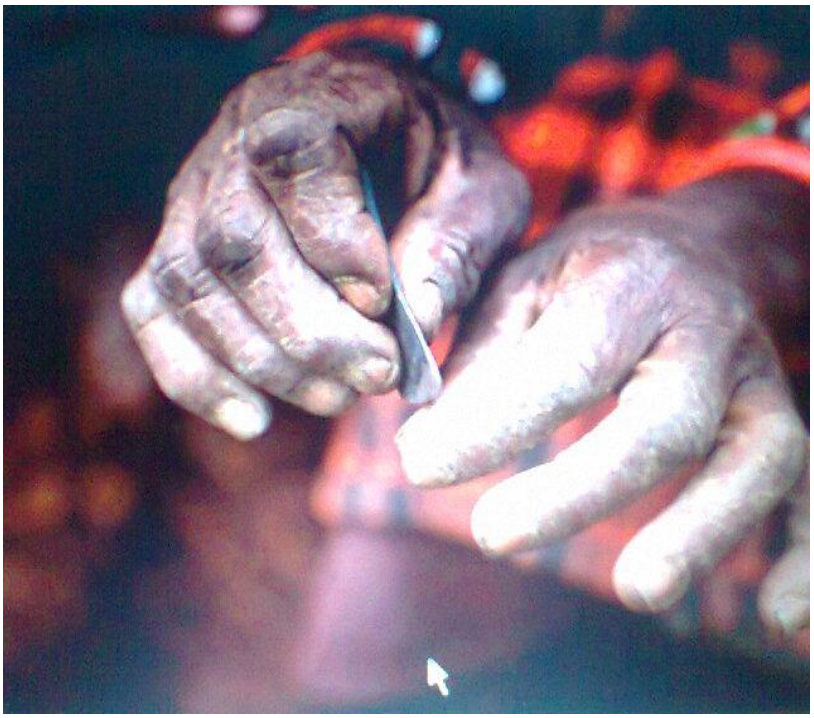
FGM is one of the most important underlying causes of the lack of progress on the MDGs in sub-Saharan region, Special insight and focus on Human rights and MDGs in North Eastern Uganda



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Acknowledgements

I thank the PROYECTO KALÚ: Humanitarian Aid Studies Centre - Centro de Estudios en Ayuda Humanitaria which has given us the opportunity to study Master's in International Cooperation and Humanitarian Aid programme. Special thanks to the Professors and Administrator Sandra Manrique, Baron, Alberto Martos, Francisco José Muñoz Berenguel, Marilise Turnbull , Ignacio Cristobal Alcarraz and Marie-Jeanne Perreletfor having contributed to the knowledge base from which this concept note has been derived.

We appreciate the contribution of a number of people especially classmates and those who have played a big role in helping us with this research work.

I thank my classmates for the friendship and interaction and shared educative ideas during the tough times of the programme.

Thanks to the staff of the Reproductive Educative and Community Health programme (REACH); the Sabiny Elders Association (SEA); the Uganda Human Rights Commission; UNFPA and Care Canada Gender Specialist Insight and all the other informants who were contacted during the process of data collection. Your contribution to this study is appreciated and we pray and hope that the dream to see an end to a painful practice will be realised.

Executive summary

Apart from FGM, being a Gender Based Violence act, it is a dangerous practice and violation of human rights for Infants, young girls and women, huge a hindrance to attaining the millennium development goals MDG 3, 4, 5 and 6.

Female genital mutilation/cutting/circumcision (FGM or FGC) are terms used to incorporate a wide range of traditional practices that involve the partial or total removal of the external female genitalia basically for traditional and cultural reasons in mostly African societies.

This concept paper is to document to what extent FGMs **is** one of the most important underlying causes of the lack of progress on achieving MDGs with a special focus on the community tribes in the North Eastern part of the Republic of Uganda.

This study is partially a desktop and field research conducted by gathering literature with a focus on the community tribes in the North Eastern part of the Republic of Uganda and organisations working to eliminate the practice. In executing this study, both qualitative and quantitative methods were used. Mostly secondary data was also used in this study medical literature, International agencies and Ugandan advocate and traditional cultural literature.

The findings indicated that there are still divided opinions about female genital cutting among the community tribes in the North Eastern part of the Republic of Uganda after criminalizing the practice. There are those who do not regret abandoning the practice, while others regret abandoning their culture, livelihood as source of income with empty promises of alternative Income generating activities by the government and local community initiative groups.

A big segment of the local community, together with the Uganda Government and the international boards like UN agencies and INGOs are involved in efforts to bring about change in the community by eliminating the tradition.

Perceptions held by those who are in favor of the practice are based on a number of motivating factors, tradition norms topping the list and as an economic livelihood means. There are various efforts that are being employed by the local community as well as Ugandan government to eliminate the tradition including enacting anti FGM law. In 2008 Uganda parliament passed a bill abolishing FGM and practicing is punishable by law as a result of these efforts, there has been a change in the community; however this does not yet mean that the tradition has been eliminated.

Interagency Statement expresses the common commitment of these organizations to continue working towards the elimination of female genital mutilation. Female genital mutilation is a dangerous practice, and a critical human rights issue.

"Progress has been achieved on a number of fronts: female genital mutilation is internationally recognized as a violation of human rights; a global goal to end the practice has been set by the United Nations General Assembly Special Session on Children (UN General Assembly, 2002); policies and legislation to prohibit the practice have been put in place in many countries; and, most importantly, there are

indications that processes of social change leading to abandonment of the practice are under way in a number of countries.

We now have more knowledge about the practice itself and the reasons for its continuation, as well as experience with interventions that can more effectively lead to its abandonment. Application of this knowledge through a common, coordinated approach that promotes positive social change at community, national and international levels could lead to female genital mutilation being abandoned within a generation, with some of the main achievements obtained by 2015, in line with the Millennium Development Goals.

The United Nations agencies confirm their commitment to support governments, communities and the women and girls concerned to achieve the abandonment of female genital mutilation within a generation".

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CEDAW	Convention on Elimination of all Forms of Discrimination against Women
ARP	Alternative Rights of Passage
CRC	Convention on the Rights of the Child
FGC	Female Genital Cutting/Circumcision
FGD	Focus Group Discussion FGM Female Genital Mutilation
FORWARD	Foundation for Women's Health & Development
HIV	Human Immune-Virus
INGOs	International Non Governmental Organisations
MDGs	Millennium Development Goals
NGOs	Non Government Organizations
PATH	Programme for Appropriate Technology in Health
REACH	Reproductive Educative and Community Health Programme
SEA	Sabiny Elders Association
UHRC	Uganda Human Rights Commission
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USE	Universal Secondary Education WHO World Health Organisation

CHAPTER ONE
Introduction

Definitions of concepts

Evolution FGM terminology

The terminology used for this procedure has undergone various changes. During the first years in which the practice was discussed outside practising groups, it was generally referred to as "female circumcision". This term, however, draws a parallel with male circumcision and, as a result, creates confusion between these two distinct practices.

The expression "female genital mutilation" gained growing support from the late 1970s. The word mutilation establishes a clear linguistic distinction from male circumcision, and emphasizes the gravity and harm of the act. Use of the word "mutilation" reinforces the fact that the practice is a violation of girls' and women's rights, and thereby helps to promote national and international advocacy for its abandonment.

In 1990, this term was adopted at the third conference of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, in Addis Ababa, Ethiopia. In 1991, WHO recommended that the United Nations adopt this term. It has subsequently been widely used in United Nations documents and elsewhere and is the term employed by WHO.

From the late 1990s the terms "female genital cutting" and "female genital mutilation/cutting" were increasingly used, both in research and by some agencies. The preference for this term was partly due to dissatisfaction with the negative association attached to the term "mutilation", and some evidence that the use of that word was estranging practising communities and perhaps hindering the process of social change for the elimination of female genital mutilation.

To capture the significance of the term "mutilation" at the policy level and, at the same time, to use less judgmental terminology for practicing communities, the expression "female genital mutilation/cutting" is used by UNICEF and UNFPA.

For the purpose of this Interagency Statement and in view of its significance as an advocacy tool, all United Nations agencies have agreed to use the single term "female genital mutilation".

Sexual and Gender Based Violence Prevention and Response, Northern Uganda – Care International Note

Sexual and gender based violence prevention and response in Northern Uganda was a six month (July-December 2007) CARE Uganda Project that addressed the need for mobilizing communities to prevent and respond to the increasing cases of violence and abuse of women and girls based on sex and on gender.

In partnership with other stakeholders, CARE sake to initiate and scale up gender based violence prevention and response activities in 15 camps in Gulu, Amuru and Pader districts. The main activities include awareness raising on rights of women and girls, advocacy for protection of rights, training in issues of SGBV prevention and advocacy, capacity building of local CBOs and NGOs involved in responding to SGBV, supporting provision of psychosocial support services to survivors including referral services for legal, medical and other appropriate services.

These activities were implemented in partnership with the district local governments of the three districts and two local Community Based Organisations based in Gulu and Pader.

CARE provided technical support to ensure adherence to international standards of sexual and gender based violence prevention and response. CARE also guided the partners in accountability, documentation, reporting and management of project activities within the changing security environment. CBOs are supported to establish community based SGBV monitoring and response

1.2 Statement of problem

As stated in the 2012 report of the Secretary General of the UN General Assembly on the Girl Child, ending FGM will contribute to the achievement of the MDGs and to the implementation of the Convention of the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women. Hence, development of legal, policy and prevention measures at community level to end FGM is necessary to the achievement of MDG 3, 4, 5 and 6.

Respect for human rights, equality between women and men, protection of the rights of the child should be on foremost road to achieving MDGs of Developing countries. These values should be promoted and enhanced in developing countries internal and external activities, policies and legislation.
They should ensure that comprehensive and tangible actions are taken to end violence against women and FGM as they directly challenge these values and impede progress on the MDGs.

In addition, the developing countries institutions need to ensure respect for human rights and coherence of developing countries' internal and external policies. A human rights based approach to development policies is necessary. Thus the work towards the achievement of the MDGs needs to take on board and to be strengthened by external human rights policies such as the EU guidelines on violence against women and girls and combating all forms of discrimination against them.

This inquiry seeks to document how female genital cutting is a violation of Human rights and special hindrance to the achievement of MDGs and to examine the initiatives developed by the local

communities in their struggle to fight and abandonment of this practice in Uganda. In addition, it is aimed at exploring the role played by Government in eliminating FGC.

1.3 OBJECTIVES

- To establish Female Genital Mutilation is a special hindrance to the achievement of MDG 3, 4, 5 and 6.
- To explore in-depth initiatives taken by the local community initiative groups in Uganda to enact law criminalising and abolish the practice.

1.4 Specific guidance questions

- What is the relationship between MDGs 3, 4, 5 & 6 and female genital mutilation?
- What is the relationship between Human rights and female genital mutilation?
- What initiatives have been put in place by the local community to abolish this practice?
- What should Ugandan Government do to enforce the law put in place criminalising female genital circumcision?

1.5 Study area and scope of the study

In our study area, we chose North Eastern Uganda where FGM practice is rampant in the communities of Sabiny and across the Uganda – Kenya Border.

The research gathered information on what the local community (organisations) were undertaking, in the struggle to end the practice as well as the various efforts being carried out by the Government. The informants included Sabiny girls and women, local organisation employees from the Reproductive Educative and Community Health Programme (REACH); the Sabiny Elders Association (SEA); and employees from the Uganda Human Rights Commission (UHRC). Other resource persons in Kapchorwa district were contacted like the Town Clerk and a health worker. Informants contacted were mainly Sabiny girls and women and also the opinion of men was sought.

1.6 Organisation of the Concept Note

My concept note is organised in seven chapters. Chapter one contains general introduction and definition information about the study in the global context; Chapter two contains literature published by different scholars on FGM; Chapter three presents the a brief note on MDGs Indicators; Chapters four presents FGM and Human Rights, Chapter five FGM and MDGs, Chapter six contain a special insight on how local community initiative groups resulted into Uganda government organs enact a law criminalizing FGM findings and Chapter seven contains the Conclusion and Recommendations of the study.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

2.1.1 Background of FGM

"Female Genital Mutilation/Cutting" (FGM/C) refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It is recognized internationally as a violation of the human rights of girls and women and constitutes an extreme form of discrimination against women due to the severe health consequences and the pain and risks involved.

Female Genital Mutilation/Cutting (FGM/C) is a harmful traditional practice with severe health complications, deeply rooted not limited to only Sub-Saharan African countries.

WHO calculates that between 100-140 million women and girls in the world have been victims of some kind of FGM/C and that each year about 3 million girls are at risk or are subjected to some kind of FGM/C, essentially in 28 countries in sub-Saharan Africa, northern Iraq (Kurdistan), Malaysia and Indonesia, plus Europe, USA and Australia among many other countries where migrants carry along their culture.

In many societies it is a rite of passage to womanhood with strong, ancestral sociocultural roots. Rationalizations for the perpetuation of FGM/C include: preservation of ethnic and gender identity, femininity, female purity/virginity and "family honour"; maintenance of cleanliness and health; and assurance of women's marriage ability

The WHO/UNICEF/UNFPA Joint Statement classified female genital mutilation into four types. Experience with using this classification over the past decade has brought to light some ambiguities.
The present classification therefore incorporates modifications to accommodate concerns and shortcomings, while maintaining the four types (see Annex 2 for a detailed explanation and proposed sub-divisions of types).

Classification of FGM
Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and a positioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

About 28 countries in Africa are said to be practicing FGM. According to *The Hosken Report* published in 1979, which showed a global review and country by country estimates of the prevalence of the practice, some countries like Somalia have an estimated prevalence of about 98% while countries like Uganda have an estimated prevalence of about 5% (Skaine 2005:36-37). The presence of increasing numbers of refugees and immigrants from countries where female genital mutilation is practised it is spreading in non practicing countries among the immigrant communities. Some of these countries include Norway, Denmark, Netherlands, Sweden, United Kingdom and France (WHO 1997b:3; WHO 1998:18-19).

2.2 FGM and Religion

While there is no religion that requires this practice, it is widely practiced in Morocco, Sierra Leone among the Muslims and among the orthodox Christians in Ethiopia. However this procedure is not practiced in Iran, Libya or Saudi Arabia which are Muslim countries, (Toubia 1995:21). In Uganda female genital cutting is practiced among the Sabiny for purely traditional reasons.

FGM in traditional African cultures and religions

Girls in Ancient Egypt

The traditional cultural practice of FGM predates both Islam and Christianity. A Greek papyrus from 163 B.C. mentions girls in Egypt undergoing circumcision but it is not widely accepted to have originated in Egypt and the Nile valley at the time of the Pharaohs. By Graeco-Roman times, however, it was an accepted practice. Evidence from mummies has not shown both Type I and Type III FGM present, although some sources dealing primarily with the modern issue state otherwise. (Note that the earliest evidence of male circumcision is also from Ancient Egypt.) Amnesty International says that the prevalence of the practice of FGM is unknown, and that the procedure is now only practiced by some Muslims and animists.

The U.S. Department of Health and Human Services states that the custom of FGM "cuts across religions and is practiced by Muslims, Christians, Jews and followers of indigenous religions."

Traditional African cleanliness

Medical justifications offered by cultural tradition are regarded by scientists and doctors as unsubstantiated. Some African societies consider FGM part of maintaining cleanliness, as it removes secreting parts of the genitalia. Vaginal secretions, in reality, play a critical part in maintaining female

health. Some Bambara and Dogon believe that babies die if they touch the clitoris during birth. In some areas of Africa, there exists the belief that a new born child has elements of both sexes. In the male body, the foreskin of the penis is considered to be the female element. In the female body, the clitoris is considered to be the male element. Hence when the adolescent is reaching puberty, these elements are removed to make the indication of sex clearer.

While there are differing rates of FGM prevalence in different religions like Islam and Christianity, prevalence rates also vary by culture. These variances preclude an unequivocal link between religion and FGM. However, there is debate as to whether FGM functions as a religious practice or a cultural one in particular religious subcultures.

Views in monotheistic religions

Christianity

FGM has never been part of Christianity as a faith system. There are no scriptural or doctrinal documents existing within the larger Christian tradition that even address the issue. The only contemporary examples of Christians practicing FGM are in Africa. As FGM rituals predated the missionaries' work in North Africa, many African tribes continue the practice as a matter of cultural tradition, unrelated to religious belief.

Judaism

While Brit Milah is mandated by the Bible, and considered one of Judaism's most basic commandments, mention of female circumcision appears nowhere in Judaism. The *Oxford Dictionary of the Jewish Religion* states that female circumcision was never allowed in Judaism.

The minority Ethiopian Jewish community (Beta Israel) practice FGM in a non-religious ceremony. It may be performed only by a Jewish woman. Toubia (1995) states that," female circumcision is even mentioned in any religious text," and that scholars in Africa "would testify that in Africa traditional and tribal rituals commonly supersede religion". Many Ethiopian Jews who emigrate to Israel abandon the practice of FGM.

Islam

In Islamic texts, FGM is referred to as *khafḍ* (Arabic: خفض) or *khifaḍ*[1] (Arabic: خِفَض). According to McAuliffe, female genital cutting is not commanded by the Qur'an, however, Type 1 circumcision (also called Sunna Circumcision) is practised by many Sunni Muslims although it has a controversial religious basis in Islam, and is mainly derived from culture. Cultural and religious intertwining caused the incorrect belief that female circumcision is related to the religion of Islam.

Sheikh Ali Gomaa has stated that "excision is a practice totally banned by Islam because of the compelling evidence of the extensive damage it causes to women's bodies and minds."

In May of 2012 it was reported by several news sources that the Muslim Brotherhood in Egypt was working to decriminalize female circumcision (FGM). According to reporter Mariz Tadros, "in Egypt the Muslim Brotherhood have offered to circumcise women for a nominal fee as part of their community services, a move that threatens to reverse decades of local struggle against the harmful practice. ... The Brotherhood's strategy to undermine the national campaign to end FGM is three-pronged. Firstly, they contest the notion that the practice is not religiously prescribed. Many of the Brothers (and Salafis) argue that while it is not mandatory, it is nevertheless *mukarama* (preferable, pleasing in the eyes of God). They also quote *hadith* (saying attributed to the Prophet) which stipulates that FGM should involve "cutting, but only lightly". Renowned Egyptian Islamist scholars such as Mohammed Emara and Mohammed Selim el Awa (the latter a presidential hopeful) have written and publicly endorsed the position that FGM is not an Islamic practice, and that there is nothing in Islamic jurisprudence to endorse it - most Muslim countries, including Saudi Arabia, do not practice FGM. However, among the Muslim Brotherhood rank and file there is no consensus on rejecting the practice."

Sunni view

None of the four Sunni schools of law (Madhhab) speaks explicitly out against or in favor of female genital mutilation. There are dichotomous differences of opinion among Sunni scholars in regards to female genital cutting. These differences of opinion range from forbidden to obligatory. The debate focuses around a hadith from the Sunni collections. One narration states that "a woman used to perform circumcision in Medina. Muhammad said to her, 'Do not cut severely as that is better for a woman and more desirable for a husband.'" Abu Dawood, who relates the narration in his collection, states the hadith is poor in authenticity. Ibn Hajar al-Asqalani describes this hadith as poor in authenticity, and quotes Imam Ahmad Bayhaqi's point of view that it is "poor, with a broken chain of transmission" Zein al-Din al-Iraqi points out in his commentary on Al-Ghazali's Ihya ulum al-din (I:148) that the mentioned hadith has a weak chain of transmission." Yusuf ibn Abd-al-Barr comments: "Those who consider (female) circumcision a sunna, use as evidence this hadith of Abu al-Malih, which is based solely on the evidence of Hajjaj ibn Artaa, who cannot be admitted as an authority when he is the sole transmitter. The consensus of Muslim scholars shows that circumcision is for men".

Imam Shams-ul-haq Azeemabadi asserts that, "[t]he Hadith of female circumcision has been reported through so many ways all of which are weak, blemished and defective, and thus it is unacceptable to prove a legal ruling through such ways."[While some scholars reject hadiths that refer to FGM on grounds of inauthenticity, other scholars argue that authenticity alone does not confer legitimacy. One of the sayings used to support FGM practices, is the hadith (349) in *Sahih Muslim*: Aisha narrated an authentic hadith that the Prophet said: "When a man sits between the four parts (arms and legs of his wife) and the two circumcised parts meet, then ghusl is obligatory." Dr. Muhammad Salim al-Awwa, Secretary General of the World Union of the Muslim Ulemas, states that while the hadith is authentic, it

is not evidence of legitimacy. He states that the Arabic for "the two circumcision organs" is a single word used to connote two forms; however the plural term for one of the forms is used to denote not two of the same form, but two different forms characterized as a singular of the more prominent form. For example, in Arabic, the word with the female gender can be chosen to make the dual form, such as in the expression "the two Marwas", referring to the two hills of As-Safa and Al-Marwa (not "two of the same hills, each called Al-Marwa") in Mecca. He goes on to state that, while the female form is used to denote both male and female genitalia, it is identified with the prominent aspect of the two forms, which, in this case, is only the male circumcised organ. He further states that the connotation of circumcision is not transitive. Dr. al-Awwa concludes that the hadith is specious because "such an argument can be refuted by the fact that in Arabic language, two things or persons may be given one quality or name that belongs only to one of them for an effective cause." [e.g the usage in "Qur'an in Surah Al-Furqan(25):53", "bahrayn" is the dual form of "bahr" (sea) meaning "sea (salty and bitter) and river (sweet and thirst-allaying)", and not "two seas"].

In March 2005, Dr Ahmed Talib, Dean of the Faculty of Sharia at Al-Azhar University, stated: "All practices of female circumcision and mutilation are crimes and have no relationship with Islam. Whether it involves the removal of the skin or the cutting of the flesh of the female genital organs... it is not an obligation in Islam." Both Christian and Muslim leaders have publicly denounced the practice of FGM since 1998. A conference at Al-Azhar University in Cairo (December 2006) brought prominent Muslim clergy to denounce the practice as not being necessary under the umbrella of Islam. Although there was some reluctance amongst some of the clergy, who preferred to hand the issue to doctors, making the FGM a medical decision, rather than a religious one, the Grand Mufti Ali Jumaa of Egypt signed a resolution denouncing the practice.

In Mauritania, where "health campaigners estimate that more than 70 percent of Mauritanian girls undergo the partial or total removal of their external genitalia for non-medical reasons", 34 Islamic scholars signed a fatwa banning the practice in January 2010. Their aim was to prevent people from citing religion as a justification for genital mutilation. The authors cited the work of Islamic legal expert Ibn al-Hajj as support for their assertion that “such practices were not present in the Maghreb countries over the past centuries". FGM is "not an instinctive habit, according to the Malkis; therefore, it was abandoned in northern and western regions of the country," added the authors.

2.3 Social Theory and Female Genital Mutilation

Female genital mutilation is a deeply rooted historical, cultural and religious tradition that has been the subject of considerable debate. Baron and Denmark (2006:339), argue that from a human rights point of view it is an unsafe and unjustifiable practice that violates bodily integrity; and feminists argue that it is an inhumane form of gender-based discrimination that capitalises on the subjugation of women, yet nations that endorse the practice define it as an integral feature of the culture.

In social theory, the intention to perform a particular act is seen as a consequence of the relative weight of attitudes and normative considerations. Packer (2005:224) argues that attitudes are determined by

beliefs about the consequences of a particular behavior. Normative considerations consist of social pressure to perform or not to perform a particular behavior. The norms on which these considerations are based are communicated by important „others through socialisation and social interaction and the individuals' motivation or desire to comply with these (ibid).

Similarly Barth (1982:14) argues that human behavior is shaped by consciousness and purpose. It is explained by the utility of its consequences in terms of values held by the actor and the awareness on the part of the actor of the connection between an act and its specific results. The perception of other people in the community shapes one's behaviour and way of life.
Jenkins says that,

> "*Individuals are unique and variable, but selfhood is thoroughly socially constructed: in the processes of primary and subsequent socialisation, and in the ongoing processes of social interaction within which individuals define and redefine themselves and others throughout their lives" (Jenkins 1996:20-21).*

Socialisation therefore plays an important role in the development of values and this affects the way people behave later in life.

Change and mutability are endemic in all social identities but they are more likely for some identities than others. In cases where locally perceived embodiments is a criterion of any social identity, fluidity maybe the exception rather than the rule (Jenkins 1996:21). For the case of female genital mutilation, change is bound to be slow because of the fact that its justification is embedded in the culture of the people practicing it.

Individuals seek to comply with the belief they perceive the significant leaders of their community hold, notably that girls should be circumcised. The theories referred to above explicitly incorporate the influence of the immediate social context on individual behaviour, (Packer 2005:224). A web of socio-cultural norms where a person lives affects their behaviour and decision making, (ibid: 224-225). In Africa social and cultural norms remain strongly in favour of female circumcision. The family and community are the most significant transmitters and guardians of norms. It is through the family that the practice of female circumcision is maintained and upheld as a tradition, (ibid).

In looking at FGC the idea of universality and cultural relativism of human rights needs to be addressed. According to Kwateng-Kluvitse (2005:61), if human rights are not made universal, states could place their traditions and cultural practices above international standards. Cultural relativists however argue that efforts of international organisations like the UN to end the practice are dangerous examples of ethnocentric meddling.

2.4 Prevalence of FGM

WHO estimates that between 100 and 140 million girls and women worldwide have been subjected to one of the first three types of female genital mutilation (WHO, 2000a). Estimates based on the most recent prevalence data indicate that 91,5 million girls and women above 9 years old in Africa are currently living with the consequences of female genital mutilation (Yoder and Khan, 2007).

There are an estimated 3 million girls in Africa at risk of undergoing female genital mutilation every year (Yoder et al., 2004). Types I, II and III female genital mutilation have been documented in 28 countries in Africa and in a few countries in Asia and the Middle East (see Annex 3).

Some forms of female genital mutilation have also been reported from other countries, including among certain ethnic groups in Central and South America.

Growing migration has increased the number of girls and women living outside their country of origin who have undergone female genital mutilation (Yoder et al., 2004) or who may be at risk of being subjected to the practice.

2.4.1 Prevalence scale of FGM

The prevalence of female genital mutilation has been estimated from large-scale, national surveys asking women aged 15–49 years if they have themselves been cut.

The prevalence varies considerably, both between and within regions and countries (see Table 1 and Figure 1), with ethnicity as the most decisive factor.

In seven countries the national prevalence is almost universal, (more than 85%); four countries have high prevalence (60–85%); medium prevalence (30–40%) is found in seven countries, and low prevalence, ranging from 0.6% to 28.2%, is found in the remaining nine countries. However, national averages (see Annex 3) hide the often marked variation in prevalence in different parts of most countries (see Figure 1).

Table 1: Estimated prevalence of female genital mutilation in girls and women per country

Country	Year	Estimated prevalence of female genital mutilation in girls and women 15 – 49 years (%)
Benin	2001	16.8
Burkina Faso	2005	72.5
Cameroon	2004	1.4
Central African Republic	2005	25.7
Chad	2004	44.9
Côte d'Ivoire	2005	41.7
Djibouti	2006	93.1
Egypt	2005	95.8
Eritrea	2002	88.7
Ethiopia	2005	74.3
Gambia	2005	78.3
Ghana	2005	3.8
Guinea	2005	95.6
Guinea-Bissau	2005	44.5
Kenya	2003	32.2
Liberia*		45
Mali	2001	91.6
Mauritania	2001	71.3
Niger	2006	2.2
Nigeria	2003	19
Senegal	2005	28.2
Sierra Leone	2005	94
Somalia	2005	97.9
Sudan, northern (approximately 80% of total population in survey)	2000	90
Togo	2005	5.8
Uganda	2006	0.6
United Republic of Tanzania	2004	14.6
Yemen	1997	22.6

* The estimate is derived from a variety of local and sub-national studies (Yoder and Khan, 2007).

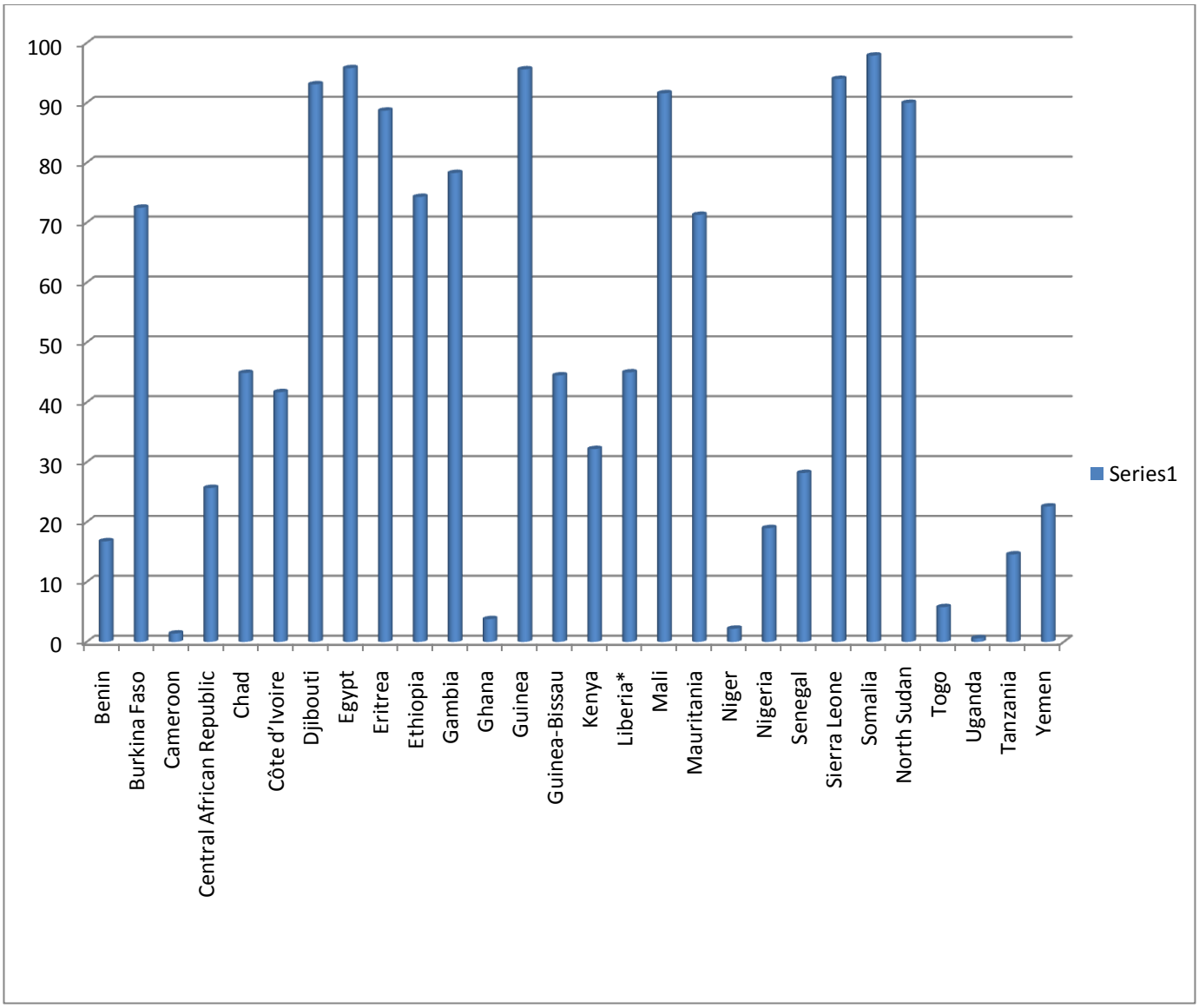

Figure 1: Estimated prevalence of female genital mutilation in girls and women per country

2.4.2 Target Age group

Female genital mutilation is mostly carried out on girls between the ages of 0 and 15 years. However, occasionally, adult and married women are also subjected to the procedure. The age at which female genital mutilation is performed varies with local traditions and circumstances, but is decreasing in some countries (UNICEF, 2005a).

Table 2: Prevalence % of female genital mutilation categories per

COUNTRY	PREVALENCE (%)	TYPE PERFORMED
Benin	16.8	II
Burkina Faso	76.6	II – Performed throughout the country in all but a few provinces.
Cameroon	1	I, II
Central African Republic	35.9	I, II
Chad	44.9	II – Widely practiced in all parts of Chad.III – Confined to areas bordering Sudan in the eastern part of the country.
Cote d'Ivoire (Ivory Coast)	44.5	II
Djibouti	90-98	II – Performed on girls of Yemeni origin.III – Most common among the Issa and Afar.
DRC (Congo)	Unknown	II
Egypt	97.3%	I, II, III
Eritrea	88.7	I, II, III
Ethiopia	79.9	I – Commonly practiced among Amharas, Tigrayans and the Jeberti Muslims living in Tigray. II – Most commonly practiced form. The Gurages, some Tigrayans, Oromos and the Shankilas practice this form. III – Practiced in the eastern Muslim regions bordering Sudan and Somalia. IV – Referred to as "Mariam Girz" in Ethiopia, it is practiced mainly in Gojam in the Amhara region.
Gambia	60-90	I – The Sarahulis perform this on girls one week after birth. The Bambaras perform the procedure on girls between 10-15 years of age. II – Nearly all Mandinkas, Jolas and Hausas practice this form on girls 10-15 years old. III – The Fulas perform a procedure similar to Type III that is described as "vaginal sealing" on girls from one week old to 18 years old. IV – The Fulas perform this type on girls from one week old to 18 years old.

Ghana	5.4	I, II, III
Guinea	98.6	I, II, III, IV
Indonesia	100	I, IV
Kenya	32.2	I and II most common. III – found in the far eastern areas bordering Somalia.
Liberia	50	II
Mali	91.6	I, II, III (Type III practiced in southern areas of country)
Mauritania	71.5	I, II
Niger	4.5	II
Nigeria	19	I, II, III, IV (Type I and II more prominent in the south; Type III more prominent in north)
Senegal	28.2	II, III (Type II is most common)
Sierra Leone	80-90	II
Somalia	90-98	I – practiced mainly in the coastal towns of Mogadishu, Brava, Merca, and Kismayu. III – Approximately 80% of the circumcisions are this type.
Sudan	90	I, II, III (Type III is most common)
Tanzania	17.7	II, III
Togo	12	II
Uganda	5	No information available.
Yemen	22.6	II, III

Table and definitions compiled and authored by H. L. DIETRICH Source: www.fgmnetwork.org

Table 3: Similarities in Attitudes and Misconceptions toward Infant Male Circumcision in North America and Ritual Female Genital Mutilation in Africa

Clitoridectomy and Infibulation in Africa	Infant Male Circumcision in North America
"She loses only a little piece of the clitoris, just the part that protrudes. The girl does not miss it. She can still feel, after all. There is hardly any pain. Women's pain thresholds are so much higher than men's." "The parts that are cut away are disgusting and hideous to look at. It is done for the beauty of the suture."	"It's only a little piece of skin. The baby does not feel any pain because his nervous system is not developed yet." "An uncircumcised penis is a real turn-off. It's disgusting. It looks like the penis of an animal."
"Female circumcision protects the health of a woman. Infibulation prevents the uterus from falling out [uterine prolapse]. It keeps her smelling so sweet that her husband will be pleased. If it is not done, she will stink and get worms in her vagina."	"An uncircumcised penis causes urinary infections and penile cancer. It generates smegma and smegma stinks. A circumcised penis is more hygienic and oral sex with an uncircumcised penis is disgusting to women."
"An uncircumcised vulva is unclean and only the lowest prostitute would leave her daughter uncircumcised. No man would dream of marrying an unclean woman. He would be laughed at by everyone."	"An uncircumcised penis is dirty and only the lowest class of people with no concept of hygiene leave their boys uncircumcised."
"Leaving a girl uncircumcised endangers both her husband and her baby. If the baby's head touches the uncut clitoris during birth, the baby will be born hydrocephalic [excess cranial fluid]. The milk of the mother will become poisonous. If a man's penis touches a woman's clitoris he will become impotent."	"Men have an obligation to their wives to give up their foreskin. An uncircumcised penis will cause cervical cancer in women. It also spreads disease."
"A circumcised woman is sexually more pleasing to her husband. The tighter she is sewn, the more pleasure he has."	"Circumcised men make better lovers because they have more staying power than uncircumcised men."
"All the women in the world are circumcised. It is something that must be done. If there is pain, then that is part of a woman's lot in life."	"Men in all the 'civilized' world are circumcised."
"Doctors do it, so it must be a good thing."	"Doctors do it, so it must be a good thing."
Sudanese grandmother: "In some countries they only cut out the clitoris, but here we do it properly. We scrape our girls clean. If it is properly done, nothing is left, other than a scar. Everything has to be cut away."	My own father, a physician, speaking of ritual circumcision inflicted upon my son: "It is a good thing that I was here to preside. He had quite a long foreskin. I made sure that we gave him a good tight circumcision."

35 year old Sudanese woman: "Yes, I have suffered from chronic pelvic infections and terrible pain for years now. You say that all if this is the result of my circumcision? But I was circumcised over 30 years ago! How can something that was done for me when I was four years old have anything to do with my health now?"	35 years old American male: "I have lost nearly all interest in sex. You might say that I'm becoming impotent. I don't seem to have much sensation in my penis anymore, and it is becoming more and more difficult for me to reach orgasm. You say that this is the result of my circumcision? That doesn't make any sense. I was circumcised 35 years ago, when I was a little boy. How can that affect me in any way now?"

CHAPTER THREE: MDGs Indicators measurement

Secondary Data

Secondary information was used to gather information on the practice of female genital mutilation. This also related to efforts put in place to eliminate the practice. A number of reports and publications from various UN documents like, MDGs, UNPFA, UNICEF and WHO publications, reports from local organisations like REACH and Sabiny Elders Association were reviewed for policies and initiatives.

A substantive amount of information was also collected from newspapers articles and journals. It was especially useful for us that two major publishers released many reports on female genital mutilation during my fieldwork. As Stewart (1984:14) argues, secondary data provides a comparative tool for the research. This helped to compare existing data with raw data for purposes of examining differences or trends. However the limitation of using secondary data is that such information may be collected for purposes different from the current research (Stewart 1984:14).

Measuring progress towards the MDGs

Progress towards the eight Millennium Development Goals (MDGs) is measured through 21 targets and 60 official indicators. Most of the MDG targets have a deadline of 2015, using 1990 as the baseline against which progress is gauged. Country data are aggregated at the sub regional and regional levels to show overall advances over time. The composition of MDG regions and sub regions is based on United Nations geographical divisions, with some modifications necessary to create—to the extent possible—groups of countries for which a meaningful analysis can be carried out.

In addition to the MDG regional groupings, the report also shows data for sub regions in Africa, based on the classification adopted by the United Nations Economic Commission for Africa. Although the aggregate figures are a convenient way to track progress, the situation of individual countries within a given region may vary significantly from regional averages. Data for individual countries, along with the composition of all regions and sub regions, are available at http://mdgs.un.org.
See Annex 2 at the end of this report.

The basis for this analysis

Regional and sub-regional figures are compiled by members of the United Nations Inter- Agency and Expert Group on MDG Indicators (IAEG). In general, the figures are weighted averages of country data, using the population of reference as a weight. For each indicator, individual agencies were designated as official providers of data and as leaders in developing methodologies for data collection and analysis (see below for a list of contributing organizations).

Data are typically drawn from official statistics provided by governments to the international agencies responsible for the indicator. To fill data gaps, data for many of the indicators are supplemented by or

derived exclusively from data collected through surveys sponsored and carried out by international agencies. These include many

Reliability of the MDG Data

Country data are aggregated at the sub regional and regional levels to show overall advances over time. Although the aggregate figures are a convenient way to track progress, the situation of individual countries within a given region may vary significantly from regional averages.

In some cases, countries may have more recent data that have not yet become available to the relevant custodian agency. In other cases, countries do not produce the data required to compile the indicator, and the responsible international agencies estimate the missing values. Even when national data are available, adjustments are often needed to ensure international comparability. Data from international sources, therefore, often differ from those available within countries.

CHAPTER FOUR FGM AND HUMAN RIGHTS

4.0 FGM AND HUMAN RIGHTS

FGM, in any form, is recognized internationally as a gross violation of human rights of women and girls. Human rights—civil, cultural, economic, political and social—are codified in several international and regional treaties. The legal regime is complemented by a series of political consensus documents, such as those resulting from the United Nations world conferences and summits, which reaffirm human rights and call upon governments to strive for their full respect, protection and fulfilment.

The practice denies women and girls their right to: physical and mental integrity; freedom from violence; the highest attainable standard of health; freedom from discrimination on the basis of sex; freedom from torture, cruel, inhuman and degrading treatments; life (when the procedure results in death).

4.1 International instruments, Treaties and Consensus documents

These rights are protected in several international instruments, treaties and consensus documents, including:

International and regional sources of human rights

Strong support for the protection of the rights of women and girls to abandon female genital mutilation is found in international and regional human rights treaties and consensus documents.

These include, among others:

4.1.1 International treaties

- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Covenant on Civil and Political Rights
- Covenant on Economic, Social and Cultural Rights
- Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)
- Convention on the Rights of the Child
- Convention relating to the Status of Refugees and its Protocol relating to the Status of Refugees

4.1.2 Regional treaties

- African Charter on Human and Peoples' Rights (the Banjul Charter) and its Protocol on the Rights of Women in Africa (Maputo Protocol)
- African Charter on the Rights and Welfare of the Child
- European Convention for the Protection of Human Rights and Fundamental Freedoms
- Charter of Fundamental Rights of the European Union

4.1.3 Consensus documents

- Beijing Declaration and Platform for Action of the Fourth World Conference on Women
- UN General Assembly Declaration on the Elimination of Violence against Women
- Programme of Action of the International Conference on Population and Development (ICPD)
- UNESCO Universal Declaration on Cultural Diversity
- United Nations Economic and Social Council (ECOSOC), Commission on the Status of Women. Resolution on Ending Female Genital Mutilation. E/CN.6/2007/L.3/Rev.1.

(See Annex 1 for full details of treaties and consensus documents).

4.2 Laws for the elimination of female genital mutilation

4.2.1 Constitutional recognition of rights of girls and women

Constitutional measures to uphold the rights of women and girls, such as equality, non-discrimination and protection from violence, are critical and can shape the response of governments to eliminating female genital mutilation. Examples applicable to female genital mutilation include: "women's protection from harmful practices"; prohibition of customs or traditions that are "against the dignity, welfare or interest of women or which undermine their status", and abolition of "traditional practices" injurious to people's health and well-being. Such constitutional protections can provide guidance for drafting laws and policies and for implementing them. They can also require the revision or abolition of laws and policies that are not compatible with these principles.

4.2.2 Criminal Laws

In some countries, the existing general provisions of criminal codes have been, or can be, applied to female genital mutilation. These may include: "intentional wounds or strikes", "assault occasioning grievous harm", "attacks on corporal and mental integrity" or "violent acts that result in mutilation or permanent disability". Some governments have enacted laws that specifically prohibit the practice of female genital mutilation, many of which specify the categories of people who are potentially liable under the law. Accordingly, traditional practitioners, medical personnel, parents, guardians and persons

who fail to report a potential or already committed crime can be subject to prosecution. The type of penalty also varies and includes imprisonment, fines or, in the case of medical personnel, the confiscation of professional licenses. The penalty may differ according to the form of the mutilation, and often increases when this crime is committed against minors or results in death.

4.2.3 Child Protection Laws

A number of countries have declared the applicability of child protection laws to female genital mutilation, while others have enacted and applied specific provisions for the elimination of harmful practices, including female genital mutilation. Child protection laws provide for state intervention in cases in which the State has reason to believe that child abuse has occurred or may occur. They may enable authorities to remove a girl from her family or the country if there is reason to believe that she will be subjected to female genital mutilation. These laws focus on ensuring the best interests of the child.

4.2.4 Civil Laws and Remedies

In countries with adequate mechanisms for adjudicating civil claims and enforcing judgements, female genital mutilation can be recognized as an injury that gives rise to a civil lawsuit for damages or other redress. Girls and women who have undergone female genital mutilation can seek redress from practitioners and/or others who participate in such an act. Other laws may be available and utilized to prevent the procedure from occurring in the first place, such as child protection laws.

4.2.5 Asylum and immigration regulations

It has been widely recognized that gender-based violence, including female genital mutilation, can amount to persecution within the meaning of the refugee definition of the 1951 Refugee Convention and its 1967 Protocol. Regional resolutions and specific national regulations require that women and girls who are at risk of undergoing female genital mutilation in other countries are granted refugee status or complementary forms of protection. Furthermore, in some cases, immigration authorities are required to provide information to immigrants about the harmful effect of female genital mutilation and the legal consequences of the practice. Some of these regulations contain instructions that such information should be provided in a sensitive and culturally appropriate manner.

CHAPTER FIVE: FGM AND THE MILLENNIUM DEVELOPMENT GOALS

5.0 INTRODUCTION

5. FGM AND THE MILLENNIUM DEVELOPMENT GOALS

MDG 3 - Promote Gender Equality And Empower Women

The target of MDG 3 is to eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015. The technical indicators agreed for the monitoring of progress focus on: the ratios of girls to boys in primary, secondary and tertiary education; the share of women in wage employment in the non-agricultural sector; and the proportion of seats held by women in national parliament.

Violence against women is one of the most serious and damaging structural disadvantages that impede gender equality and women's empowerment. The practice of FGM and other harmful traditional practices perpetuate these structural disadvantages and effectively hinder the full empowerment of women in all areas of society. In relation to the technical indicators agreed for MDG 3: the physical and psychological consequences of FGM cause girls to miss school thereby putting them in a distinct disadvantage in all levels of education; women's participation in wage employment and political life is hampered by the continued physical difficulties that they often experience as a result of FGM.

MDG 4 - Reduce Child Mortality

The target of MDG 4 is to reduce by two-thirds, between 1990 and 2015, the under-five mortality rate. The technical indicators agreed for the monitoring of progress focus on: under-five mortality rate; infant mortality rate; and the proportion of 1 year-old children immunised against measles.FGM is often practiced on infants and young girls with possible severe health consequences, sometimes death.

Moreover, women who have been subjected to FGM commonly experience increased difficulties in child delivery and studies have shown that FGM contributes to still births and neonatal deaths. According to a WHO study conducted in six Sub-Saharan countries it is estimated that "in the African context an additional 10 to 20 babies die per 1000 deliveries as a result of the practice".

The UN estimates that in 27 countries there has been no progress in reducing childhood death rates since the adoption of the goal in 1990 and the large majority of these countries are in Sub-Saharan Africa. While the causes of child mortality are many - including malnutrition, malaria and preventable diseases such as measles - the high prevalence of FGM in many countries in Sub-Saharan Africa cannot be ignored in this context in view of the documented negative impact of the practice on infant mortality.

MDG 5 – Reduce Maternal Mortality

The first target of MDG 5 is to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio. The technical indicators agreed for the monitoring of progress focus on: the maternal mortality ratio and the proportion of births attended by skilled health personnel. The second target of MDG 5 is to achieve, by 2015, universal access to reproductive health. The technical indicators agreed for the monitoring of progress focus on: contraceptive prevalence rate; adolescent birth rate; antenatal care coverage; and unmet need for family planning.

FGM is associated with a range of health complications around pregnancy and childbirth, including fistulas resulting from obstructed labor and an elevated risk for emergency caesarean sections which can be a severe challenge in resource poor locations with few births attended by skilled health personnel in hospital settings.

Sub-Saharan Africa is the region with the highest maternal mortality rates and where there has been little or no progress to date according to UN estimates. The causal connection of FGM to obstructed labor and pregnancy related health complication is not commonly known amongst FGM practicing communities.

There is therefore a clear need for research findings to be communicated not only in international settings but also at national and local level to raise awareness of the serious health consequences connected with FGM. In view of the elevated risk for childbirth complications, improved antenatal care coverage is essential for women living with FGM.

MDG 6 – Combat HIV/AIDS, Malaria and Other Diseases

Of the three targets defined for MDG 6, the first two have links to the prevalence of FGM. The first target of MDG 6 is to have halted by 2015 and begun to reverse the spread of HIV/AIDS.

The technical indicators agreed to monitor progress focus on HIV prevalence among population aged 15-24 years; condom use at last high-risk sex; proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS and the ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years.

The second target of MDG 6 is to achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it. The technical indicator agreed to monitor progress focus on: the proportion of population with advanced HIV infection with access to antiretroviral drugs.

Medical research indicates that the practice of FGM increases the risks of HIV transmission to women. FGM is often carried out on several girls at the same time, using the same knife or razorblade without it being disinfected between the individual procedures thus resulting in high risk of transmitting the infection between the girls.

Women who have been subjected to FGM are also at greater risk for vaginal tears during intercourse, rendering them more vulnerable to being infected with the virus. Finally, the increased risk of obstructed labor and health complications during pregnancies can lead to haemorrhaging and need for blood transfusions, again an increased risk to be taken into account in populations with high prevalence of HIV/AIDS.

CHAPTER SIX: An Insight of FGM and Local community groups Initiative fight in Uganda

6.0 History & Traditional Culture practice or Norm

6.1 Prevalence of FGM in Uganda

In Uganda, there is a less than 1% prevalence rate of FGM/C and while this seems like a very low percentage, the facts behind the numbers paint a shocking and intolerable situation.

In a few districts in eastern and north-eastern Uganda, particularly among some of the Sabiny, Pokot and Tepeth communities, the practice of FGM/C occurs at a more than 90% prevalence rate. There are some 200,000 Sabiny and 6,000 Pokot in Uganda, nearly 260,000 more Pokot live across the border in Kenya, as do a smaller number of Sabiny.

FGM/C is deeply rooted in tradition for example, the Sabiny believe it is an essential rite of passage that will enhance a girl's chastity and chances of marriage.

By custom, the Pokot circumcise girls between the ages of 9 and 14 every year from July through September; the Sabiny do so in December during even-numbered years.

The reality, however, is that FGM/C is a violent act that can cause permanent damage, both physically and emotionally. Young girls are cut with crude knives in open and unsanitary conditions. Despite the desperate need, girls are typically denied any medical attention after they have gone through the procedure.

6.1.2 Statistics of girls circumcised Kapchorwa North Eastern Uganda

Statistics about the numbers of girls and women circumcised every even year are very hard to access. This is because there are no records kept on the numbers of girls and women initiated by the surgeons, some girls are not forced to go for circumcision, in most cases this practice is done in rural areas with poor accessibility and also because it is conducted under covers because of the massive campaign against it in the area.

However information revealed that in 1998 in Tingey county, 193 out of a total of 5762 girls (3.3%) were circumcised while in Kween county 473 girls were circumcised out of 3027 (13.5%) between ages 14-30 years (Owuor 2000:1). Skaine (2005:236) has argued that according to anecdotal figures only 5% of all the women in Kapchorwa are circumcised. The table below shows findings from research conducted by REACH on the number of girls circumcised over the years in Kapchorwa District.

Table 4: Statistics of girls circumcised

Year	1998	2000	2002	2004	2006	2008
Number	965	621	622	594	426	7*

***The number is not accurate**

Source: *Daily Monitor* (December 4th 2008)

In 2008, there seemed to be a drastic drop in the numbers which could have been attributed to the fact that local government passed a by-law abolishing FGC in fear of punishment.

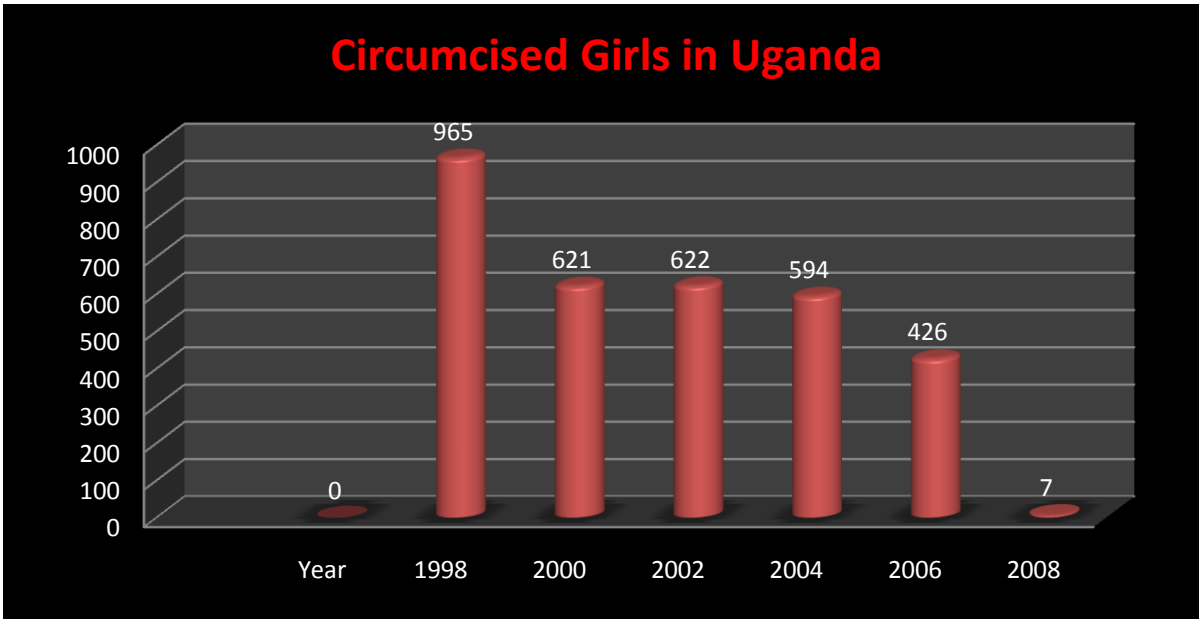

Figure 2: Number of cermucised girls in Uganda between 1998 to 2008

6.1.3 Documented Testimonies of victims and Escapees

"Ms. Cherot is one of 140 girls from the Pokot community in the Amudat district that have remained at school, refusing to go back to their homes for holidays fearing to be circumcised. "Here, we are safe and do not have to worry about forced circumcision and marriage," says 14-year-old Cherot, who is in primary five.

Cherot, together with a group of friends, escaped from their homes in Nabokotom Village in Amudat Sub-county in March this year when their parents were preparing them to face the surgeon's knife. "If you get a chance and watch the way a girl or a woman cries while going through the process, you will feel like to killing the surgeon that time," she said." www.monitor.co.ug The Daily Monitor (September 15th 2012)

Girls in Amudat District in north-eastern Uganda seek refuge from schools and authorities over forced circumcision

A young woman from a practicing community who was cut at the tender age of 14 years was asked to describe her experience.

She said: “After I was circumcised, the whole world turned upside down. I did not believe what I was experiencing. I fainted several times. I bled seriously and felt a lot of pain in my private parts, which had then become swollen and yet I could not access modern medicine. Three of my friends bled to death in the hands of the cutter.”

Sadly, these kinds of stories are far too common, but there is hope. Progress toward total abandonment is being made through the work of the UNFPA-UNICEF Joint Programme on FGM/C.

Pokot girls set for circumcision. The girls are circumcised as early nine years of age.
Source: Photo by Steven Ariong. www.monitor.co.ug The Daily Monitor (July 9th 2012)

6.2 Local Community Initiative

6.2.1 Reproductive Educative and Community Health (REACH)

REACH was founded in 1996 as a project with support from the UN Population Fund, UNFPA. The purpose was to fight the practice of female genital mutilation (FGM) which was seen as a human rights violation and a danger to the health of women and girl children.

Being a cultural practice, it took a long time for the community to say no to the practice through a culturally sensitive procedure that aims to eliminate the actual cut but promotes the positive aspects of culture.

For better results and for a wider coverage, UNFPA conducted a survey and recommended the REACH programme to operate as an NGO. So, in 2007, REACH was granted NGO status to cover all areas in Uganda that practice female genital mutilation: Sabiny region, Karamoja region, Teso region, Busoga region, parts of Bugisu, parts of Western and Central Uganda (Districts detailed above.)

REACH among other developments lobbied for a law criminalising FGM. The law is now being used to arrest whoever promotes FGM in Uganda.

However, although the REACH has a number of donors, expanded coverage needs a lot of support. On top of that, implementing the new law against the practice should be a responsibility of all stakeholders, most especially those from the NGO sector.

The organisation looks at their core areas of human rights, education and health. By disclosing FGM, means the reproductive health conditions of females should be checked.

Since the inception of the REACH programme, many achievements have been recorded:

- Due to sensitisation many girls have gone back to school.
- Government has been able to look at the practice of FGM as affecting the quality life of Ugandans.
- Positive change of community attitude towards FGM.
- FGM has been treated as a human rights violation.
- Although the anti-FGM law is part of government support, the law is treated as a special achievement.
- Community support for the law and the mandate of the REACH programme.

REACH embarked on disseminating the law but due to limited resources there is need for support.

6.2.2 Sabiny Elders Association (SEA)

The Sabiny Elders Association (SEA) is an association that was formed in 1992 by male and female elders of the Sabiny in Kapchorwa. The purpose of its formation was to:

- Unite the Sabiny people and promote peaceful development
- Ensure that local problems would be solved locally
- Protect the Sabiny culture by preserving songs, dances, funeral and marriage rites and other positive customs and eliminate the old harmful traditions including female genital cutting.

In 1998, SEA was given recognition from the United Nations Population Fund (UNFPA) for its efforts in the fight against FGC. A building was constructed with this award money to house their offices and other Non Governmental Organisations that are involved in the struggle to do eliminate this tradition.
There is the Reproductive Education and Community Health Programme (REACH), which is a pilot project that was initially funded by the UNFPA in 1996 to fight this practice in Kapchorwa. Ugandan women activists like Francis Jane Kuka and Beatrice Chelangati, now the Coordinator of the programme, led by Francois Farah who was then director of the UNFPA developed this programme to serve the people of Kapchorwa.

Collaboration of REACH and SEA

Today REACH and SEA work hand in hand. The objective of REACH is to fight the practice of FGC through educational programmes while upholding the good objectives of the practice and improving the reproductive health conditions.
Since 1996, REACH operated as a project under UNFPA funding. In 2007 it gained the status of a Non Governmental Organisation. REACH uses the community based approach to deal with the issue of female genital cutting. Like McCulloch (2005:120), REACH emphasises that community based approaches involve the participation of the people themselves in efforts to improve their lives and the provision of technical and other services which encourage inventiveness, self help and mutual support which makes it more effective.

6.3 Uganda Government - Legal Instruments & FGM

6.3.1 Uganda penal code Act

Uganda penal code has provisions protecting young children and women in general but never was traditional harmful acts like FGM addressed.

In A simple booklet on Harmful Traditional Practices (2008:18-20) published by Law and Advocacy for Women in Uganda, it is stated that the Penal Code Act prohibits the infliction of unlawful grievous harm upon persons, the unlawful wounding of another by making an incision that pierces any exterior membrane of the body and the commission of negligent acts that are likely to spread infectious disease. The latter includes the case of using the same razor blade or knife to cut more than one woman, a practice that puts the victim at risk. It contains several provisions that render female genital mutilation a criminal offence.
Section 219 provides that, “any person who does grievous harm to another commits a felony and is liable to imprisonment for seven years.” Section 222 provides that, “any person who unlawfully wounds another commits a misdemeanor and is liable to imprisonment for three years.” Section 236 provides that, “any person who commits an assault occasioning actual bodily harm commits a misdemeanor and is liable to imprisonment for five years”.

Female genital mutilation is criminal as it inflicts grievous harm on the girl or woman. Furthermore it does not matter whether the girl or woman consented to the cutting, this is because Section 226 provides that, "consent by a person to the causing of his or her own maim does not affect the criminal responsibility of the person by whom such maim is caused" (ibid). This means that whoever does the cutting is committing a crime regardless of whether the girl or woman has consented to the procedure.

6.3.2 The Constitution of 1995

The 1995 Constitution of Uganda (Uganda Government 1995) contains Chapter four which is essentially a Chapter that provides for protection and promotion of fundamental and other human rights. In Chapter four of this thesis, it has been argued that female genital mutilation is a violation of human rights specifically, rights of the child and women.

The laws of Uganda forbid certain acts that are related to female genital mutilation. Article 32(2) of the Constitution prohibits customs and traditions that are against the dignity, welfare or interest of women and Article 44(a) prohibits any derogation of the right to be free from torture, cruel inhumane or degrading treatment.

Article 34 provides for the rights of children and Article 34:1 state that in addition to laws enacted in the children's best interests, care of children by their parents or those entitled to them by law is paramount.

6.3.3 The Children's Statute

The Children's Statute of Uganda (1998) is another legislation that has been put in place by the Ugandan Government to fight for children's rights. Female genital mutilation infringes on the rights of girl children as evidenced in the fact that most children do not give consent to undergo the procedure. Section 8 of the Uganda Children Statute states that, "a child has the right to be protected from any social or customary practices that are dangerous to the child's health."

6.3.4 Other Government Roles.

The fact that Government officials are involved in the annual Sabiny cultural day celebrations is a sign of commitment in the struggle against female genital circumcision in Kapchorwa. In 1998, the President together with the Vice president of Uganda expressed support to the struggle by attending the cultural day and addressing the residents of Kapchorwa. Their presence did not only motivate the people involved in the fight against female genital mutilation, it also led to a lot of media coverage on the issue in the country.

Universal Secondary Education can be seen as an indirect and direct effort on the side of the government in the struggle against female genital mutilation. Government implemented the policy of secondary education in 2007. According to the uncircumcised girls talked to in the focus group discussions and individual interviews, girls who might have dropped out after primary education have hope to continue with their education. They assumed that girls will be able to make more informed decisions as regards to their life when it comes to culture and the practices involved therein.

Conclusion

Bill signed into law in 2010 additional to the already laws in place that addresses the issue of female genital mutilation specifically, a number of legislation, instruments and institutions that play a vital role in elimination of this tradition. If these established laws are effectively executed, there would be a change. However there is need to think about how to enforce this new law.

Like Packer writes, "the existence of legislation is at the least, one step toward the eradication of female circumcision because it establishes standards as a matter of law and thereby creates a framework for implementation of public policy," (Packer 2005: 235-236). However with a new specific legislation, it should not be forgotten that most national criminal codes make female genital mutilation illegal but the implementation is still lacking. As seen in the words of Baroness of Scotland in (Mohammad 2005:135), "Law on its own will not stop it (female genital mutilation), it's just one of the ingredients that we need to have to make sure the change that we aspire to happen actually takes place".

6.4.1 The Long Road to a National Law

The process leading up to passage of the FGM law in Uganda involved the commitment and leadership of a number of key individuals at the grassroots level. *This story offers useful lessons for other countries striving to eradicate FGM. "What excites us," says Brenda Malinga of UNFPA, "is that this was not a top-down approach; it was a bottom-up approach."*

It began in 1988, when members of the Sabiny community became concerned that their cultural values were eroding because a growing number of girls had been avoiding genital cutting. "The fathers of these girls were enlightened," says Beatrice Chelangat, coordinator of REACH, an organization supported by UNFPA. "Every two years during cutting season, these fathers took their daughters for refuge to nearby districts where FGM is not practiced." The girls' mothers probably acquiesced to this arrangement.

To determine the extent of Sabiny support for FGM, the local district council of Kapchorwa, led by elder Peter Kamuron, commissioned a study on public attitudes toward FGM in 1988. When the study revealed that most people did support the practice, the council voted 20 to five in favor of a resolution making FGM mandatory.

While not legally binding, the resolution empowered and encouraged the community to harass young women who had avoided cutting and to pressure them into submitting to the procedure.
"These were no longer girls," explains Ms Chelangat.

"By this time they were married women– some even held important positions–but they were still called girls because they hadn't undergone the ritual. So the community felt that they needed to be cut. They believed that if you have not undergone FGM, you remain a girl forever.

" Among both the Pokot and Sabiny, tradition stigmatized uncut females and, among other things, barred them from engaging in everyday tasks, such as milking a cow or repairing a house.

With FGM endorsed by the resolution, the uncut adult daughters of the five dissenting council members traveled to Kampala with their fathers to seek the intervention of the central government, which they expected to be sympathetic to their cause. In response, the Minister of Gender and the Minister of Local Government, who happened to be a Sabiny, flew to Kapchorwa to discuss the negative implications of the resolution with the community leaders.

The following year, Peter Kamuron and the district council rewrote the resolution, making FGM optional for adults aged 18 and above. (Kamuron has since become a staunch opponent of FGM and a human rights activist.) "Considering the level of knowledge in the community, it was not possible for the council to abolish FGM outright," says Ms Chelangat. "So the nearest thing was to make it optional."

6.2.3 Attacking FGM on many fronts

But the original dissenting elders on the council would not give up on their objective of an unqualified rejection of FGM. They decided they had to work to change local attitudes and convictions about FGM and other issues.

In 1992, they established the Sabiny Elders Association under the leadership of George William Cheborion. (With his daughter Jessica, Mr Cheborian had been part of the group that had travelled to Kampala four years before.)

The association's goal has been to preserve cultural practices that are benign and that promote human rights, such as story-telling, proverbs, community celebrations, marriage ceremonies and traditional foods, while eliminating practices "that are brutal and dehumanize some sections of the community." See **6.2. 2**.

These latter practices included not only FGM and related taboos but traditions such as widow inheritance and revenge killings. The Elders Association also vowed to promote education, especially for girls, and to protect the environment.

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In order to mount an effective campaign to stop FGM, the Sabiny Elders needed financial resources and technical support. They approached President Museveni through their fellow Sabiny the Minister of Local Government, and the receptive President contacted UNFPA. In 1996 UNFPA, in collaboration with the Sabiny Elders Association and the Population Secretariat of the Ministry of Finance, launched the Reproductive, Educative and Community Health Project (REACH) based in Kapchorwa.

Figure 3

Illustration on REACH wall **Source:** Photo from fieldwork

One of REACH's first actions was to establish Sabiny Culture Day, now in its 19th year. "REACH's goal was to facilitate change," says Ms Chelangat, "and the change agents were the Elders. Most of us on the EACH staff had just left university, so it was difficult for us to communicate with the common man in the villages. So we asked the Elders–the people who are listened to and who are influential–to move around the villages, speak about local problems with the people and discuss possible solutions." As a result of this advocacy work, in 1998 the Elder George Cheborian received UNFPA's annual Population Award for his leadership in working to abolish FGM. UNFPA continued to support REACH until 2006, when it became part of the UNFPA-UNICEF Joint Programme on FGM.

Another active partner in the campaign was the Hon. Dr. Yekko John Arapkissa, today a Member of Parliament for Kapchorwa. For many years starting in 1978 he had been the only medical doctor serving the Sabiny and Pokot communities in Uganda. Working with REACH, he developed a package of pictorial materials that explained the painful and potentially dangerous health consequences of FGM for mothers and babies, such as the risk of infection and the fact that women who have been cut are often unable to deliver a baby because of scar tissue. Many have to be cut again during childbirth, sometimes with fatal consequences. For many years Dr. Arapkissa traveled around the villages sharing this kind of information with people.

Nevertheless, despite some progress in changing attitudes about FGM, between 1998 and 2002 there was a backlash in the community. Still worried that the local culture was being eroded by these and other reform efforts, a number of influential Sabiny–professors, magistrates, local government leaders, agricultural officers and teachers–actually formed a pro-FGM group to counteract messages from the Elders and REACH.

During the "cutting season" in December 1998, they contributed enough money to give 50,000 Ugandan shillings (about US $23) to every family who agreed to have a daughter cut, along with a woman's sarong and a calendar. That year, the number of girls cut nearly doubled, from 544 in 1996 to 1,100 in 1998. The participation of individuals who were well educated clearly suggests that they were defending Sabiny identity more than FGM per se. In a rapidly changing world, there are people everywhere who feel that their cultural identities–indeed, their collective sense of self–are under threat.

An important lesson was learned from the setback in Uganda. It had become clear that in addition to sensitivity toward local culture and persuasion, the campaign against FGM had to be bolstered by some kind of legal framework. In 2000, REACH and the Sabiny Elders Association once again petitioned the district council to prohibit FGM. The council refused, saying, "This is our culture let it be optional, those who are cowards–let them refuse FGM but those who are brave Sabiny and Pokot girls–let them continue with FGM!" "So," Ms Chelangat recalls, "we had to go back to the drawing board and come up with another strategy."

6.2.4 The Law gains momentum

In 2004 REACH and the Sabiny Elders contacted an organization called Law and Advocacy for Women in Uganda (LAW Uganda) and asked them to draft a document annunciating the principles underlying a law that would prohibit genital cutting.

In 2005, 100 community leaders from the 16 sub-counties of Kapchorwa district petitioned local authorities to enact a bylaw based on the LAW Uganda draft. It passed in 2006. UNFPA, LAW Uganda and the Kapchorwa district council then got a district level ordinance prohibiting FGM passed in 2008. "This gave us a strong stepping stone to reach the Parliament and pass the national law," says Beatrice Chelangat.

The Joint Programme then helped to arrange a meeting between President Museveni, the elders of the Sabiny and Pokot, REACH staff and medical personnel on June 29, 2009. Some 40 people attended and the meeting lasted for about four hours. "We were able to convince the President of the need for a law," says Brenda Malinga of UNFPA. "He asked questions about FGM and maternal and child health: Does it actually increase maternal mortality? The doctors explained how that happens. That's how the President used this information later in his speech."

In the past, Ms Malinga notes, President Museveni had occasionally touched on the issue of FGM, but he had not discussed it in depth because he thought it should be left up to the communities who practiced it. "But now we came to him with demands from the communities themselves," she says. "This wasn't the Minister of Gender or the Minister of Health talking to him, this was the Sabiny and Pokot elders saying, 'No, we don't want this thing to continue and we need a law to help us with our campaign."

6.4 Ugandan Parliament

In December 2009, Ugandan parliament unanimously passed a bill banning female genital mutilation. The object of the Bill is to provide for legislation necessary for criminalising the practice, prosecution of offenders and protection of victims. President Yoweri Museveni signed it into law on March 17, 2010 and it took effect on April 9, 2010

Convicted offenders face 10 years in prison, but if the girl dies during the act, those involved will get a life sentence.

"A majority of Ugandans felt it is a disgusting act, but you have to remember that this is a cultural belief that has been practiced for generations," said Fred Opolot, the Ugandan government spokesman. "That's what took the bill so long to pass."

6.5 FGM practice as a form of Livelihood and Income generating activity

In an interview found in The New Vision (January 13th 2009), Kokop one of the „surgeons" in Kapchorwa said female genital mutilation was something they depended on for everything. She earns Shs 80.000/= (eighty thousand shillings only), a goat and a jerry can of local brew for every operation she does. According to that article, she has been in position to pay dowry for her children as well as construct a house using the money she gets from carrying out the procedure.

Employment opportunities for women in communities that practice female genital mutilation are limited and therefore performing this procedure is their livelihood.

This is true for some women in Kapchorwa District. In another article in The New Vision (13th January 2009), one of the caretakers of the girls in Kapchorwa echoes the same issue as regards to the source of income. According to her, taking care of the girls both before and after circumcision is the only way she can put food on the table. Her children have been able to go to school as well as being able to construct a small hut as a result of taking care of these girls. For every girl she initiates she gets Shs 40.000/= (forty thousand shillings only) or a higher fee if she initiates a girl from a rich family, a jerry can of local beer and a cock.

Anti FGM advocates' leader Charles Chelimo says the practice is still common in the sub counties of Chekwasta

, Kabei and Chesower in Bukwo district and Benet, Kabroron and Kwanyi sub-counties in Kapchorwa district.

With the bulk of REACH funds coming from the United Nations Population Fund (UNFPA) amid decreasing contributions to the UN body from donors, the project has been limited in its campaign against the ritual.

Some of the anti FGM advocates are former mutilators and mentors who are asking for alternative sources of income, claiming that they used to earn a living out of the act. "Some of us were promised heifers but we have never got them and those who are still in the business of cutting women are now laughing at us. We are being tempted by this ridicule practice. It is only that some of us have been sensitised on the negative effects of the practice and we have resolved never to do it again," Kokop, a former traditional surgeon (mutilator) says.

Benet Youth Councilor Felix Mande says some of the residents request to be given money before they can drop the practice. But Chelimo says the financial constraints cannot allow REACH to meet all the needs of the advocates in the short term.

6.6 Anti-FGM activists face hostility

Despite criticism from several activists, female genital mutilation is still a much-respected practice in Kapchorwa. It is still so popular that some women who have decided to stop supporting the practice have been ridiculed by their colleagues.

Ms Eunice Chesiro of Sipi sub-county has had to pay the heavy cost of spearheading the fight against the practice commonly known as FGM. A former surgeon, Chesiro is now one of the change agents trained by the Reproductive, Educative and Community Health (REACH) project.

"They are abusing me. They bring girls and forcefully command me to cut them but I have resisted. During the last cutting season, they kicked the door of my house asking if the girls to be circumcised were my daughters," a worried Chesiro says.

Chesiro who hails from Kenya but is married to a Ugandan is now thinking of going back home until the circumcision period is over. She says she and her colleagues who have chosen to join the fight against FGM stand a risk of harassment and hostility during the circumcision season that runs through December.

Girls smeared with ash wait to undergo the circumcision ritual in Amudat District recently.

Source: Photo by Steven Ariong. www.monitor.co.ug The Daily Monitor (September 15th 2012)

What can be done?

Community education, improvements in women's socioeconomic status and traditional and religious leader involvement would be critical for FGC eradication with support of INGOs and government institutional bodies enforcing the anti FGM 2008 law.

6.7 Empowerment of women

As female genital mutilation is a manifestation of gender inequality, the empowerment of women is of key importance to the elimination of the practice. Addressing this through education and debate brings to the fore the human rights of girls and women and the differential treatment of boys and girls with regard to their roles in society in general, and specifically with respect to female genital mutilation. This can serve to influence gender relations and thus accelerate progress in abandonment of the practice (WHO, 2000b; Population Reference Bureau, 2001, 2006; UNICEF, 2005b; UNFPA, 2007a).

Programmes which foster women's economic empowerment are likely to contribute to progress as they can provide incentives to change the patterns of traditional behavior to which a woman is bound as a dependent member of the household, or where women are losing traditional access to economic gain and

its associated power. Gainful employment empowers women in various spheres of their lives, influencing sexual and reproductive health choices, education and healthy behavior (UNFPA, 2007a).

6.8 Local Community Groups Initiatives - Awareness Campaign programmes

6.8.1 Alternative rites of passage (ARP)

According to Martin Chelangati, REACH has borrowed a leaf from one of its counterparts in the district of Meru district in Kenya who have an organisation called "Maendeleo Ya Wanawake" (Development for Women) and running an alternative to female genital circumcision called „Circumcision Through Words (Ntanira na Mugamba). Gruenbaum (2001:195; Muteshi, J. et al, 2005:27-29) mention of groups of families that bring together their daughters of an appropriate age to spend a week in seclusion and they are taught about their traditions as regards to their roles as women and future parents, messages on health and hygiene, reproductive issues, communication skills, self-esteem and dealing with peer pressure.

Community celebrations of feasting, singing and dancing affirm girls' transition to their new roles. Gruenbaum argues that such approaches recognize that female circumcision has deep cultural significance and if that significance can be preserved while the actual cutting is discontinued, then change can be seen. Martin Chelangati said, "We organise seminars and trainings for girls who are coming of age to be circumcised." A number of issues are discussed during these seminars and trainings like home economics, counseling, family life, and education of children, trauma management and many other things. These are similar to the things talked about during the initiation preparation. "Graduation ceremonies are organised and certificates are given out before the children are „passed out (graduate). „Sometimes gifts are given to the girls," said Martin Chelangati.

The purpose of this alternative ritual is to replace female genital cutting with other less aggressive rituals. What is done in the trainings and seminars is symbolic of the traditional practice where the girls upon being „passed out are referred to as women in the community. There is a chance the girls will not be fully considered as women by the traditionalists who hold onto the traditional practice, but to the girls themselves they are considered as women. Packer (2005:236) argues that campaigns must be sustained to address the importance of the cultural values. The values that are attached to the traditional practice need to be maintained. The alternatives that have been developed by the Sabiny people include symbolic gift giving, singing, dancing and other traditional festivals which mark a girl's initiation as a fully fledged member of the community thereby honoring their cultural values, (ibid).

6.8.2 Culture Day

FEBRUARY 6 is the International Day of Zero Tolerance to Female Genital Mutilation/ Cutting (FGM/C). This Culture day was established with the help of SEA and REACH to celebrate the positive aspects of the Districts traditions. It coincides with the opening of the circumcision period according to

Martin Chelangati. The Cultural day is celebrated annually in Kapchorwa and usually prominent people in the government are invited to show their support, The Daily Monitor (December 4th 2008).

Information from REACH and SEA revealed that in 1998 the President of Uganda attended the Cultural day in Kapchorwa to support the efforts of the people who were fighting female genital circumcision in the district. His presence can be interpreted in two ways. On the national and international scene, his presence could have meant commitment by the Government to the cause of fighting this traditional practice. However the traditionalists who treasure this practice may have viewed his presence as a sign of outside interference in their traditional affairs.

According to the focus group discussions, usually different Non Governmental Organisations, Local Government as well as the Sabiny residents gather at the district ground on the Cultural day and celebrate aspects of Sabiny culture. Activities include plays and dramas on a number of issues like female genital circumcision, family life, HIV/AIDS and family planning. Rituals of the tribe are also demonstrated, usually by the elders.

The Cultural day is celebrated to bring about the positive attributes of the Sabiny culture and give people a sense of pride. The people who are against the practice are the ones who get involved in the cultural day to provide an alternative to festivals that mark the beginning of the circumcision ceremony. Cultural day is aimed at promoting the positive aspects of the Sabiny culture, while highlighting the dangers of the negative aspects. The presence of high ranking government officials in the district may have contributed to the abandonment of the circumcision festivals in public. It may, however, have caused a transition to private ceremonies in secluded places or behind closed doors.

6.8.3 Peer Education

In its efforts to fight FGC, REACH had a programme for ten years that encouraged education of girls. This was done through scholarships that were given to the girls to enrol in schools especially after primary level. The programme was established to help girls who would otherwise drop out of school. After being circumcised, the only thing on their minds was marriage because that is what they were prepared for during the initiation ceremonies. This was before the introduction of Universal Secondary Education (USE) a government policy that was implemented in 2006.

REACH programme was being implemented by mentioning the incentives as follows: two girls from each of the 54 parishes of the district were selected on two conditions. First the girls vowed not to be circumcised and secondly that they would act as peer educators in the schools and also in their parishes on the dangers of circumcision on condition that their fees was subsidized. This programme was sponsored by UNFPA together with REACH which was implementing it. It is important to note that there are other organisations in the district that are paying fees for the girls.

One of the best known organisations is the Godparents Association which promotes cultural change through education since 1998, The New Vision (July 30th 2002).

However for some girls this is not the case. In The New Vision (January 1st 2009), recently circumcised girls reckon that education and being in school is not important to them. They argue that if rich men come and want to marry them because they are now "adult" they will willingly drop out of school.

The purpose of educating these girls was to promote cultural change by empowering the girls through the education. Most of the girls are from families that cannot afford payment of fees and marrying off their girls is the only way of providing for their families. Even when the girls do not want to drop out of school, the circumstances may force them to do so.

The use of peer educators seems to be an effective way of passing on the message to the younger generation because the peers are of the same age bracket and therefore bound to be listened to as compared to the older generation. It is assumed that when people have the right information, they would be in position to make the right decision, although right in this case might be relative depending on the circumstances.

REACH is using peer educators to inform girls of their age group in the community about the dangers of female genital mutilation. In an article in The New Vision (11th, February 2005), Beatrice Chelangati said that by that time the programme boasted of 354 peer trained advocates who vowed not to be circumcised and promised to tell other girls about the dangers associated with female genital circumcision and its implication on their health.

In the focus group discussions of circumcised girls and women, a lot was said about REACH not keeping its promises of providing scholarships for girls in the villages and therefore once they dropped out of school, the only solution to their problem was circumcision so that they could get married and thus help the financial situation of their families.

6.8.4 Sensitisation Programmes

Information from REACH revealed that sensitisation programmes are run in the community to provide information on the dangers of the practice of female genital cutting while promoting the health of women. Like George Cheborion the chairman of SEA and teacher by profession said, "As a young man I approved of the practice but I changed my mind when I learnt of the harm this practice has on the young women." Sensitising the community on the dangers this practice poses to their health has a great impact in as far as efforts to eradicate it are concerned. Boyle (2005:243) reports on a case in Senegal, the Tostan project where it is said that about 174 villages have renounced female genital mutilation. This has been achieved through a sensitisation programme similar to the project run in the Sabiny community.

Beatrice Chelangati, attributes the decline in numbers of girls and women circumcised to the sensitisation programmes that have been conducted in the community. This was reflected in a report she presented on 30th December 2008, at the 13th Annual Sabiny Cultural day which was held at Boma grounds in Kapchorwa, Uganda. The report stated that 426 girls (28%) underwent circumcision in 2006 as compared 621 girls (43.5%) who had undergone circumcision in 2000 (refer to table 3 presented in Chapter four

page 32). The way these figures are arrived at is not properly documented and this makes it hard to establish the different percentages of the number of girls circumcised every season. It is important to bear in mind that with the passing of the by-law, the people practicing FGC could be doing it underground; girls might refuse to go for treatment in case of complications and not report to officials for fear of being caught. This is a concern also expressed Muteshi et al (2005:21) about legislation.

In an interview with one of the field mobilizers working with REACH, he said that in his village, for the season of 2008, no girl had been circumcised and he attributed this to the sensitisation programmes being carried out by REACH. We also saw in the previous Chapter in Table 3 on page 32 a sharp decline in numbers for 2008. However, as a result of shortage of funds, facilitating officials to go the villages and ascertain the number the number of girls who have been circumcised is a problem since FGC is illegal. According to Beatrice Chelangati, a considerable number of "surgeons" have denounced the practice, The Daily Monitor (December, 4th 2008) and this may have had an impact on the numbers as well.

In sensitising the community, there is need to have everyone in the community on board especially the men who are responsible for decision making in most families. Like Packer (2005:238) writes the tradition of foot binding in China was eliminated because men were educated and young men across China began to insist on marrying girls with unbound feet. Men maintain control over many traditional practices in Africa, they typically pay for their daughters to be circumcised, negotiate the marriages of their daughters and receive the bride-price, (ibid: 238). Men are therefore important change agents in this struggle to end female genital circumcision and should not be left out. Hosken, an activist against female genital circumcision quoted by Packer (2005:239-240) has this to say about the involvement of men in the fight against this practice, "The next critical issue that needs to be examined is the responsibility of [female circumcision] by men. She affirms that, "men are in control of everything in Africa, especially women and children… [Female circumcision] is a marriage requirement demanded by men, therefore the practice continues." An article by UNFPA entitled, struggling to end Female genital cutting in Uganda, REACH is using the community based and multi sectoral approach it its efforts to eliminate FGC. The article talks about the people involved in the implementation of the programme and these include church leaders, village elders, local politicians, youth and most important of all, the women who perform the procedure and depend on it for their livelihoods. Ellen Gruenbaum an anthropologist writes about the importance of grass root approaches which might not achieve international fame but their efforts are significant, (Gruenbaum 2001:178). The efforts of REACH cannot be ignored in the fight against female genital cutting because they are directed to the local people.

In all the focus group discussions, it was expressed that eliminating female genital cutting would be done through increased sensitisation about the dangers of the practice. One of the uncircumcised girls said, "I heard about the dangers of this practice from a programme that was organised by REACH in my area. That is when I decided that I would not be circumcised because I did not want to suffer in the name of culture." Another girl who is circumcised expresses the same idea in an interview in The New Vision (January 1st 2009). She reckons that the idea of sensitising the community will end circumcision. This

illustrates that telling the community about the dangers of this traditional practice makes a difference in the community. However as a result of lack of funds, REACH is no longer carrying out any sensitisation programmes in the community says Beatrice Chelangati, The New Vision (January 20th 2009). This is bound to have a number of implications as regards to the practice. As a result of stoppage in the sensitisation programmes, cases of female genital cutting in the year 2008 season seem to have increased as compared to the previous years in other areas, for example in Bukwo (another district where female genital cutting is being practiced by the Sabiny who live there). This was expressed not only by the employees at REACH but also by the girls and women that I talked to. Although through the sensitisation programmes, the number of girls being circumcised has reduced, it is reported that because of unkept promises, „surgeons who had denounced the practice have now resorted back to the practice because to them circumcising girls is a source of income. A good case to note is that of Ms Kokop (mentioned in Chapter four page 27) who is said to have denounced circumcision and laid down her tools as seen in an article from UNFPA (ibid), however in The New Vision (January 13th 2009), the same lady argues that because REACH did not keep its promises, she reverted to circumcision.

This is significant because even if these people know and have knowledge of what will happen to them if they are circumcised, they still continue to follow this tradition. I therefore conclude by saying that female genital circumcision among the Sabiny has close relationships with the socio economic situation of the people in that area. There are a number of push factors that motivate girls to be circumcised like poverty, social acceptance in the community and tradition.

In an interview with one of the circumcised women, she said that if REACH had started doing its work earlier before she was circumcised, she would never have accepted to be circumcised because then she would have known the side effects that she is experiencing since the day of circumcision. She now volunteers in the community telling the young girls about the dangers of female genital circumcision.

Government support

Building on the historic passing of legislation that banned the practice in 2010, UN agencies are joining together with the Government of Uganda on two fronts, legally and at the grass roots level.

“The Government of Uganda has shown a strong commitment to the elimination of Female Genital Mutilation,” said Theophane Nikyema, UN Resident Co-ordinator for the Uganda/UNDP Resident Representative. “However, now that the law has taken effect, it is imperative that we ensure that it is implemented effectively so that FGM becomes a practice of the past.”

In 2010, UNFPA and UNICEF supported the Government of Uganda and partners to create a simpler version of the law that has been disseminated to 34-high risk practicing sub-counties.

Last year, 500 local law enforcement officials and key advocates were trained in how to enforce the legislation and as a result, arrests of cutters and parents were made.

- **Joint programme to create social change through community dialogue and education**

Social change through community dialogue and education Continued and more extensive training and distribution of the simplified version of the law was planned and carried out in 2011. Another key focus of the joint programme has been creating social change through community dialogue and education.

"We know from experience, that the abandonment of cutting girls has to come from the community as a whole," said Janet Jackson, the UNFPA Uganda Country Representative. "Women and girls have to be empowered to be able to say 'No' without fear of being shunned by their communities. Convinced elders are continuing to bring on board other elders. It is only through this kind of social change, dialogue and education, that will we be able to experience zero tolerance toward FGM in Uganda."

Through the joint programme, there has been an increased focus on intensifying the role of community elders to bring about lasting change.

- **Regular community meetings to discuss about Cultural rituals**

Support is being provided to hold regular community meetings to educate and inform, not only on the extremely harmful effects of FGM, but also on introducing alternative rites of passage into womanhood — one in which the girls can celebrate their future with joy and hope. In August 2010, as a result of such interventions, in the district of Pokot, 84 girls were saved from being cut.

"Lessons learnt from our global experience are that programmes to persuade traditional practitioners to discontinue the practice of Female Genital Cutting are ineffective," said Jackson. "Interventions must, therefore, focus on encouraging communities to abandon this harmful practice." This year, UNFPA and UNICEF will accelerate their interventions and build on past successes. To date, funds invested towards this programme from 2009 to 2010 have totaled $487,000.

6.9 Challenges

6.9.1 Misconception complexity

In The New Vision (13th January 2009), there is a good lesson to learn as regards to efforts in fighting female genital circumcision. Jackline Chelmo, a Sabiny young woman who shunned circumcision after hearing about the evils in school got married after she dropped out of school and faced a number of problems as a result of financial hardships. Her husband abused her whenever he got home drunk and threatened to leave her because his fellow men used to laugh at him. Her mother in-law used to say that

the son had made a mistake marrying a learned girl who had no respect for culture, so even though she did not want to be circumcised, she went in to be circumcised as a result of social pressure (ibid).

In the efforts to fight female genital mutilation, this shows the complexity and challenges faced in the struggle to end the practice. Understanding the motivating factors (push factors) that force these girls to be circumcised even when they know of all the dangers is paramount. This was also talked about by the girls talked to while in the field.

6.9.2 Promised educational scholarships and Jobs

Although REACH has tried to eliminate female genital cutting through educational scholarships, it brought a number of challenges as well. It is argued by the circumcised girls and women I talked to that they have heard of stories of girls who were promised scholarships but REACH did not come through with their promises and this has hampered on the success of their efforts to fight female genital cutting. This is echoed and confirmed in a statement found in The New Vision (January 1st 2009), "my daughter was promised a scholarship to study in Kampala, but they did not come back." This last statement maybe a case of misunderstanding because according to the information from REACH, the scholarships were given to girls to study in Kapchorwa and change the community there and not leave the District.

6.9.3 Relaxed Uganda - Kenya Border which allows movement of Girls into Western Kenya for FGM

Other challenges that will also be addressed is the increased movement of young girls crossing the border into western Kenya to be cut, and the bringing in of 'cutters' from western Kenya into Uganda. It is possible that these scholarships could have been promised by other Organisations that pay scholarships for girls who are „running away from the tradition of the tribe. Our personal assessment shows that it is hard for people who have little or no education to make a distinction between different organisations. Nevertheless this sense of disappointment has a number of implications not only for REACH and SEA but also for other organisations involved in the fight against female genital circumcision. Trust is lost and not much can be done without trust. Despite all the successes the programme has encountered in the previous years, like the saying goes, "one rotten tomato spoils all the rest." This might just be the case for REACH. As a result of no funding, REACH stopped the scholarships after nearly ten years and this had severe implications on its efforts to fight female genital cutting.

6.9.4

CHAPTER SEVEN

Conclusion and recommendations

Conclusion

In our study, the most important message is to document is that with FGM not being addressed MDGs indicators are misleading and achievement of most MDGs cannot be fully achieved.

The efforts of the pioneers in the struggle to end female genital mutilation should not go unnoticed. They involve the participation of all in the community in a bid to address social norms, perceptions, beliefs and attitudes.
Our study shows then that complete elimination of FGM is a complicated procedure because there are many vested interests to perpetrate the practice and changing perceptions and attitudes is a slow, long and arduous process. Intensive sensitisation of practicing communities is the most effective way to reduce this practice though this might be against the wishes and cultures of peoples practicing it.

Legislation without political commitment and other proactive interventions (media campaigns, community education and empowerment programmes) is ineffective. However legislation provides an official platform to back up positions of opponents of female genital mutilation by empowering them with the necessary legal support.

Community education, improvements in women's socioeconomic status and traditional and religious leader involvement would be critical for FGC eradication with support of INGOs and government institutional bodies enforcing the anti FGM 2008 law.

Recommandations to the end FGM call

- All developing countries should ensure that violence against women and in particular FGM, one important underlying cause of the lack of progress on the MDGs, is raised and given visibility during the review of the MDGs at the UN. Following from this, indicators should be reviewed and in particular indicators on violence against women and FGM should be included in the MDG 3, 4, 5 and 6.

- All nations should continue linking human rights and the achievement of the MDGs -in its report on human rights in the world- and highlight the underlying factors which prevent the achievement of the MDGs such as violence against women and FGM.

- United Nations through UN Member States should take concrete steps to audit/review their MDG policies and strategies to ensure their consistency with international human rights standards, include indicators on violence against women and FGM and their impact on achieving the MDGs.

- International community and Donors Working Group on Female Genital Mutilation/Cutting to link their initiatives to end FGM with the MDGs, to ensure that their support to end FGM facilitates the participation of people living in poverty in planning, implementation and monitoring at all levels, and in particular focuses on the empowerment and equal participation of women.

- In Uganda, advocates want other stakeholders to join UNFPA in funding the FGM fight. Otherwise, the recently passed AU Continental Policy Framework for Sexual and Reproductive Health and Rights, Uganda government law criminalizing FGM and other international laws and treaties, which calls for the elimination of harmful tradition practices such as FGM among others, may not be realized.

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APPENDICES

ANNEX 1

International and regional human rights treaties and Consensus documents providing protection and containing safeguards against female genital mutilation

International treaties

- Universal Declaration of Human Rights, adopted 10 December 1948. General Assembly Resolution 217. UN Doc. A/810.

- Convention relating to the Status of Refugees, adopted 28 July 1951 (entry into force, 22 April 1954).
- Protocol relating to the Status of Refugees, adopted 31 January 1967 (entry into force, 4 October 1967).

- International Covenant on Civil and Political Rights, adopted 16 December 1966 (entry into force, 23 March 1976).

- International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966 (entry into force, 3 January 1976).

- Convention on the Elimination of all Forms of Discrimination against Women, adopted 18 December 1979 (entry into force, 3 September 1981).

- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted and opened for signature, ratification and accession by General Assembly resolution 39/46 of 10 December 1984 (entry into force, 26 June 1987).

- Convention on the Rights of the Child, adopted 20 November 1989. General Assembly Resolution 44/25. UN GAOR 44th session, Supp. No. 49. UN Doc. A/44/49 (entry into force, 2 September 1990).

- Committee on the Elimination of All Forms of Discrimination against Women. General Recommendation No. 14, 1990, Female circumcision; General Recommendation No. 19, 1992, Violence against women; and General Recommendation No. 24, 1999, Women and health.

- Human Rights Committee. General Comment No. 20, 1992. Prohibition of torture and cruel treatment or punishment.

- Human Rights Committee. General Comment No. 28, 2000. Equality of rights between men and women. CCPR/C/21/rev.1/Add.10.

- Committee on Economic, Social and Cultural Rights. General Comment No. 14, 2000. The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4.

- Committee on the Rights of the Child. General Comment No. 4, 2003. Adolescent health and development in the context of the Convention on the Rights of the Child. CRC/GC/2003/4.

Regional treaties

- European Convention for the Protection of Human Rights and Fundamental Freedoms, adopted 4 November 1950 (entry into force, 3 September 1953).

- American Convention on Human Rights (entry into force, 18 July 1978).

- African Charter on Human and Peoples' Rights (Banjul Charter), adopted 27 June 1981. Organization of African Unity. Doc. CAB/ LEG/67/3/Rev. 5 (1981), reprinted in 21 I.L.M. 59 (1982) (entry into force, 21 October 1986).

- African Charter on the Rights and Welfare of the Child, adopted 11 July 1990. Organization of
- African Unity. Doc. CAB/LEG/24.9/49 (entry into force 29 November 1999).

- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted 11 July 2003, Assembly of the African Union (entry into force 25 November 2005).

Consensus documents

- United Nations General Assembly, Declaration on the Elimination of Violence against Women, UN Doc. A/RES/48/104 (1993).

- World Conference on Human Rights, Vienna Declaration and Plan of Action, June 1993. UN Doc. DPI/ 1394-39399 (August 1993).

- Programme of Action of the International Conference on Population and Development, Cairo, Egypt, 5−13 September 1994. UN Doc. A/CONF.171/13/Rev 1 (1995).

- Beijing Declaration and Platform for Action of the Fourth World Conference on Women, Beijing, China, 4−15 September 1995. UN Doc. A/CONF.177/20.

- UNESCO Universal Declaration on Cultural Diversity, adopted 2 November 2001.

- Convention on the Protection and Promotion of the Diversity of Cultural Expressions, adopted October 2005 (entry into force March 2007).

- United Nations Economic and Social Council (ECOSOC), Commission on the Status of Women. Resolution on the Ending of Female Genital Mutilation. March 2007. E/CN.6/2007/L.3/Rev.1.