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Dynamics for the Effective Elimination of Female Genital Cutting in Senegal

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1 – BACKGROUND

- 140 million girls and women mutilated/circumcised;
- Risk of undergoing FGM/C faced by 3 million girls and women every year;
- 27 Countries in Africa and the Middle East/Arab World.

1 – CTD

FGM/C PREVALENCE (15 – 49) Source: PRB, 2008

- **Benin: 12.9%**
- **Egypt: 95.8%**
- **Ethiopia: 74.3%**
- **Gambia: 78.3%**
- **Ghana: 3.8%**
- **Kenya: 32.2%**
- **Mali: 85.2%**
- **Nigeria: 19%**
- **Uganda: .6%**
- **Senegal: 28.2%**
- **Yemen: 38.2%**

- Burkina Faso: 76.6%
- Cameroon: 1.4%
- Chad: 44.9%
- Ivory Coast: 36.4%
- Djibouti: 93.1%
- Eritrea: 88.7%
- Guinea: 95.6%
- Guinea Bissau: 44.5%
- Mauritania: 71.3%
- Niger: 2.2%
- RCA: 35.9%
- Sierra Leone: 94%
- Somalia: 97.9%
- Sudan: 90%
- Tanzania: 14.6%
- Togo: 5.8%

1 – CTD

1) Twenty year-old Initiative in Senegal (1988);
2) Development/Implementation of an Experimental Program of Informal Education by TOSTAN for increasing the literacy rate in rural areas in Senegal (using local language/Pulaar);
3) Initial step of 20 villages in the Southern part of Senegal known for high prevalence of FGM/C;
4) Popularity of the Program with local communities / Request to TOSTAN from local authorities for extending the program to more communities;
5) Starting point for Social Gathering/Resource Mobilization for abandoning FGM/C including Early Marriage in areas in Senegal where it was practiced by 80% of women.

2 – THE SENEGALESE INITIATIVE

1. Mobilization/involvement of Strategic Partners including MoH/Family, Representatives from local/selected communities, Community Based Organizations (CBOs), Civil Society Groups including Human and Civil Rights Networks (RADHO), USAID, Population Council, UNICEF, Etc.;
2. Development of a Basic Education Program called ***VILLAGE EMPOWERMENT PROGRAM (VEP)*** as part of a scale-up effort;
3. Development of Training Curricula with focus on four modules: a) Hygiene, b) Problem Solving, c) Women's Health, and d) Human Rights (HR).

2 – CTD

4. Emphasis was placed on empowering the participants (who were mostly women) to analyze more effectively their own situation and thus find the best solutions for their communities;
5. A Social Mapping Study / 90 communities were selected in the Southern part of Senegal where the prevalence of FGM/C is high;
6. TOSTAN sought and received funding from GTZ for implementing the VEP.

3 – PROGRAM IMPLEMENTION

1. Informing the traditional and religious leaders and the elected politicians of the area about project activities;
2. Cooperation with, and building capacity of a local NGO and CBOs to carry out the VEP;
3. Selection of coordinators, facilitators and supervisors from the communities participating in the program;
4. Classes, each of two hours, were held three times a week during the implementation process, covering Human Rights, Problem Solving and Hygiene;
5. One facilitator per community trained 30 participants in each community in local languages (Pulaar and Mandingo);
6. Follow-up of the classes in all 90 villages was undertaken by the coordinator, the supervisors, and by members of CBOs involved in the process;
7. A total of 2,339 women and 221 men participated in the program.

3 – CTD

8. During the rainy season, participants were given books to help them revise and remember what they had learned in their classes; they also carried out awareness/social mobilization activities;
9. Setting up and training Community Management Committees (CMC) to manage project activities and to ensure that progress can be sustained;
10. Participating villages established committees to coordinate classes and related public events, and class participants were encouraged to share their new knowledge with others in their villages;
11. Inter-village meetings were held by the CMC in support of the VEP aims to exchange experiences and to take and confirm decisions concerning collective actions;
12. Choosing 10 neighboring villages in each targeted area to pursue social transformation of the area.
13. Information and social mobilization activities were held in the 90 villages and in other neighboring communities, supported by MoH and other local partners.

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4 – PROGRAM EVALUATION

An Evaluation took place as a key component of the VEP

1. Assess the effect of the VEP on people's knowledge, beliefs and attitudes concerning RH and HR issues;
2. Assess the effect of the VEP on people's awareness of the negative consequences and HR issues associated with FGM/C;
3. Assess the combined effects of the VEP and community mobilization activities on the willingness of community members to abandon the practice of FGC;
4. Determine the factors that lead to changes in social attitudes towards FGM/C.

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4 – PROGRAM EVALUATION (CTD)

A quasi-experimental design

Target Areas

20 selected villages into the intervention zone;

20 comparison villages that did not receive the VEP;

Target groups

1. Women and men directly exposed to the intervention *(those who participated in the education program)*;
2. Women and men indirectly exposed to the intervention *(those living in villages where the education program was implemented but who did not themselves participate in the program)*;
3. Women and men not exposed to the intervention *(those living in the comparison villages)*.

4 – PROGRAM EVALUATION (CTD)

1) Representative samples of program participants, non-participants and residents in the comparison villages were recruited for the evaluation process;
2) It was estimated that approximately 30 women per village would participate in the program, thus giving a total of 600 women for the group of 20 intervention villages;
3) In addition, a maximum of ten men per village were included in the program, giving a total of 200 men for the group of 20 intervention villages;
4) These two groups of respondents were to be followed over time, with the same group of individuals interviewed at baseline, immediately post-intervention and at endline.

4 – PROGRAM EVALUATION (CTD)

1. Compared changes in knowledge, attitudes, and behavior of men and women in 20 villages in the intervention area (including both study participants and non-participants) with those living in 20 non-intervention villages;
2. Changes were measured using pre and post intervention surveys of women and men in the intervention and control areas (including non participating men and women in the intervention villages);
3. Qualitative interviews with key community members (including traditional excisors, healers, and local civic and religious leaders);
4. Assessed pre and post-intervention changes in the number of girls under 10 who had been cut (to test the impact of the program on community members' willingness to abandon FGM/C).

5 – FINDINGS AND PROGRAM IMPACTS

1. VEP significantly increased the awareness of women and men about human rights, gender-based violence, FGM/C and RH;
2. The consequences of FGM/C were better known, as were issues concerning contraception, pregnancy surveillance and child survival;
3. Women's knowledge improved more than men's, except for STI/HIV;
4. Diffusion of information from the VEP within villages worked well, as other women and men living in the intervention villages also increased their knowledge on most indicators.

5. Communities have mobilized around maintaining peace and reducing discrimination, through establishment of committees for peace and management of conflicts;
6. A Forum was organized by young girls who expressed strongly their opposition to FGM/C, and Early and Forced Marriage;
7. Public Declarations to support abandonment of FGM/C took place to reinforce the above mentioned changes in attitudes and behavior:
   - **First Public Declaration** against FGM/C, Early and Forced Marriage involved 300 villages in June 2, 1998;
   - **Second Declaration** held on November 27, 1999 including 105 villages;
   - **Third Declaration** on March 25, 2001 including 108 villages;
   - **Fourth Declaration** was organized on June 5, 2002, with 300 villages;
8. In June 2009 in Senegal, **3464** villages already Publicly Declared the end of FGM/C into their respective communities.

6 – LESSONS LEARNED

6.1 – Determine Goals and Tailor Approaches

6.2 – Use a Multi-Faceted Approach

6.3 – Engage Key Partners

LESSONS 6.1 – DETERMINE GOALS AND TAILOR APPROACHES

Determine Goals and indicators

1. It is vital to clearly determine the goals of any anti-FGM/C intervention before implementation, through setting benchmarks for success, including appropriate indicators, and planning to evaluate the effects rigorously;
2. Well-designed projects that are informed by empirical evidence and designed to allow strong scientific evaluation are crucial if valid conclusions are to be made regarding their effectiveness;
3. Challenges in measurement of abandonment of FGM/C exist because of difficulties in confirming the validity of people reporting whether or not the practice has taken place; denial of the practice is common in situations where the practice is illegal or socially unacceptable;
4. Measuring progress with, and understanding the social dynamics of, the process by which abandonment of FGM/C happens is critical in order to make conclusions that can be useful to communities and program managers.

LESSONS 6.1 – CTD

Abandon the practice or only make it safer?

1. Anti-FGM/C campaigns that focus solely on the negative health consequences of FGM/C have, in some cases, inadvertently led to the practice being undertaken by health personnel (termed "medicalization") and to less severe forms of cutting, rather than communities giving up the practice;
2. Health providers must be made aware that practicing FGM/C abuses the human rights of girls and goes against medical ethics, and so they must be supported to resist the financial motivation to provide medicalized cutting.

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LESSONS 6.1 – CTD

Interventions and goals should match a community's readiness for social change.

1. FGM/C is practiced for a variety of reasons that can differ by ethnic group even within the same country;
2. It is essential, therefore, to tailor any intervention to address the community's rationale for FGM/C and to take into account its readiness to openly question and address the issue;
3. Where questioning is already underway within a community, assertive advocacy strategies may add momentum to ongoing social change;
4. Where communities continue to strongly support FGM/C, efforts to encourage abandonment should stimulate community-wide discussions about the socio-cultural reasons for cutting, by identifying reasons why it is a harmful practice.

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LESSONS 6.2 – USE A MULTI-FACETED APPROACH

Multi-Faceted Approaches

1. The most effective approaches for the abandonment of FGM/C are multi-faceted, intervening at many strategic points and promoting a different norm publicly;
2. A community-led education program using a holistic approach can accelerate a collective decision to abandon FGM/C;
3. Interventions to eliminate FGM/C within existing community-based reproductive health care projects can increase knowledge of the harmful physical, social, and psychosexual effects of FGM/C, elicit public debate on the practice and public declaration of abandonment.

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LESSONS 6.2 – CTD

Reducing Social Support for the Practice

1. Understanding the socio-cultural context and the rationale for the timing and type of cutting practiced by a community is essential before activities to stimulate abandonment are initiated;
2. Approaches that focus only on seeking to "convert" practitioners through education and providing alternative revenue or the passage of laws to criminalize the practice are not sufficient because they do not address the underlying social norms supporting FGM/C;
3. Focus on reducing social support for the practice rather than abandonment by practitioners.

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LESSONS 6.2 – CTD

Laws against FGM/C

1. Laws against FGM/C are an important policy commitment and create an enabling environment. When adequately implemented their impact on the abandonment of FGM/C is effective;
2. The law needs to be preceded and complemented by education campaigns and advocacy and sensitization of leaders;
3. Implementing laws against FGM/C is an effective component of change.

LESSONS 6.2 – CTD

- Ghana 1994
- Senegal 1999
- Benin 2003
- The Gambia 2009

- Guinea 1965
- Republic of CA 1966
- Burkina Faso 1995
- Djibouti 1995
- Ivory Coast 1997
- Tanzania 1998
- Togo 1998
- Niger 2003

LESSONS 6.3 – ENGAGE KEY PARTNERS

- Use the media: Public discussion of FGM/C, led by respected community leaders and supported through intensive media campaigns, can help communities to openly question and confront this traditional norm;
- Confrontation of longstanding cultural norms is facilitated by existing changes of generation, migration, education and the globalization of the culture facilitated by media;
- In areas where the practice of FGM/C is entrenched through a belief, the engagement of credible traditional and religious leaders as advocates for total abandonment of the practice (and not reduction in severity or medicalization) is a critical and absolutely necessary initial step.

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LESSONS 6.3 – CTD

- Health providers are an important potential resource in campaigns to eradicate FGM/C, but a concerted effort is needed to ensure that they can become effective behavior change agents;
- Addressing providers' attitudes and enhancing their communication skills is crucial so that they can advocate against FGM/C and become effective change agents within their community.

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