000 per day (WHO, 2000).

While USAID's overall goal is the abandonment of the practice of FGC, the Bureau for Global Health (GH) has chosen to make the objective of this Strategy, ***Advance and Support the Reduction of FGC***. To support this Strategic Objective, GH is committed to two intermediate results:

IR 1: Improved enabling environment to reduce FGC practices
IR 2: Improved quality and effectiveness of community-based FGC abandonment activities

Over the three-year strategy period, GH, in collaboration with the Africa Bureau, will promote the abandonment of FGC using the lessons learned in its work thus far. The strategy described in this document capitalizes on the Agency's strategic advantages of global leadership, international collaboration and technical assistance in the field. Working in conjunction with other donors and international partners, GH will work to:

- Increase donor support for FGC abandonment programs;
- Improve collaboration among organizations working in this area;
- Enhance advocacy, leadership and policy development through its leading role in the global community of FGC abandonment;
- Improve the community-level environment to reduce FGC practices;
- Mainstream anti-FGC activities into GH portfolios, USAID missions, and national programs; and
- Involve other NGOs and donors to adopt and implement successful models and best practices of FGC abandonment.

Based on the criteria of prevalence, severity of practice, donor and government support, and Mission involvement, the following countries have been identified by USAID as high priority: Egypt, Ethiopia, Eritrea, Kenya, Mali, Guinea, Senegal, Djibouti and Sudan.

There has been significant progress in FGC abandonment around the world in the past 10 years. With the strategic approach proposed here, USAID can help to strengthen and expand these achievements in key regions around the world.

Background

Female genital cutting (FGC) is practiced in more than 28 African countries, in pockets of Asia such as Indonesia, and in parts of the Middle East including Egypt, Oman, Yemen, and the United Arab Emirates. There have also been reports of FGC among certain ethnic groups in Central and South America, but little information is available. FGC has been reported in Australia, Canada, Denmark, France, Germany, Italy, the Netherlands, Sweden, the UK, and the United States, occurring predominantly among immigrants from countries where FGC is practiced. An estimated 135 million women and girls worldwide have undergone FGC, and two million women and girls a year are at risk of being cut—nearly 6,000 per day[1]. Details of the geographic distribution of the practice are presented in Appendix I.

FGC may be performed during infancy, childhood, marriage or during a first pregnancy, but is typically carried out on young girls between the ages of 4 and 12. The procedure is generally undertaken by a medically untrained person—often an older woman—from the local culture or community. The conditions are often harsh and not sterile, and a variety of instruments are used, ranging from a scalpel to a piece of glass[2]. Increasingly, FGC is also performed by trained health personnel, including physicians, nurses and midwives in an effort to make the practice safer. However, this medicalization of FGC is condemned by the World Health Organization and USAID since it perpetuates the practice rather than preventing or reducing its practice[3].

Consequences of FGC

The potential physical complications and psychological trauma resulting from the procedure are numerous. As FGC is often carried out without anesthesia, it is immensely painful. Short-term complications, such as severe bleeding—which can lead to shock or death—are greatly affected by the type of FGC performed, the degree of struggle by the woman or girl, the unsanitary nature of the operating conditions, the level of experience of the practitioners and the adequacy of the medical services once a complication occurs. There is a high risk of infection, with documented reports of ulcers, scar tissue and cysts around the wound. Other lasting effects that commonly result from Type II or Type III procedures include urine retention, resulting in repeated urinary infections and obstruction in menstrual flow, which may lead to frequent reproductive tract infections, infertility, chronic pelvic pain, dermoid cysts and keloid scars (see Appendix II for a detailed description of the types of FGC). Although there is limited evidence, FGC is also likely to increase the risk of HIV infection. Particularly in the Greater Horn of Africa, infibulated (Type III) women experience complications in pregnancy and childbirth and they must undergo a deinfibulation procedure to remove the obstruction in front of the vaginal opening to allow the exit of the fetal head.

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[1] WHO Fact Sheet No. 241, June 2000.
[2] Ibid
[3] USAID Policy on Female Genital Cutting, September 2000.

Why FGC Persists

FGC is done for many complex and poorly understood reasons; it is a deeply rooted cultural practice. In some cultures, the practice is based on the desire to protect the girl child: it is viewed as a culturally important practice that has social significance for females. Some societies support FGC because they consider it a "good tradition" or a necessary rite of passage into womanhood. Specifically, FGC announces to the community that this particular woman is ready and available for marriage—in fact, she is unmarriageable until she has undergone the procedure. The identification of FGC with womanhood has clear implications on a girl's socialization into her role as woman, wife and mother.

There are traditional and local beliefs that also contribute to the continuation of FGC, including the belief that FGC curbs female sexual desire and maintains virginity; that the clitoris is an unhealthy, unattractive organ which is seen as a threat to the penis; and that the practice may have religious significance, protects family honor, and enhances male sexual pleasure.

Rationale for Investment

Female genital cutting violates a young girl's right to physical and mental health, including good reproductive health. FGC is considered by the international community to be a violation of children's rights under the United Nations Convention on the Rights of the Child (see Appendix III, International Efforts to End EFC). The treaty contains several clauses that are intended to protect children from harmful practices that jeopardize their health, including FGC. In support of the international community, USAID issued an official policy on FGC in 2000 (see Appendix IV). USAID has placed FGC abandonment on its development agenda in response to:

- Expressed needs of national governments, civil society and the international community to address FGC;
- Unequivocal consensus reached at world conferences on the need to combat all forms of violence against women, including FGC; and
- Rising concern and demand for action by the U.S. government.

Statement of Support for FGC Abandonment Worldwide
Congress directed that USAID should allocate funding from its budget to "develop and integrate, where appropriate, educational programs to eradicate FGC into [USAID's] population, education, and women in development activities."
--Sense of Congress Resolution passed in June 1995

Process of FGC Strategy Development

USAID/GH undertook the following process to develop the FGC Strategy:

- Collection of information through interviews, document reviews and attendance at FGC intra-agency and partners working group meetings;
- Identification of the most important lessons learned from previous work; and
- Synthesis of this information into a draft strategy, followed by several internal meetings of USAID staff to revise the strategy and discuss funding mechanisms.

This process was carried out in close collaboration with staff in several Offices of USAID; in particular, the Africa Bureau has played a pivotal role in supporting activities, identifying most effective approaches, and developing this strategy.

The Contribution of FGC Abandonment Activities to the GH Strategic Objectives (SOs)

The Bureau for Global Health (GH) defines its three main roles as global leadership, state of the art research, innovation, and dissemination, and technical support to the field. The Bureau's programs are directed to five strategic objectives. This section highlights how reducing the practice of FGC contributes to four of these five SOs.

- ***SO1 Advance and support voluntary family planning and reproductive health programs worldwide***
  FGC abandonment is an integral part of the promotion of family planning/reproductive health (FP/RH) and will be incorporated into policy, advocacy and services. Lessons learned, best practices and knowledge generated will be disseminated to the field to implement effective and sustainable FP/RH programs.

- ***SO2 Increased use of key maternal health and nutrition interventions***
  FGC represents a health threat to women, especially during child birth. It is important to train health care providers to recognize and manage the complications during delivery of women who have undergone FGC.

- ***SO3 Increased use of key child health and nutrition interventions***
  Abandoning FGC of young girls will be an important step toward improving child health and reducing infant and child mortality. In addition, FGC abandonment reduces the risk of birth complications among affected women thereby decreasing the risk of infant mortality.

- ***SO4 Increased use of improved, effective, and sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic***
  The practice of FGC may pose a risk for HIV transmission as a result of repeated use of cutting instruments, increased trauma during sexual intercourse, potential increased need for blood transfusions due to hemorrhaging, and the presence of genital ulcers and dermoid cysts.

Results Framework

USAID and its partners are working toward the goal of total abandonment of FGC worldwide. While this goal cannot be accomplished within a three-year period, the objective of this Strategy, ***Advance and Support the Reduction of FGC***, contributes directly to the goal of abandonment. From USAID's experience in working to eradicate FGC over the past five years, important lessons have been learned.

Key Lessons Learned on FGC

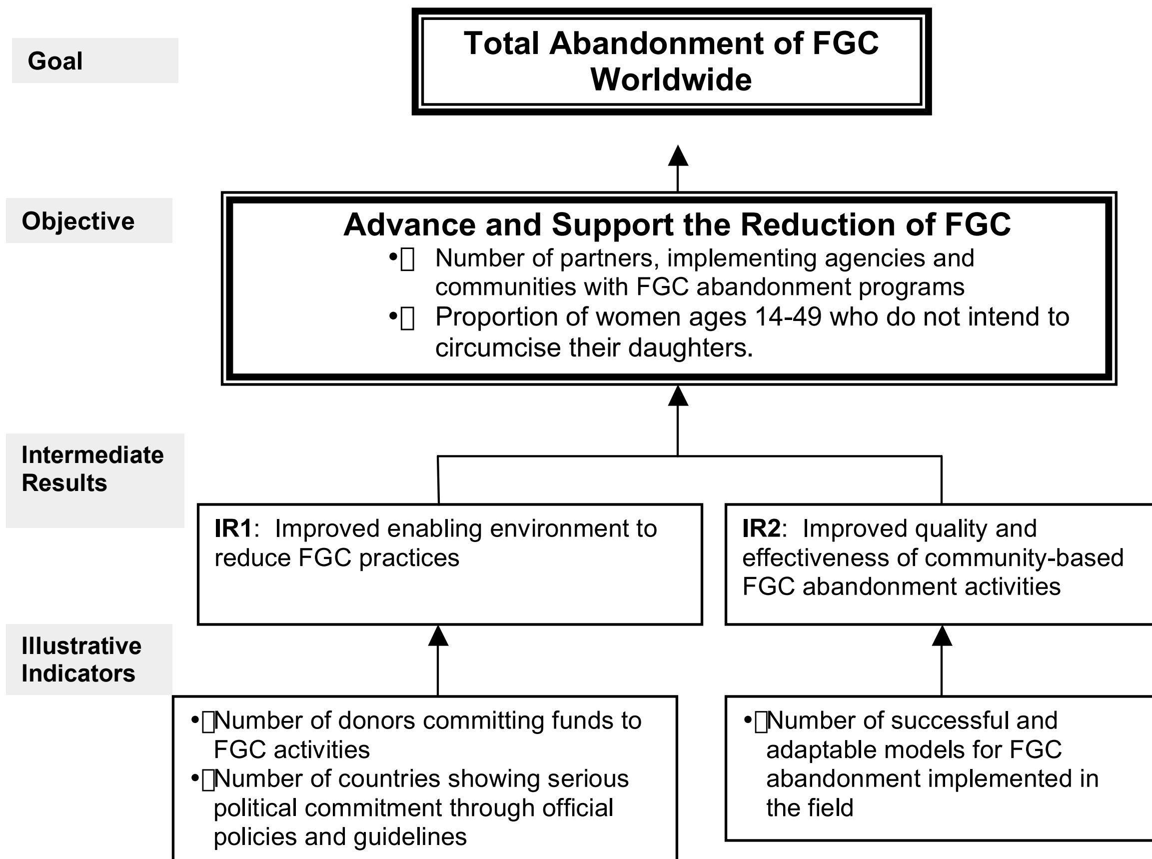
- Sensitize groups of people and adapt anti-FGC messages to fit cultural norms regarding rites of passage (Kenya).
- Integrate FGC abandonment into a range of social and economic development initiatives that focus on women's empowerment (Ethiopia, Senegal, and Burkina Faso).
- Develop alternative rituals to substitute for cutting ceremonies (Kenya).
- Empower women through participatory techniques to collectively decide about FGC and negotiate community support (Senegal).
- Involve community stakeholders in discussions to evaluate the costs and benefits of continuing or abandoning FGC (Kenya, Ethiopia, and Uganda).
- Validate and praise individuals who have challenged or deviated from conventional societal expectations and explored successful alternatives to cultural norms, beliefs or perceptions (Egypt).
- Work with health workers to help them treat FGC-related complications and to empower them to be advocates against FGC for medical, psychological, and human rights reasons (Mali, Kenya).

Critical Assumptions

USAID has achieved a number of successes with regard to FGC-abandonment initiatives and activities, and significant lessons have been learned as indicated above. In order to make further progress, it is important for an environment conducive to the abandonment of FGC to be in place. Consequently, the following critical assumptions have been made:

- There will be a sustained U.S. government commitment to FGC abandonment in the form of funding and investment from USAID;
- In addition to U.S. commitment, other donors and host-country governments will also demonstrate serious and sustained commitment to FGC abandonment;
- There will be continued political will in key countries to address FGC as a cultural practice that needs to be either abandoned or replaced with an alternative rite of passage;
- There will be support for efforts to establish and ratify anti-FGC legislation in countries with high FGC prevalence;

- There will be a multi-sectoral approach to FGC abandonment and this will be supported by a consistent effort over time at all levels, including community, policy, national, and donor investment;
- There will be a continued focus on the importance of gender and social equity in addressing FGC taking into account the increasing role of men (including religious leaders), as well as increasing the empowerment of women; and
- The medical community will support the anti-medicalization movement.



Intermediate Results and Supporting Activities

IR 1: Improved enabling environment to reduce FGC practices

USAID will work with bilateral donors, multilateral agencies, and private foundations to expand support for FGC abandonment activities. As Secretariat of both the Donors' Working Group and the Inter-Agency Working Group on FGC, USAID will facilitate communication and partnerships among donors, partners, implementing agencies and

communities in the FGC field (a table on the Donors' Working Group activities is presented in Appendix V). Strengthening collaboration and partnership among diverse groups is an important element in successfully achieving IR1. USAID will strengthen national leadership and policies of foreign governments at community, regional and national levels. A global dialogue between donor groups will be fostered and maintained in support of positive government policy and legislation changes. USAID will disseminate best practices of cooperating agencies aiming at the abandonment of FGC on a local, national and international level.

Supporting Activities
Global Leadership
GH is refocusing its efforts to develop strategic alliances with new public and private partners in order to bring substantial resources, ideas, and technologies to address global health issues. Today many new public and private partners are joining forces with traditional bilateral and multilateral donors to invest in FGC abandonment activities.

As the Secretariat of the FGC Donors' Working Group, USAID has been able to exert global influence and leverage funds with organizations such as the Ford Foundation, the World Bank, the Department for International Development (DFID) and other European governments.

In working with donors and partners, USAID seeks to increase funds for activities in the Greater Horn of Africa and disseminate and promote the scaling-up of best practices for FGC abandonment to be included in host country policies and strategies. In addition, GH will encourage local USAID Missions to integrate FGC into existing health programs.

IR 2: Improved quality and effectiveness of community-based FGC abandonment activities

Abandonment strategies that work in one community may not work in another, even within the same country or region. It is therefore of great importance that FGC abandonment activities be developed and modified to suit cultural traditions and practices in a particular community. Activities must be designed and implemented that address the roles of community-based organizations, civil society and religious leadership in order to educate and incorporate community leaders and health professionals as advocates for FGC abandonment. USAID will work in collaboration with partners and other donors to build upon existing, successful FGC abandonment programs at the community level. This will be done primarily by applying lessons learned/best practices and integrating FGC into health, social, education and economic activities already underway in country.

Supporting Activities
State of the Art Research, Innovation, and Dissemination
The Bureau for Global Health is the repository for state-of-the-art thinking on FGC abandonment. Along with its cooperating agency partners, GH will develop, test, and disseminate new methodologies that contribute to successful field program implementation and evaluation of FGC programs. GH has supported pioneering work in

results monitoring and has facilitated global collaboration in the development of tools for program evaluation and trend analysis in the global health sector. Therefore, it is recommended that GH do the following in the areas of research, innovation, and dissemination:

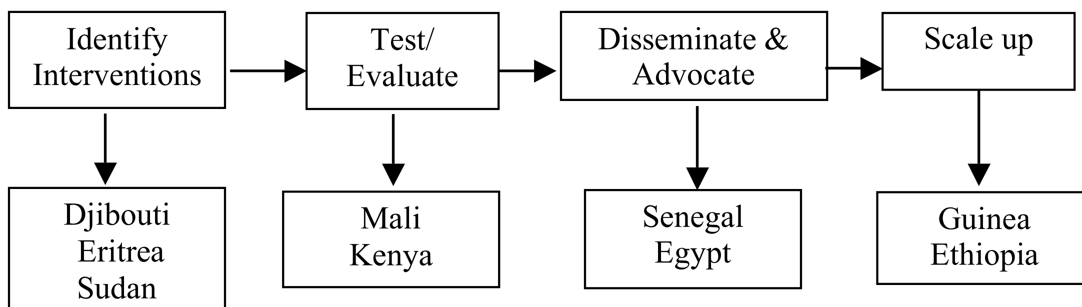
- Continue research on effective FGC abandonment programs fostering behavior change, building on lessons learned;
- Initiate research on integrating FGC abandonment activities in health posts, primary, secondary and tertiary level service delivery sites to train health care providers to advocate for FGC abandonment;
- Identify further research gaps; and
- Incorporate results of research and lessons learned into FGC policies, materials, guidelines and programming.

Technical Support to the Field and Country Programs
GH follows a field-driven and field-centered approach to developing and testing new program approaches. This Strategy has a strong focus on documenting lessons learned, disseminating the results, and integrating the results into other USAID-funded anti-FGC activities.

GH will undertake the following activities to provide technical support to the field:

- Convene a group of experts to agree upon standardization of measures and indicators;
- Integrate FGC reduction into USAID's global health programs;
- Assist missions in initial design, implementation, and evaluation of FGC reduction strategies and programs using best practices methodologies;
- Leverage FGC funds with missions and other donors for expanded programming.

High priority countries for funding and technical assistance from the Bureau for Global Health are: Egypt, Ethiopia, Eritrea, Kenya, Mali, Guinea, Senegal, Djibouti and Sudan. The starting point for each country is the identification of the most effective anti-FGC interventions, then testing and evaluating the various interventions. The diagram below shows where the target countries are in the different stages of the process.



At this point, comprehensive community-based interventions appear to be the most effective. For instance, lessons learned and the positive results of anti-FGC activities have been disseminated among ministries, national and international organizations in Senegal and Kenya in FY04. In Guinea, Egypt and Ethiopia, the USAID missions provided field support to integrate anti-FGC activities into the FP/RH projects, a commendable commitment that other missions are encouraged to follow.

In partnership with the Bureau for Global Health, USAID country programs should:

- Develop national plans to scale up FGC abandonment programs;
- Work with governments, training institutions, and professional organizations to establish policies to support the abandonment of FGC;
- Identify appropriate local groups to collaborate within community efforts;
- Work with community leaders and health professionals to advocate for FGC abandonment;
- Facilitate the networking of professional and religious societies to serve as advocates for policy and program implementation;
- Support the involvement of civil society such as women's groups, religious and community leaders/organizations and youth in the fight for FGC abandonment;
- Fund community-based activities that will encourage social mobilization and promote behavior change in the reduction of FGC; and
- Support "Lessons Learned" workshops and meetings that will lead to pilot activities or the scale up of existing programs.

Implementing FGC Abandonment Activities

FGC programming will be locally driven and culturally appropriate. Community-level participation is crucial to the success of FGC programming and interventions, and as such, every attempt will be made to maximize input and participation of community members as well as local leadership. Gender and social equity will be highlighted in addressing FGC, including the empowerment of women and male involvement in the process of change. FGC work will also pursue a high level of coordination among international donors, and between donors and governments at the national, regional and local levels. Efforts will be made to integrate FGC abandonment best practices with other initiatives such as the Implementing Best Practices (IBP) and Maximizing Access and Quality Global Leadership activities. In the development of the Results Framework, lessons learned from previous work were incorporated. For a list of the substantial accomplishments to date, please see Appendix VI.

The following key themes will guide the implementation of the FGC Strategy:

- Standardization of training materials, guidelines, indicators, etc.;
- Expansion and institutionalization of FGC reduction programs at the country level;
- Identification of successful models by working intensively in a number of focus countries;

- Leadership in identifying further research, compilation of research and field implementation findings regarding the impact of FGC reduction programs and providing this information to donors to mobilize global resources to enable the scale-up of FGC programs; and
- Monitoring and evaluation of activities through the results framework.

Over the next three years there will be a focus on building on existing linkages and coordination at all levels to strengthen the implementation of FGC abandonment programs:

- Service delivery level. Better linkages within health facilities so that women who have been cut receive appropriate reproductive health care;
- Country level. Better linkages at the country level among missions, local organizations, national committees and other stakeholders to facilitate scaling up of programs;
- Cooperating Agency (CA) cooperation and coordination. Better linkages among CAs to minimize duplication of effort and share lessons learned; and
- USAID/Washington. Better linkages among different units at USAID; the Office of Population and Reproductive Health should look for more ways to link with the Office of Health, Infectious Diseases and Nutrition (Maternal and Child Health Division), the Office of HIV/AIDS, and the Africa Bureau.

Funding

The FGC Special Initiative is based in the Bureau for Global Health and derives funding from the Office of Population and Reproductive Health (PRH) and the Office of Health, Infectious Disease, and Nutrition (HIDN). The initiative has received substantial support from the Africa Bureau and has also received funds from the Office of Women in Development (EGAT Bureau).

Estimated 3-year Support (US $) in FY04 – FY06

	1st Year	**2nd Year**	**3rd Year**	**Total**
Core Funding	$630,000	$500,000	$400,000	$1,530,000
Mission Resources	$1,200,000	$1,400,000	$1,600,000	$4,200,000
Total	$1,830,000	$1,900,000	$2,000,000	$5,730,000

- Core Funding: The above table shows a yearly breakdown of the estimated level of funding pending availability of funds over the next three years. It should be noted that this estimate does not include investments in other core-funded PRH agreements that may include an FGC component in their activities. The main support for the Initiative comes from the Office of Population and Reproductive Health. As other organizations and donors increase their support, the level of funding from the Office

of Population and Reproductive Health will decrease. At the same time, it is expected that funding from missions will increase.

- Africa Bureau: It is anticipated that the Africa Bureau will provide an estimated $200,000 in support annually, subject to the availability of funds.
- Missions: USAID missions in the countries where FGC is being practiced are beginning to contribute funding for integration of FGC into the development projects. We plan to encourage a sustained involvement and expansion of this support.

Personnel

USAID will continue to support FGC with substantial staff time in order to plan and monitor the activities as described in the Strategy with assistance and collaboration from other members of the Intra-Agency Working Group. USAID staff will coordinate FGC programs and activities and raise awareness about FGC among USAID staff in Washington as well as the field, and among CAs. USAID will work closely with the Partners and Donors Working Groups on FGC and contribute as a member of the Africa Bureau's reproductive health team.

Programming of Resources

Since funds are limited, strategic choices have to be made. Funding for each year will build upon existing programs. New initiatives, pending the availability of funds, will be placed in high priority countries. The high priority countries will be selected on the basis of most or all of the following criteria:

1. Prevalence - high FGC prevalence rates which would affect a large proportion of the population, demonstrating a need for intervention and programming; or conversely, low or decreasing prevalence rates which could potentially be eradicated within the next three years.
2. Consequences related to FGC - high prevalence rates of the more severe types of FGC (Type II or III), and therefore higher maternal mortality and morbidity rates as well as general reproductive health consequences.
3. Donor and local government support - financial and technical support of the donor community as well as that of the local government, whether this comes in the form of legislation, the formation of a national committee to address FGC, or another alternative.
4. Mission involvement - Mission support through resources and funding, which suggests that the Mission has successfully been able to integrate FGC programming into its strategy and views FGC abandonment activities as an important aspect of the country plan.

According to the above criteria, the high priority countries for funding and technical assistance from the Bureau for Global Health are: Egypt, Ethiopia, Eritrea, Kenya, Mali, Guinea, Senegal, Djibouti and Sudan.

Performance Monitoring & Evaluation

The Bureau for Global Health is committed to monitoring and evaluating achievements of the results outlined in this Strategy. CAs receiving funds to implement FGC activities are required to report progress on a regular basis. USAID staff monitor the quality of field implementation and at conclusion assess the overall outcome.

The following achievements will be tracked:

- Standardized FGC materials, guidelines, and policies produced;
- Best Practices integrated and applied to existing USAID and partners' FGC programs;
- FGC mainstreamed within USAID's portfolio from being a vertical and special initiative to become an integrated and integral component of USAID's Global Health program, including FP/RH, maternal and child health, and HIV/AIDS, among others; and
- Global support for FGC and commitment of donor funds increased.

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Appendix I: Geographic Distribution of FGC

Globally, an estimated 135 million women and girls have undergone genital cutting, and two million girls a year are at risk of the procedure - approximately 6,000 per day. FGC is reportedly practiced in more than 28 African countries.[4] Data indicating FGC prevalence in Asia are not available. FGC has also been reported among Muslim populations in Indonesia, Sri Lanka and Malaysia, although very little is known about the practice in these countries. In India, a small Muslim sect, the Daudi Bohra, practice clitoridectomy (Type I). In the Middle East, FGC is practiced in Egypt, Oman, Yemen and the United Arab Emirates. Additionally, there have been reports of FGC among certain indigenous groups in Central and South America, but little information is available. The most severe forms of FGC, Type III and IV, are found in the Greater Horn of Africa.

In industrialized countries, genital cutting occurs predominantly among immigrants from countries where cutting is practiced. It has been reported in Australia, Canada, Denmark, France, Germany, Italy, the Netherlands, Sweden, the UK and the United States.

The following is a complete listing of the countries which undertake FGC as a cultural practice and the prevalence of FGC among women 15-49 years old[5] in Africa and Middle East:

1. Djibouti (98%)
2. Guinea (98%)
3. Somalia (98%)
4. Egypt (97%)
5. Mali (92%)
6. Eritrea (89%)
7. Sierra Leone (70%)
8. Sudan (89%)
9. Ethiopia (80%)
10. Gambia (60%)
11. Burkina Faso (76%)
12. Chad (60%)
13. Liberia (60%)
14. Benin (17%)
15. Kenya (32%)
16. Togo (12%)
17. Central AR (43%)
18. Cote d'Ivoire (43%)
19. Nigeria (19%)
20. Ghana (5%)
21. Mauritania (71%)
22. Cameroon (1.4%)
23. Niger (5%)
24. Senegal (20%)
25. Tanzania (18%)
26. DR of Congo (3%)
27. Uganda (2%)
28. Yemen (23%)

[4] WHO, 2001; Amnesty International. See FGM in Africa: Information by Country (ACT 77/07/97).
[5] Sources: DHS, WHO and Amnesty International. Revised July 2005.

Appendix II: Types of FGC

DEFINITION OF FGC

Female genital cutting (FGC) is the term used to refer to the removal of part, or all, of the female genitalia. The most severe form is infibulation, also known as pharaonic circumcision. An estimated 15% of all cuttings in Africa are infibulations. The procedure consists of clitoridectomy (where all, or part of, the clitoris is removed), excision (removal of all, or part of, the labia minora), and cutting of the labia majora to create raw surfaces, which are then stitched or held together in order to form a cover over the vagina when they heal. A small hole is left to allow urine and menstrual blood to escape. In some less conventional forms of infibulation, less tissue is removed and a larger opening is left. The vast majority (85%) of genital cuttings performed in Africa consists of clitoridectomy or excision. The least radical procedure consists of the removal of the clitoral hood. In some traditions a ceremony is held, but no cutting of the genitals occurs. The ritual may include holding a knife next to the genitals, pricking the clitoris, cutting some pubic hair, or light scarification in the genital or upper thigh area.

TYPES

TYPE	DEFINITION	CLINICAL TERM
I	Removal of the clitoral hood with or without the removal of part of the clitoris or the entire clitoris	Clitoridectomy
II	Removal of both the clitoris and part or all of the labia minora	Excision
III	Removal or part or all of the external genitalia (clitoris, labia minora and labia majora) and the stitching of the two sides of the remaining labia together, so when the skin heals, it forms a bridge of scar tissue over the vagina. A small opening is preserved for the passage of urine and menses (sometimes the size of a match head or the tip of the small finger).	Infibulation
IV	A group of other procedures on the external genitalia, including pricking, piercing, stretching or incising the clitoris or labia or both; cauterization; incision to the vaginal wall; scraping or cutting or both of the vagina and surrounding tissues; and/or the introduction of corrosive substances or herbs into the vagina.	N/A

Appendix III: International Efforts to End FGC

FGC first appeared on the agenda of the United Nations (UN) in 1958 within the context of the Universal Declaration of Human Rights (UDHR), and was followed by increased interest among international non-governmental organizations (NGOs) during the UN Decade for Women (1975-1985) which highlighted the status of women in developing countries. The Programme of Action of the UN World Conference on Women held in Copenhagen in 1980 called for urgent steps to combat negative traditional practices detrimental to women's health.

The 1979 WHO seminar in Khartoum, Sudan set the direction for international initiatives. Its recommendations, aimed mainly at the 10 governments from eastern and western Africa represented at the meeting, called for:

- the adoption of clear national policies in the eradication of FGC;
- the establishment of national commissions to coordinate the activities of various official bodies in the implementation of anti-FGC legislation;
- the enactment of legislation where appropriate; and
- the organization of public education and outreach involving health workers and traditional healers.

Additionally, African leaders and women's organizations were demanding that greater attention to be paid to harmful traditional practices. As a direct result, the UN Working Group on Traditional Practices Affecting the Health of Women and Children was created in 1984. Two regional seminars were organized by the UN in Burkina Faso (1991) and Sri Lanka (1994) to assess the human rights aspects of FGC and other traditional practices affecting women and children. These seminars - a forum for discussion between national officials, UN specialized agencies and NGOs - led to the 1994 Plan of Action for the Elimination of Harmful Traditional Practices Affecting the Health of Women and Children, which states that FGC "is a human rights violation and not only a moral issue... [It] is an expression of the societal gender subordination of women." The Plan of Action contains 62 measures for governments to take at a national level. Key among these requirements is:

- giving a clear undertaking to end traditional practices, and in particular FGM;
- ratifying and implementing relevant international instruments;
- drafting legislation prohibiting such practices; and
- creating bodies and mechanisms to ensure adopted policies are implemented.

At an international level, the Plan of Action recommends the inclusion and integration of FGC in the work of various UN specialized agencies and other UN bodies, including the Commission on the Status of Women and relevant treaty bodies such as the Committee on the Rights of the Child. It also urges NGOs to integrate and reinforce their activities.

In 1994, the International Conference on Population and Development (ICPD), held in Cairo, highlighted the intimate interconnections between women's health and women's human rights. The Conference declaration urged governments to prohibit FGC and to provide support to community organizations and religious institutions working to eliminate the practice.

The Cairo Conference was followed by the Fourth UN World Conference on Women, held in Beijing in 1995, which represented a historic attempt to overcome the traditional neglect and indifference surrounding women's human rights. The Beijing Declaration and Platform for Action underscored the obligations of governments to combat violence against women - including FGC - as a priority.

In April 1997, three UN agencies - the World Health Organization, United Nations Children's Fund and United Nations Population Fund - unveiled a Joint Plan to bring about a major decline in FGC within ten years, and to completely eradicate the practice within three generations. The plan emphasizes the need for a multi-disciplinary approach, and the importance of teamwork at a national, regional and global level, bringing together governments, political and religious institutions, international organizations and funding agencies. The basis for this cooperation at a country level would be national "inter-agency teams" supported by international organizations. The plan takes a three-pronged approach:

1) educating the public and law makers on the need to eliminate FGC;
2) "de-medicalizing" FGC - tackling it as a violation of human rights as well as a danger to women's health; and
3) working with the entire UN system to encourage every African country to develop a national, culturally specific plan to eradicate FGC.

This represented a welcome step toward greater integration and coordination of the activities of UN agencies on FGC. Now that recognition of FGC as a human rights issue has been reflected in international instruments, the challenge is to ensure that those instruments are translated into effective action at the national level. This goal can only be achieved in collaboration with the national and international NGOs who for years have been at the forefront of awareness raising, lobbying and other eradication efforts.

Appendix IV - USAID Policy on Female Genital Cutting (FGC)

Effective Date: 09/01/2000

1. Policy**:** By this guidance, USAID recognizes FGC as a harmful, traditional practice that violates the health and human rights of women and hinders development.

USAID opposes any practice of or support for Female Genital Cutting (FGC) and works toward the goal of total elimination of FGC. Under no circumstances does USAID support the practice of FGC by medical personnel.

As a highly sensitive and culturally specific problem, USAID believes that entire communities must be involved in efforts to eliminate FGC to create an enabling environment for change. This policy on FGC is designed to support the Agency Strategic Plan and other existing U.S. Government (USG) policies, in addition to supporting the international community's policies and efforts to reduce the incidence of FGC in the affected areas. While taking into account the Agency's staffing, programmatic, and financial constraints, USAID will undertake the following actions to ensure that the issue of FGC is effectively integrated into and deliberately considered within Agency policy, programs, and strategies:

a) Update the Agency strategy to guide future activities in the areas of health (especially reproductive health), human rights, education, gender, democracy, governance and other relevant areas;

b) Support indigenous NGOs, women's groups, community leaders, and religious organizations to ensure that eradication activities are culturally appropriate and will reach all stakeholders, including men and boys;

c) Acknowledge that, while USAID supports host country legislation against the practice of FGC, a successful elimination process is one that ends the demand for the practice. Therefore, USAID will continue to work in close partnership with indigenous groups at the community level, as well as with global and national policymakers, to promote broader education and dissemination of information on the harmful effects of FGC in order to reduce demand;

d) Establish a regular liaison with other develop a framework for research and advocacy that will enhance collaboration and coordination of elimination efforts, share lessons learned, and stimulate public understanding of FGC as a health-damaging behavior and a violation of fundamental human rights;

USAID has established an Intra-Agency Working Group on FGC that has taken the lead in building capacity and commitment to addressing FGC eradication. Members represent Africa Bureau, the Center for Population Health and Nutrition, Office of Women in Development, Bureau for Policy and Program Coordination, and Bureau of Humanitarian Response. The Agency's approach is cross-sectoral, recognizing that FGC affects female reproductive health, the status of women, democracy and human rights.

2. Rationale:
FGC is a serious human rights violation of women and girls that has grave health consequences. It directly violates both Article 3, "Everyone has the right to life, liberty, and security of person," and Article 5, "No one shall be subjected to torture or to cruel, inhuman, or degrading treatment or punishment," of the Universal Declaration of Human Rights. As it is indicative of women's subordination, it further violates the Universal Declaration's Article 7, "All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination." Although FGC occurs primarily in Africa, its practice is not confined to that continent. Through migration, it has spread to Europe and North America; minority groups in some Asian countries (e.g., India, Indonesia) also practice it. In affected countries, FGC is typically required for women and girls during childhood or before marriage. It is considered by the international community, under the United Nations Convention on the Rights of Child, a breach of the rights of children. The Convention stipulates: States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development (Art.32(1)).

Some of the short-term health consequences of FGC include pain, injury to adjacent tissue of the urethra, hemorrhage, shock, acute urine retention, infection, and failure to heal. Long-term complications include recurrent urinary tract infection, pelvic infections, infertility, keloid scars, dyspareunia, fistulae, and obstructed labor. The type and severity of complications depend on the type of FGC performed. Almost all of the practicing communities believe that FGC preserves the girl's virginity by diminishing sexual desire. For families in FGC-practicing countries, the ultimate goal of FGC is to render a woman marriageable. It is also believed that a circumcised woman will attract a favorable dowry, thus benefiting her family. Cited reasons for FGC also include giving pleasure to the husband, religious mandate, maintaining good health, and achieving good social standing. The practice is perceived as an act of love to daughters that will ensure full community recognition. When the medical complications noted above occur, they are not generally understood as having resulted from the practice of FGC.

The Agency has placed FGC elimination on its development agenda in response to:

a) The expressed needs of national governments, women's NGOs, and other African institutions. While governments and citizens of societies where FGC is practiced must take the initiative for eradication, it is clear that outside support is often desired and vital. USAID has offered assistance to local elimination efforts since the 1980s in response to stakeholder requests;

b) Unequivocal consensus reached at world conferences on the need to combat all forms of violence against women, including FGC;

c) Rising concern and demand for action by the Administration, the American public, and members of the U.S. Congress:
In June 1995, the House of Representatives passed a Sense of Congress Resolution Regarding Female Genital Cutting. This resolution urged the President to seek to end the practice of FGC worldwide, by "ensuring that all appropriate programs in which the U.S. participates include a component pertaining to FGC, so as to ensure consistency across the spectrum of health and child related programs conducted in any country in which FGC is known to be a problem." Congressional funding was made available that year to "develop and integrate, where appropriate, educational programs to eradicate FGC into [USAID's] population, education, and women in development activities." In September 1996, the practice of FGC was prohibited in the United States.

d) The United States' status as a signatory, along with the governments of most countries where FGC is practiced, to the International Conference on Population and Development Programme of Action (1994) and the Fourth World Conference on Women Platform for Action (1995). Both documents call for states to adopt policies/legislation to prohibit FGC and support efforts among community organizations to eliminate the practice. Furthermore, the Organization of African Unity has recently made a commitment to African NGOs to support elimination efforts.

ANNEX to USAID Policy on Female Genital Cutting (FGC):

Explanation of Terminology

Female Circumcision (FC), Female Genital Mutilation (FGM), Female Genital Cutting (FGC), Female Genital Surgeries (FGS) are all terms that have been used to refer to the tradition of altering female genitalia. Under current policy, USAID uses the neutral term, Female Genital Cutting (FGC). This decision has been prompted by the rejection of the term FGM by many practicing communities and activists who consider it judgmental, pejorative and not conducive to discussion and collaboration. Those who link activism against FGC to the colonial period consider the term FGM to be evidence of cultural imperialism.

Issues of identity, culture and other social norms are interwoven in the practice. Naming the tradition after its physical effects ignores the cultural underpinnings of FGC. Further, the practicing societies regard circumcision as a beautification process while the campaigns against FGC seek to convince those who practice FGC that it is "mutilation." Calling a woman 'mutilated' insults her and may lead to psychological trauma, particularly for young girls and women living in non-practicing societies. For those who practice FGC, it is considered a beneficial act. FGC renders a girl marriageable in societies where a woman's quality of life depends on her status as a wife and a mother, and a respectable woman who qualifies for a good status in her community even if she does not get married. The term "female genital mutilation" stigmatizes the practice to the detriment of the programs trying to change it.

Appendix V: FGC Donors' Working Group Table

Donor Organization	Country/Region	Type of Activity
The Ford Foundation	Middle East, North Africa (mainly Egypt), Yemen	Research, creation of task force; design and publication of materials; positive behavior change
The Public Welfare Foundation	Mali, Guinea, Burkina Faso, Senegal, Gambia, Kenya, Somaliland, Sudan, Somalia, Egypt	Technical assistance to local communities and grassroots organizations
The Wallace Foundation	Africa	Qualitative/programmatic research; advocacy; evaluation of activities; small-scale programs
The World Bank	Decided by individual country operations	Analysis of costs; integration of FGC; creating legal frameworks; advocacy
Department for International Development (DFID)	Africa Region	Policy and advocacy
UNICEF	Have country offices in almost all countries with FGC prevalence	Behavior change; evaluation and monitoring; in-country coordination; FGC database; establishing in-country networks
UNFPA	Have country offices in almost all countries with FGC prevalence	Policy; information and advocacy; integration and capacity-building; training of health workers in reproductive health
WHO	Africa, Eastern Mediterranean Region	Advocacy; research and development; support of national networks/organizations; support training of health professionals in prevention of FGC and consequence management
Netherlands	Ethiopia, Sudan	Global advocacy; policy changes through IAC and RAINBO

Appendix VI: Accomplishments to Date

The following are accomplishments and activities that have been undertaken during the year of 2003, and the funding for the projects described below has been obligated from FY03 budget.

A. Funded seven national/community based activities in FGC in high prevalence countries (with partners identified in parenthesis):

1. Establishment of an active multidisciplinary team to support Guinea's efforts in FGC abandonment and to decrease the medicalization of FGC in this country (WHO/AFRO).
2. Independent evaluation of Mali's FGC project funded by UNFPA and the Luxemburg government (PATH).
3. Additional technical support to the community based FGC program in Ethiopia (PRIME).
4. International Day "Zero Tolerance to FGM" held in Washington D.C. on February 6, 2004. A major advocacy event that raised awareness and augmented funding from other donor organizations (PRB).
5. Capacity building and dissemination of lessons learned from CARE's multi-country projects in the East Africa Region (Ethiopia, Sudan & Kenya) (FRONTIERS).
6. Capacity building and dissemination of lessons learned in the West Africa Region (Senegal & Guinea) (FRONTIERS).
7. Consortium of cooperating agencies to compile lessons learned and best practices in the abandonment of FGC that will be disseminated to implementing partner for application in country as well as the establishment of a database on FGC practices (PRB).

B. Provided technical leadership and disseminated lessons learned in national and international meetings (Senior Technical Advisor in FGC):

1. Provided technical direction on FGC policy and advocacy for 10 Anglophone countries, August 2003, Addis Ababa, Ethiopia.
2. Attended the Expert's Consultative meeting in June 2003 (Egypt) where legal tools in the prevention of FGC were drafted. Participated in the Cairo Declaration which presented guidelines to countries that wished to enact, implement and reinforce laws against FGC. Provided technical guidance to individual countries that expressed an interest in making statements against FGC.
3. Participated in the June 2002 WHO/AFRO regional workshop that developed country level action plan for 10 West African nations, Bamako, Mali.
4. Participated in the April 2002 scientific meeting of researchers on FGC – document that compiled the lessons learned and provided guidelines for research on this topic, Nairobi, Kenya.

C. Assumed the lead role in donor coordination activities on all topics related to FGC, its prevention and abandonment (Senior Technical Advisor to FGC):

- Participated and presented at the June 2003 FGC Donor Working Group meeting where USAID was formally asked to be the Secretariat of this international coordination body (Egypt).
- Presented USAID's policy and position in the February 2003 FGC International meeting, the largest ever gathering of First Ladies and their designees on the subject of FGC abandonment, Addis Ababa, Ethiopia. This landmark meeting saw over 30 countries formally declare their support for the concept of "zero tolerance" for the practice of female genital cutting.
- As the lead organizers of the FGC Donor's Working Group meeting to be held in April 2004 (Washington D.C.), initiated the dialogue and logistics that will bring together bilaterals, multilaterals and private foundations around a joint working plan in FGC for the coming years (Duration TBD).
- Compiled the FGC Donor Activity Matrix so that informed decisions can be made in funding gaps and in providing technical assistance to high prevalence countries.
- Managed a listserv on FGC, an activity that is heralded by the Donors Working Group as a resounding success and is the only international communication tool readily accessible for diverse partners and implementing agencies in all parts of the world.

D. Establishment of the International Network to Analyze, Communicate and Transform the Campaign Against FGC/FGM/FC (INTACT), a network of scholars, scientists, researchers and activists promoting FGC/M evidence-based research to accelerate positive social change. INTACT launched a non-profit web-site so that partners and implementing agencies who work in the field of FGC abandonment can have a web-based resource for evidence-based results in this field.

E. Organized an expert speaker series on FGC - its practice, lessons learned and success stories for the Washington-based activists and partners in FGC.

Technical Assistance at the country level (Senior Technical Advisor in FGC):

1. Guinea - Assisted the USAID mission in reviewing unsolicited proposals and in making informed decisions on funding rural community-based activities and projects in preventing FGC. In addition, assisted the mission with drafting its strategic plan for FGC elimination in Guinea.
2. Egypt - Fine tuned the in-country program using best practices and the latest global findings on strategies for FGC abandonment.
3. Senegal - Worked with the Population Council in evaluating the Tostan project.
4. Gambia - Met with the MOH and Ministry of Women's Affairs to address issues of FGC. Also attended a regional maternal mortality prevention

workshop organized by West African Health Organization where USAID presented its FGC policy and its successful programs on abandonment.

5. Mali - Met with the MOH on issues related to FGC and participated in the regional meeting of OB/GYNs on the topic. In addition, provided technical direction to the USAID-funded PRIME project on FGC.
6. Ethiopia - Worked with the Mission in integrating FGC within its reproductive health activities and within its broader bilateral health program implemented by Pathfinder. Monitored and provided technical assistance to the PRIME-funded FGC program. In addition, worked with the National Committee for the cessation of Harmful Traditional Practices affecting women in Ethiopia. Finally provided technical assistance to CARE on its community-based FGC programs.
7. Kenya – Worked with CARE in Somali refugee camps on prevention and mitigation of FGC amongst the resident populations.

Appendix VII: Acknowledgements

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