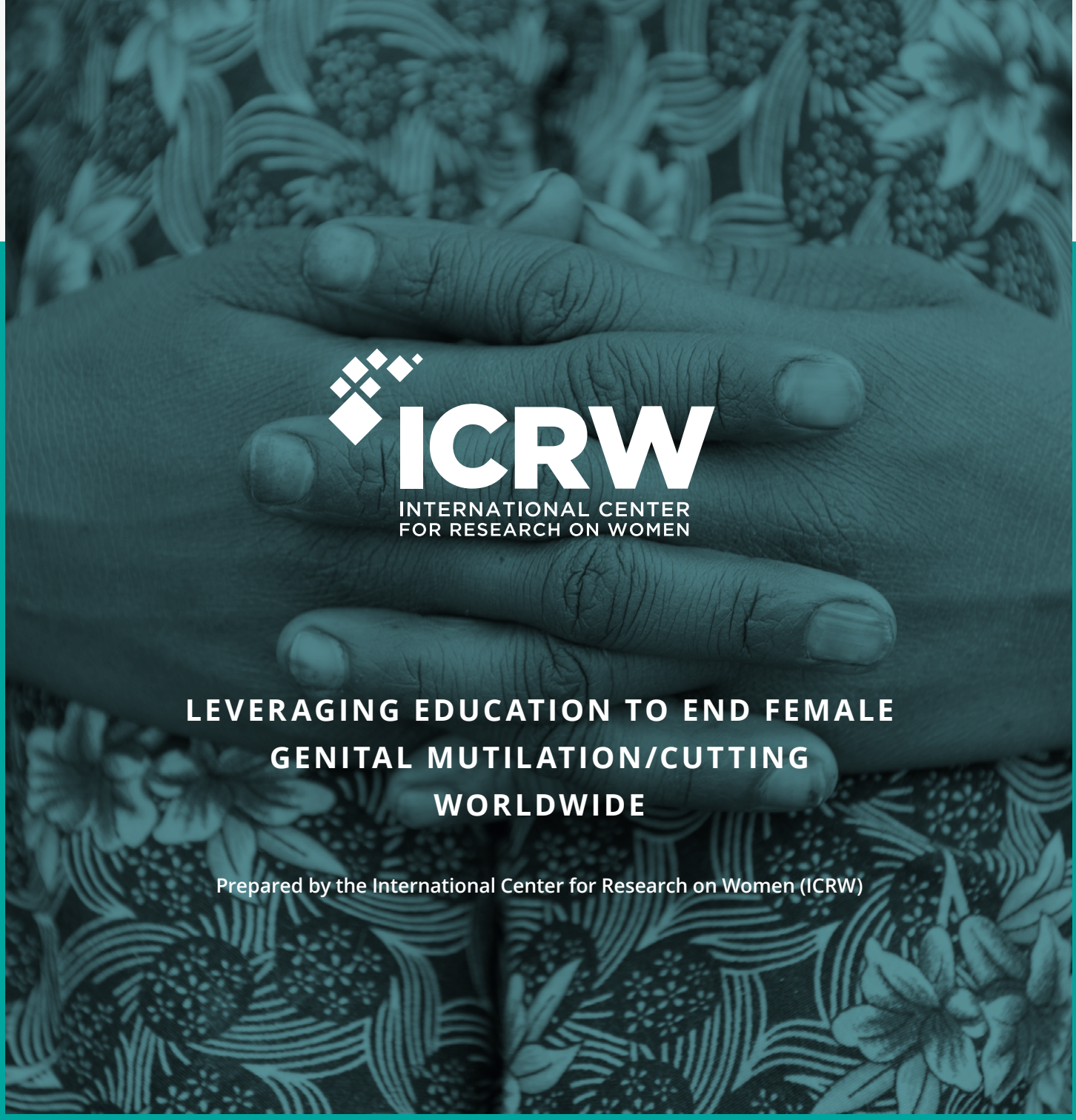

ICRW
INTERNATIONAL CENTER
FOR RESEARCH ON WOMEN

LEVERAGING EDUCATION TO END FEMALE GENITAL MUTILATION/CUTTING WORLDWIDE

Prepared by the International Center for Research on Women (ICRW)

This paper was prepared under a grant funded by the Wallace Global Fund. It synthesizes the evidence linking female genital mutilation/cutting and education, highlighting promising approaches to address both issues. This paper also provides actionable guidance to programmers, policymakers and funders to move these issues forward.

OVERVIEW OF FEMALE GENITAL MUTILATION/CUTTING (FGM/C)

Female genital mutilation/cutting (FGM/C)[1] is a practice that involves the complete or partial removal of the female genitalia for non-medical reasons (WHO, 2008). Worldwide, estimates indicate that more than 200 million girls and women have undergone FGM/C and more than three million girls and women are currently at risk of FGM/C. With the global population expected to rise in countries where FGM/C is concentrated, the number of women and girls at risk of FGM/C annually is expected to increase to about four million by 2050 (Shell-Duncan et al., 2016; UNICEF, 2016).

FGM/C occurs worldwide, with evidence of its practice highly concentrated in 27 countries in sub-Saharan Africa. Other countries for which nationally representative data exist include Iraq, Yemen and Indonesia. Figures on FGM/C prevalence should be regarded with caution as many data gaps remain, for example, in countries where the practice reportedly occurs but where no data exist at all. Anecdotal reports, pilot studies and small scale studies seem to indicate this hidden practice also occurs in Colombia, India, Iran, Malaysia, Oman, Saudi Arabia and the United Arab Emirates, but our understanding is limited given that no nationally representative data exist (UNICEF, 2016; Shell-Duncan et al., 2016). Two-thirds of all women who have experienced FGM/C reside in just four countries: Egypt, Ethiopia, Nigeria and Sudan (Shell-Duncan et al., 2016) and one in every five women who has experienced FGM/C is from Egypt (UNICEF, 2013).

While FGM/C is primarily performed on children and adolescents, age at cutting varies widely, with some girls undergoing FGM/C during infancy, while other girls and women undergo FGM/C later in life, often in preparation for marriage. In the 22 countries for which nationally representative data on age at cutting are available, the majority of girls in 12 countries were cut before the age of five. But notable exceptions such as Egypt, Kenya and the Central African Republic exist, where cutting continues well into the teen years (Shell-Duncan et al., 2016).

In developed countries, FGM/C occurs predominantly among diaspora communities representing countries where FGM/C is prevalent. FGM/C has also been reported in Western Europe, the United States, Australia, New Zealand and Canada, although data on the practice in these diaspora communities have been difficult to obtain (Shell-Duncan et al., 2016). Approximately 513,000 women and girls in the United States have undergone or were at risk for FGM/C in 2012, which is more than three times higher than 1990 data (Goldberg et al, 2016). In 2011, there were at least 103,000 immigrant women and girls in the United Kingdom who had experienced FGM/C (Macfarlane & Dorkenoo, 2015).

TYPES OF FGM/C

The World Health Organization (WHO) defines four types of FGM/C, using a numerical classification system ranging from I-IV (WHO, 2016). Type I is defined as partial or total removal of the clitoris, and Type II is partial or total removal of the clitoris and labia minora, with or without excision of the labia majora. Type III is narrowing of the vaginal orifice, by cutting and a portion the labia minora and/ or the labia majora, with or without excision of the clitoris to then create a seal for this newly created opening (infibulation). Type 4 comprises all other harmful procedures to the female genitalia for non-medical purposes (e.g., pricking, piercing, scraping).

[1] As of February 2016, WHO began referring to this practice exclusively as "female genital mutilation". Past definitions of this practice included "female genital mutilation/cutting". The term "cutting" was incorporated into terminology referring to this practice in part because the term "mutilation" was 1) difficult to translate while preserving its meaning, and 2) was used while shaming or questioning longheld traditions (UNICEF, 2005). In recognition of the research and literature reviewed and referred to within this paper that used terminology such as "female genital mutilation/cutting" or "female genital cutting", we will continue to refer to this practice as "female genital mutilation/cutting" (FGM/C) throughout the paper.

Girls living in diaspora communities also are at risk for so-called "vacation cutting," in which they are sent to their family's country of origin or across the border to a neighboring country under the guise of vacation or cultural learning, but instead are forced to be cut while abroad (Equality Now, 2016). In the United States, vacation cutting, defined as "knowing transportation of a girl under 18 years-old for the purpose of performing FGM/C abroad" is illegal (GAO, 2016). Today, close to 60 countries, 26 of which are in Africa and the Middle East, criminalize FGM/C (UNICEF, 2013).

Numerous international non-governmental organizations, governments and advocacy groups have called for an end to FGM/C, which was first recognized. as a human rights violation under the 1993 Vienna World Conference on Human Rights (Shell-Duncan, 2008). In 2012, the United Nations (UN) General Assembly adopted a resolution calling for global efforts to end FGM/C (UN General Assembly, 2012). More recently, the Sustainable Development Goals (SDGs), which includes a target under Goal 5 to eliminate all harmful practices, such as child, early and forced marriage and FGM/C by the year 2030, signify the international development community's commitment to work together to accelerate action towards the elimination of FGM/C globally.

FGM/C poses serious physical and psychological health risks, ranging in severity from urinary tract infections to Post-Traumatic Stress Disorder (PTSD), complications in childbirth and death (Reisel & Creighton, 2015; Wagner, 2015). Exposure to FGM/C places one at risk of immediate physical consequences, such as severe pain, bleeding and shock, difficulty in passing urine and feces and infections. Because of these health and human rights concerns, significant work has been undertaken to eliminate the practice of FGM/C, particularly through interventions that combine health and human rights approaches to tackle this problem.

DRIVERS OF FGM/C

The root causes behind the practice of FGM/C are diverse and multi-dimensional, and include social considerations related to marriageability, maintenance of family honor and respect, community acceptance and ethnic identity, ritual marking of a transition to womanhood, improvement of hygiene, religious and cultural requirements and socio-economic factors (Chesnokova & Vaithianathan, 2010; Coyne & Coyne, 2014; Kang'ethe, 2013; UNFPA, 2015; WHO, 2016). In many places, FGM/C is linked to virginity, fidelity and purity, all attributes that are considered essential for a girl's marriageability (McArthur, 1995). FGM/C is also related to a woman's modesty, as women are expected to fulfill widely-held gender roles and to maintain the family's honor.

Upholding these values in other countries and societies outside the homeland is one main factor that explains why FGM/C exists in diaspora communities. For women and girls living in areas where FGM/C is prevalent, they are often dependent upon marriage for financial stability. As a result, FGM/C is seen as a way to guarantee a woman's status, making her able to have children in a socially acceptable way and providing her with economic security, typically provided by the husband. Parents who choose to have their daughters cut consider their decision to be necessary, if not beneficial, for their daughter's future marriage prospects, in light of the financial and social constraints they may face.

Sociological and cultural traditions, such as those signifying a girl's coming of age or passage into womanhood also provide a justification for continuing the practice of FGM/C (UNFPA, 2015). Some communities also argue that FGM/C is necessary for hygienic reasons (UNFPA, 2015). Failure to undergo FGM/C might subject one to alienation, risk of physical violence or could result in a woman or girl being deemed unfit for marriage (UNICEF, 2008). In families, female elders who most often have gone through the practice, uphold the rituals, coming of age/initiation celebrations, teachings and other activities associated with the practice, and it is not uncommon for this elder to overrule the FGM/C preferences of a girl or those of her mother.

FGM/C is widely believed to be associated with religion, mistakenly linked to the Coptic/Orthodox and Islamic faiths. But the practice predates organized religion and no religion promotes or condones the practice in its scriptures (UNFPA, 2015). FGM/C also yields a financial incentive for communities to continue the practice of FGM/C, as it is often a major source of income for

community members who act as practitioners (UNFPA, 2015). It also serves to maintain the power structures present in these communities, with community and religious leaders, circumcisers and medical personnel working to maintain the practice (WHO, 2016).

FGM/C also appears to be closely linked to ethnicity rather than nationality, as FGM/C cross-border prevalence rates tend to align with one's ethnic identity, thus positioning ethnicity as a proxy for shared norms and values (Shell-Duncan et al., 2016). FGM/C is often symbolic of these norms, FGM/C prevalence in the Gambia is 72 percent, but the rates among the Wolof sub-population is as low as 12 percent, compared to 97 percent Mandinka women who undergo FGM/C (Shell-Duncan et al., 2016).

PROTECTIVE FACTORS AGAINST FGM/C

Shell-Duncan et al., note that urbanization, household wealth and education have been found to be associated with the decline or abandonment of FGM/C. In rural areas, the lack of cultural diversity makes it challenging to change long-standing social norms and traditional practices (Shell-Duncan et al., 2016). By contrast, urban settings may offer opportunity for one to engage with those individuals who do not practice FGM/C and access/exchange information and ideas that may make it easier for one to challenge the tradition. In 22 of the 30 countries in Africa and Asia with high prevalence of FGM/C, less than half of their populations reside in urban centers (UNFPA, 2015).

Increases in wealth are associated with a decline in FGM/C, or can serve as a predictor of the practice (Modrek & Liu, 2013). In a study of household wealth, FGM/C prevalence among daughters in the richest wealth quintile was found to be lower than that among those daughters from the poorest wealth quintile, with the exceptions of Mali and Guinea (UNICEF, 2013). Household wealth and mother's labor force participation were predictors of a daughter's FGM/C status, and when considered with mother's level of education, suggest that improvements in one's socio-economic status (education level, household income, participation in labor force) might have contributed to a decline in national level prevalence rates in Egypt (Modrek & Liu, 2013).

Emerging evidence illustrates that basic education can be an effective instrument for abandoning the practice of FGM/C; however additional evidence has yet to be uncovered. Given the lack of research, the Wallace Global Fund commissioned ICRW to conduct a review of the literature on the link between FGM/C and education.

OVERVIEW OF GIRLS' EDUCATION

Considerable effort has been made in improving girls' access to education worldwide. In countries where there is high prevalence of FGM/C (51 percent or more) (UNICEF-UNFPA, 2013), in at least three of these countries–Burkina Faso, Guinea, and Mali–adolescent girls do not attain the same number of years of schooling as adolescent boys (UNESCO GIS, 2016). Other factors impeding girls' access to education include school harassment, expectations that girls help with housework/chores and marriage (UNESCO, 2016). Often, the preparation for marriage requires a girl's involvement in rituals or practices such as FGM/C to facilitate her transition into adulthood.

FGM/C AND EDUCATION: WHAT DOES THE EVIDENCE BASE SAY?[2]

Our review of over 60 journal articles, white papers, synthesis reviews and news articles suggests that there is a dearth of evidence on the intersection between education and FGM/C, which points to the need for more research and investigation to better understand the linkages. It is important to note, however, that while the body of research examining the link between FGM/C and education is rather small, it is expanding with some considerable research and programmatic efforts being carried out in Africa's East Rift Valley. Education is often thought to be associated with FGM/C in that the likelihood a woman has her daughter cut diminishes as the mother's level of education rises. Access to education allows for the introduction of new concepts and the exchange of ideas, along with access to various sources of information, technology and programming in spaces that foster critical thinking and social relations (UNICEF-UNFPA, 2013).

[2] See Annex A for search methodology

There are ample evaluations that examine the relationship between girls' education–in particular around grade transition, retention, academic performance and graduation–and the harmful traditional practice of child marriage. Some select findings from the child marriage-education research highlight that with secondary level of education, a girl is nearly six times less likely to marry as a child compared to those with some or no education, and a girl with no education is three times more likely to marry by age 18 compared to those with secondary or higher education (Girls Not Brides, 2016). Child marriage-education research notes that shifting social norms is required in order to overcome strongly upheld practices such as child marriage (Lemmon & ElHarake, 2014). But few if any evaluations inclusive of those of a rigorous nature have been conducted on FGM/C programming, including those that address education and FGM/C (WHO, 2011). Below, we present learnings from evaluations, and anecdotal evidence from programs that aim to address either FGM/C or FGM/C and education, either through formal/traditional education settings or nontraditional education mechanisms such as awareness-raising campaigns in different countries and contexts.

In order to continue building the evidence base on the links between FGM/C and girls' education, we must first understand that measurement of FGM/C, specifically using items on nationally representative surveys such as the Demographic and Health Survey (DHS) and Multiple Indicator Cluster Surveys (MICS), has been refined over time, which makes it difficult to capture trends (Feldman-Jacobs, 2016; Hussein, 2016). Systematic approaches for measuring FGM/C using survey data have been adopted over time, particularly since the late 2000s, resulting in more structured attempts to capture information such as FGM/C prevalence rates for household females including FGM/C status for all daughters, and female and male attitudes and beliefs around the practice, specifically around its continuation, and mother/father intention to cut daughter (Shell-Duncan et al., 2016). There is some research linking FGM/C and education through inquiries about intention to cut daughter or FGM/C status of mother, or the educational level of girl/daughter, mother, and father. These types of studies are discussed in more detail below.

FGM/C and girls' education:

There is limited quantitative evidence on the association between FGM/C and girls' education, as studies on this subject often rely on anecdotal evidence or non-representative samples. However, the available evidence suggests a relationship between FGM/C and school dropout (Magangi et al., 2015; Nyabero et al., 2010) or diminished participation in school-related activities as a result of FGM/C (Anumaka & Sironka, 2014). As part of two small-scale studies in Kenya, the majority of teachers surveyed about FGM/C and its relationship to school attendance reported that after a girl student has been cut, typically her education ends as she is withdrawn from, or terminates, her studies (Magangi et al,. 2015; Nyabero et al., 2010). Survey data collected from students in Kuria West District (Kenya) reveal similar findings as over three-quarters of students surveyed reported that student dropout was the direct result of FGM/C (Magangi et al., 2015). FGM/C-related medical complications have been frequently cited as among the primary reasons that a girl drops out of school (Nyabero et al., 2010).

FGM/C has also been noted as an explanation for low levels of grade completion (UNGEI Uganda, 2012) and lower rates of grade transition among girls (Nyagah, 2016). Research conducted in northern Tanzania's Mara region found that girls living in communities where FGM/C is widely practiced had directly experienced social exclusion, isolation and stigma in the form of shaming (name-calling), all manifesting in the school setting because of her status as an uncut girl (Pesambili, 2013). In situations where the girl either appeared to, or actually rejected FGM/C, she experienced similar actions from family members, and in some cases, lost parental/familial support for their education (Pesambili, 2013). As indicated above, research suggests that in many cultures FGM/C is a social prerequisite for marriage in communities (Pesambili, 2013; UNFPA-UNICEF, 2013; World Vision, 2014). Existing research highlights poverty status as a driver of early marriage when impoverished families marry off their daughters – getting bride price in return – in order to improve household security (The Commonwealth, 2014; UNICEF, 2013).

One exploratory study in Kajiado Country Kenya, which focused on identifying the socioeconomic, cultural and environmental factors influencing a girl's transition between grades, found a positive correlation between FGM/C status and poverty (Nyagah & Luketero, 2016). The same study found similar association between FGM/C status and the lack of parental encouragement for a girl to continue her studies (Nyagah & Luketero, 2016).

While it is difficult to extrapolate such findings, these findings suggest that parents from impoverished households were more likely to encourage the cutting of their daughters. This is typically done in preparation for marriage in some communities in Kenya, and to receive a bride price (Nyagah & Luketero, 2016). While some girls who are cut subsequently return to school, some girls reported to have experienced a positive change in social status, in part due to others viewing her now as a woman now that she had been cut (Magangi et al., 2015; Nyabero et al., 2016).

FGM/C, mother's level of education, and beliefs around continuation of the practice:

Previous studies have shown a lower prevalence of FGM/C and greater support for the discontinuation of FGM/C among highly educated women compared to those of lower levels of education in Burkina Faso, Tanzania, Egypt, Ghana and Iraq (Msuya et al, 2002; Dalal et al., 2010; Karmaker et al., 2011; Sakeah et al, 2006; Saleem et al., 2013). Nationally representative survey data on FGM/C also found that a women's support for FGM/C decreases as her level of education increases (UNICEF-UNFPA 2013). Using the same dataset, when comparing women with no education to those with secondary education, in eight countries, there was a more than 30 percent difference between the two groups with respect to the percentage of women supporting for FGM/C. Similar findings were noted in a modeling study using data from the Kenyan DHS, which found that as a woman's level of education increased, the likelihood that she herself was cut decreased (Achia, 2014). The same study also suggested that women who had experienced FGM/C were more likely to favor continuation of the practice compared to those who had not been cut (Achia, 2014). A study in Burkina Faso found that the proportion of cut women with no education was higher than that of cut women with primary and above education (Chikungu & Madise, 2015). The same study found that the proportion of women with no education who wish to end FGM/C was smaller than that for women with a minimum level of primary education. Significant association between the mother's educational status–if she had low level of education–and her daughter's status as being cut was reported in a cross-sectional study administered in western Ethiopia (Gajaa et al., 2016). And researchers in northern Ethiopia found that more women with no education who favored continuance of this practice compared to those with some education (primary school or higher) (Gebrekristos et al., 2015).

FGM/C and father's level of education:

The educational attainment of men can also have an impact on the odds of continuing the practice of FGM/C. Secondary analysis of nationally representative data collected in Guinea found that the proportion of men favoring the discontinuance of FGM/C was larger than that for women, and that with each additional year of education, men were less likely to favor the continuation of the practice (Gage, 2016). It is important to note that favoring the discontinuation of the practice does not necessarily lead to its reduction, but identifying the knowledge levels, beliefs and positions held by residents in those communities where this practice is prevalent is an important first step in designing the most appropriate responsive program/intervention. In a cross-sectional survey administered to male secondary school students in western Nigeria, education was the most frequently mentioned intervention for stopping FGM/C (Adeniran et al., 2016). It should be noted that these male students had higher than average knowledge of FGM/C (77 percent compared to 66 percent) –the national average for male knowledge of FGM/C–as reported in the 2013 Nigeria DHS. A study in southern Ethiopia found that a girl is twice as likely to be cut if her father has no education than if he has a high school education (Tamire et al., 2013).

U.S. INVESTMENTS IN FGM/C

The U.S. Strategy to Prevent and Respond to Gender-Based Violence Globally, launched in August 2012, specifically recognizes FGM/C as a harmful practice and investments like these are critical to the achievement of the SDGs.[3] The U.S. supports host-country legislation against the practice of FGM/C, participates in the Donors Working Group on FGM/C to discuss donor coordination and best practices to eliminate FGM/C and engages civil society through public outreach to highlight current efforts to educate and invest in girls, a key to preventing FGM/C. However, U.S. assistance efforts to address FGM/C are limited. The Department of State and the U.S. Agency for International Development (USAID) each had one active standalone project in 2014 with less than 2 million dollars combined. Competing development priorities within USAID leaves little funding available for FGM/C-related efforts (GAO, 2016). The U.S. government provides funding to the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF) but, to date, has not contributed funds to those UN agencies' Joint Program in 17 countries, which works toward ending FGM/C.

The U.S is one of the largest donors in global education and global health programs, yet they have not made targeted investments to prevent FGM/C. Leveraging our investments in education, such as Let Girls Learn and the President's Emergency Plan for AIDS Relief (PEPFAR) provide immediate opportunities to support efforts to end FGM/C. Most recently, the Senate included a $5 million appropriation for U.S. contributions to a UN program on FGM/C in the committee-reported draft of its 2017 State and Foreign Operations appropriations bill. Additionally, the State Department, USAID, Millennium Challenge Corporation and Peace Corps released the U.S. Global Strategy to Empower Adolescent Girls, which includes an explicit section on ending FGM/C (United States Government, 2016). Given the linkages between FGM/C and education, targeted investments in basic and secondary education can ensure that girls are protected from cutting.

PROMISING APPROACHES THAT USE SOME FORM OF EDUCATION WHILE WORKING TOWARDS ABANDONMENT OF FGM/C

Over the past thirty years, preventing FGM/C has increasingly been the goal of interventions by both local and international organizations, national governments, development agencies and advocacy groups. A variety of programs have attempted to eliminate the practice of FGM/C in local communities. Those that have been deemed the most successful tend to focus on holistic, integrated and culturally-sensitive approaches that are community-based and involve coordination from multiple sectors (Feldman-Jacobs, 2013; WHO, 2008). First, we wish to bring attention to certain classes of approaches (interventions and programming) that are being utilized to address FGM/C and/or education:

Village/community wide campaigns:

Community-wide programs such as Tostan's multi-country FGM/C education model or the FGM Free Village Campaign led by Egypt's National Council for Childhood and Motherhood (NCCM) are programs that rely on multiple levels of coordination in order to achieve success. By focusing on the social aspects of FGM/C through educational and social media campaigns and by engaging various stakeholders such as youth, parents, religious leaders, medical personnel, journalists, judges and prosecutors, the NCCM's advocacy efforts were pivotal in the issuance of the "The Child law" in 2008 which made FGM/C illegal (UNICEF, 2010). Eventually, in 2016, Egypt moved to modify the criminal nature of FGM/C, changing it from a misdemeanor to a felony.

School-based interventions

School-based interventions that address FGM/C and work with girls can take on many forms. In Burkina Faso, the government provided anti-FGM/C trainings for teachers and helped incorporate FGM/C into the science curriculum (WHO, 2011). GAMCOTRAP, a Gambian organization, successfully lobbied the Government of The Gambia to incorporate FGM/C into the public school curriculum, beginning in the 2016 academic year.

[3] http://www.state.gov/documents/organization/196468.pdf

The Global Women P.E.A.C.E. Foundation, a USA-Liberian NGO that works to end all practices including FGM/C, will launch a curriculum targeting school personnel and administrators on how to carry out conversations around FGM/C with students in late 2016. As an alternate to the formal classroom setting, Global Women P.E.A.C.E. is hoping to work with afterschool clubs as an entry point for sharing this information.

However, formal education settings are not the only arenas for intervention. In areas with low student enrollment, confining information exchanges, learning opportunities and programming to the school setting would fail to reach community members who lack contact with this environment, which is critical to ensure the basic information from the programs reach all groups in the community, in order to foster learning and increase understanding (WHO, 2008).

Alternative Rites of Passage

FGM/C was first replaced with other "alternative rites of passage", beginning in 1996 in Kenya and continues in many places today. This process was first pioneered by the Kenyan NGO Maendeleo Ya Wanawake Organization (MWYO) and is designed to help girls transition into adulthood without having to undergo FGM/C. However, a 2011 evaluation of the alternative rites of passage approach (and its application to FGM/C-related programming) found that it is effective only in communities where FGM/C involves public celebrations (Feldman-Jacobs 2013).

Media and the Arts

Media can also be an effective means to disseminate information and increase knowledge about FGM/C and community theatre is mechanism that has been tested and validated to start conversations around gendered norms and practices such as FGM/C. Through a partnership between CBOs and professional actresses and actors with immigrant backgrounds, diaspora communities in Switzerland have organized plays around FGM/C, accompanied by rounds of discussion on the matter (Vissandjée et al., 2014).

Targeting Practitioners/Initiators

Initiators of FGM/C are often targeted in intervention approaches, and as a measure to decrease FGM/C, are expected to cease practice and seek alternate forms of income. However, such methods have proven ineffective, as initiators who give up this role are often lured back in, usually because the communal recognition (of the initiator's role) derived from such practice (Feldman-Jacobs, 2013) and its lucrative pay (WHO, 2011). Rural Women Peace Link, a Kenyan NGO, works with reformed initiators to conduct classroom outreach on FGM, highlighting the various risks tied to the practice and emphasizing the need for a girl to pursue her education.

Parents and other senior family members

Encouraging intergenerational dialogue is seen as an approach that appears to have traction as often it is the older community members who enforce norms and continue practices such as FGM/C. Initiatives like the Grandmother Project in Nigeria and Senegal, which utilizes grandmothers and seniors in the community as an entry point to talk about community traditions and values across generations, work to promote positive traditions (Feldman-Jacobs, 2013).

Tostan Education Program (Mali, Senegal, and Burkina Faso)

Tostan's Village Empowerment model is a human rights community-rooted program that promotes social change using education and literacy, which has since been expanded and scaled up since its origins in Senegal. In 2002, the program was adapted to focus on FGM/C. A four-part curriculum providing information on human rights, reproductive health, hygiene and problem-solving skills was adapted to the local context. One consistent finding across all three countries was that immediate identification of a role model/advocate for promoting positive behaviors was critical for this program/approach to gain traction in its respective community (Berg and Denison, 2013). In Mali, the focus of the country's adaptation was to generate change at both the individual and collective levels and the evaluation found that in this context, approaching FGM/C from a human rights

angle along with creating a base for social action helped increase positive individual and community health behaviors and lay the ground for efforts to abandon FGM/C (Berg & Denison, 2013). The Senegal evaluation found that while education programs were welcomed and women and men's knowledge of FGM/C increased after exposure, the project faced resistance among community members as evident in few conversations on, and little action towards, reducing FGM/C (Diop et al., 2004). The Burkina Faso evaluation found that assigning a participant to a child mentee ("godchild") facilitated knowledge sharing and dissemination of FGM/C information and messages (Ouoba et al., 2004).

FGM Free Village (Egypt)

Coptic Evangelical Organization for Social Services' (CEOSS) anti-FGM/C work in Deir-el-Besha, in the Minia region of Egypt is a noteworthy example of an FGM/C education campaign that was successful due to its integration and engagement into social and relational structures. CEOSS began working with the community in 1992 to first build trust among community members. The program then engaged local religious authorities, members of the government and women in leadership and planning roles to support FGM/C campaign work. The program specifically included women-led schools and awareness education targeting young girls. With improved social and educational awareness, Deir-el-Besha became the first village to publicly declare that they would no longer tolerate FGM/C and as of 1996, never reverted back to the practice. CEOSS has tried a similar strategy in other villages but were unsuccessful. An evaluation, which compared FGM/C rates between Deir-el-Besha against another village where there was no intervention, noted that there was a more than 30 percent difference between the two village's FGM prevalence rates; 50 percent in Deir-el-Besha compared to 84 percent in the other village (Abdel Hadi, 1998).

Change Makers (Kenya)

Society Welfare Development Program (SOWED) Kenya conducted formative research alongside stakeholder analysis to identify activity "influencers," considered to be those who influence outcomes. SOWED's current engagement as Kajiado County's health committee planning coordinator and past involvement in county anti-FGM/C campaigns facilitated planning efforts for its "Change Makers" activity. SOWED realized that there were other risks associated with FGM/C (e.g., fistula, HIV) and wanted to address this through youth-centered programming. Recognizing that the school setting is the most desired entry point, SOWED reviewed literature, environmental/health/school retention data and lessons learned documents alongside community elders and academic researchers to then identify potential intervention schools situated in high FGM/C prevalence areas. SOWED worked with various stakeholders, including parents, principals and elders to gain entry into these communities and then to sign on to participate and engage with SOWED as "Change Makers," who then team up to form school-based "peace clubs." Mandated by the Government of Kenya (GOK), peace clubs are where young people can obtain information on FGM/C as these spaces are part of the government's anti-FGM/C efforts. Currently, this campaign is limited to six schools in Kajiado with the possibility of scaling up. While basic monitoring data is collected and processed, there is strong desire from organizational leadership to have this project evaluated.

Channels of Hope

World Vision has developed the Channels of Hope (CoH) program model, which trains and equips faith and community leaders to individually and collectively respond to issues that impact the well-being of children, their families and communities. This approach tackles misconceived religious teachings from both Christianity and Islam that are used to endorse unequal attitudes towards women, and support for practices such as FGM/C and early marriage. By equipping religious and community leaders with knowledge and capacity, CoH also trains community members on how to endorse an equal view of men and women based in religious teaching.

Safe Hands for Girls (USA and The Gambia)

Safe Hands for Girls, a US-Gambian NGO, implements school-based outreach and trainings on advocacy around FGM/C. In Gambia, a nationwide school outreach program implemented by Safe Hands launched in October, 2016 alongside a pilot school-based training in FGM/C & advocacy that focuses on FGM/C, GBV, child marriage and the law (e.g. Child Protection Act) in one region. Safe Hands also implements a U.S.-based program, which targets young female immigrants or those that are recently resettled, and aims to provide them with the skills to successfully navigate through society. The Safe Hands for Girls Breaking Barriers Program, implemented in the U.S. targets young female immigrants or those that are recently resettled, and aims to provide them with the skills to successfully navigate through society. Focusing on education, Breaking Barriers, offers information/training on financial literacy, health and hygiene and includes information on FGM/C in these modules. Safe Hands is now collaborating with the Population Council to improve their research.

Global Woman P.E.A.C.E. Foundation

The mission of Global Woman P.E.A.C.E. Foundation is to empower women and girls through education to eradicate gender-based violence with a special emphasis on FGM/C. The Global Woman Center, located in the Washington, D.C.-metro area serves as support for survivors and girls at risk of being cut. This program provides a safe environment for women and girls, while also providing counseling and reconstructive surgery services. The Center also teaches children about FGM/C and helps train school teachers and counselors on how to detect the warning signs of FGM/C.

Kakenya Center for Excellence (Kenya and the USA)

The Kakenya Center for Excellence (KCE) is an international non-profit organization leveraging holistic, girl-centered education to end harmful traditional practices, empower women and girls to achieve their dreams, and transform communities in rural Kenya. KCE has three programs: the all-girls boarding school; the Health and Leadership Trainings and the Network for Excellence, which supports boarding school alumnae as they continue their education in high school and university. Each program provides vital health, legal and leadership curricula, including information about FGM/C, menstrual hygiene, sexual and reproductive health and rights and self-defense. KCE also works closely with families to cultivate meaningful relationships, transform entrenched societal norms, keep girls in school and prevent FGM/C and child marriage. To date, 100 percent of girls in the boarding school program have continued their education, remain unmarried, and have not undergone FGM/C. In 2014, KCE collaborated with Columbia University's Pangea Center to administer a survey to 100 KCE students in grades six through eight on knowledge and attitudes around statements on FGM/C. An overwhelming majority of the surveyed students - over 90 percent - stated they believed FGM/C is not necessary for one to be considered a woman, contrary to beliefs traditionally held in their community (Terrin, 2015).

CONCLUSION

Overall, more research is needed to effectively examine the intersection of education and FGM/C. While there is some quantitative data on the impact of formal education on individual attitudes and beliefs around the practice, there is still a significant gap in research to determine whether it is really education or other confounding variables that are responsible for this difference. The influence of gender norms must be considered in future research. Popular education campaigns and other programmatic efforts to inform communities about the harmfulness of FGM/C have had success in lowering the rates of FGM/C, but not in all cases and not as quickly as hoped. Additionally, some of these campaigns have not been rigorously evaluated. To that end, further research into the intersections of education and FGM/C will be critical to continue to improve efforts to combat this harmful practice, and to bring effective practices to scale.

Below are some recommendations for how funders, researchers, implementers, policymakers and advocates can address some of the gaps in understanding the connection between FGM/C and education and eliminating the practice of FGM/C across the globe.

RECOMMENDATIONS

Funders:

- Invest resources to fund long-term, evidence-based interventions to eliminate FGM/C, including through social norm change and funding girls/youth-led, women's and feminist groups working to increase the value of the girl child. Invest in building the evidence base about effective prevention strategies, including through rigorous evaluations;
- Allocate funds to document the medical costs associated with the obstetric complications of FGM/C and the financial burden that FGM/C imposes on the health system;
- Provide resources that target prevention and awareness campaigns in high FGM/C prevalence contexts;
- Provide capacity building trainings for grantees on program design, monitoring, evaluation, strategic communication;
- Create networking opportunities for grantees to leverage resources, visibility, investment, and sharing of research findings; and
- Leverage investments in related issues, including education, to specifically address FGM/C.

Researchers:

- Build the evidence base on the factors associated with the practice of FGM/C and its effect on education;
- Conduct rigorous evaluations to identify promising and effective approaches to the elimination of FGM/C;
- Conduct research on the prevalence of FGM/C in the United States to understand the magnitude of the problem;
- Quantify the medical costs of obstetric complications including the costs of treating FGM/C-related psychological and sexual health problems;
- Develop and pilot test indicators for standardized and consistent measurement of FGM/C;
- Investigate the link between child marriage and education in intervention design and testing;
- Conduct qualitative research with community members who choose not to practice FGM/C in order to identify the key factors that lead to decreased likelihood of FGM/C;
- Investigate the challenges that girls face in high FGMC prevalent contexts which limit their completion of school;
- Collaborate with implementers to build their capacity in program design, monitoring and evaluation, and research dissemination; and
- Evaluate the implementation and impact of policies to address FGM/C.

Implementers:

- Use existing evidence on the effectiveness of FGM/C prevention efforts to improve the design of programs that target girls;
- Budget for rigorous evaluation of FGM/C interventions. Process and impact evaluations of programs require strategic development and investment;
- Adopt holistic and multi-sectoral approaches that aim to involve multiple stakeholders and achieve impact at various levels (individual, relational, household, community, societal);
- Engage popular opinion leaders including social influencers (i.e., religious leaders) and family influencers (i.e., elder family members) throughout program design and implementation to garner buy-in and support;
- Design and implement culturally-responsive programming that takes into account ethnicity, culture, and community social norms;
- Interventions should empower women economically and girls through education and awareness-raising campaigns;
- Use non-"human rights" language in messaging
  - This terminology or these approaches might actually induce harm (from participation) and failure of program uptake;

- Develop formal and informal forums to emphasize the importance of a girl's completion of school, the consequences of FGM/C and the benefits of eliminating FGM/C in schools, communities and religious settings. A respected member of the community should be the entry point to start the community dialogue;
  - Use the school club function as means to share awareness raising information as opposed to school/classroom-based curriculum;
  - Conduct intergenerational dialogues which enable young and older community members, including boys and men, to reflect upon their traditions, values about FGM/C and girl's completion of school. As popular opinion leaders, engaging older members of the community is crucial to changing FGM/C practice; and
  - Create community-based systems for reporting, monitoring, and tracking cases of FGM/C, including those that have been reported to law enforcement.
- Conduct targeted programming towards high-risk populations including women from rural areas and specific ethnic groups;
- Integrate FGM/C programming into other gender-based violence prevention and response interventions;
- Train teachers, health personnel, social workers, law enforcement and child protection officers in the U.S. on warning signs and how to support FGM/C survivors; and
- Collaborate with embassies and organizations that work with immigrant communities from high prevalence FGM/C countries to provide education on the harmful consequences of FGM/C and ensure a coordinated response for support to FGM/C survivors

Policymakers (e.g., House/Senate/USAID/ Department of Education)

- Review existing policies to assess where explicit linkages to FGM/C could be added, if they do not already exist, starting with gender, education and health;
- Evaluate the impact of existing policies designed to end FGM/C, and publish results;
- Develop action plans to achieve SDG 5.3, to cost those plans and allocate resources accordingly, and to utilize standardized indicators when measuring FGM/C prevalence and progress in (practice) reduction efforts;
- Enact and enforce international conventions, treaties and national laws outlawing the practice of FGM/C, taking great care not to demonize families and communities and drive the practice underground;
- Enact and enforce policies that affirm and protect the fundamental human rights of girls and women, and empower youth- and women- led movements for change;
- Create opportunities (e.g., technical working groups) for coordination across ministries/departments that link FGM/C and education;
- Tailor relevant policies and programs toward achieving SDG target 5.3, to end harmful practices including FGM/C by 2030;
- Replicate effective strategies from the President's Emergency Plan for AIDS Relief (PEPFAR) to inform the integration of FGM/C programming in Let Girls Learn. PEPFAR supports significant work to incorporate efforts to prevent and respond to gender-based violence into existing HIV treatment and prevention programs;
- Provide global health funding to prevent FGM/C within existing global health efforts; and
- Review opportunities within PEPFAR to end FGM/C under planned GBV response activities. For the 3 DREAMS countries that are among the top prevalence FGM/C countries, efforts to end the practice should be included in country plans.

Advocates

- Lobby governments and ministries to develop action plans to achieve SDG 5.3, to cost those plans and allocate resources accordingly, and to utilize standardized indicators when measuring FGM/C prevalence and progress in reduction efforts;

- Advocate, where applicable, for laws and policies to prevent and respond to FGM/C.
  - Policies that support FGM/C prevention in the school system;
  - Policies that require school personnel, administration to be trained in FGM/C awareness; and
  - Policies that support community-wide FGM/C information "education" campaigns, especially for reaching vulnerable girls – in particular, out of school girls.
- Collaborate with other international, regional, national FGM/C and girls education coalition platforms on shared messaging; and
- Engage representatives from Congress to serve as champions to promote the abandonment of FGM/C.

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ANNEX A. Literature search methodology

This literature review brought together existing academic literature, grey literature and media pieces examining the linkages between FGM/C and education. Journal articles were sourced primarily through JSTOR and Project Muse databases, was expanded to additional databases as needed. Grey literature and media pieces was sourced primarily through open internet searches, including Eldis, BRIDGE, the Development Clearinghouse (DEC) and Development Gateway, as well as Google and Bing search engine queries. In all cases, found literature was examined for additional relevant citations to further the knowledge base. In searching for relevant literature on FGM/ and education, the following keywords have been identified as yielding potentially fruitful results: female genital mutilation, female genital cutting, female genital mutilation/cutting, female circumcision, FGM, FGM/C, female genital mutilation AND education, female genital cutting AND education, female circumcision AND education, FGM AND education, harmful traditional practices AND education, FGM and community education program, FGM AND programming, and FGM interventions.

ANNEX B. List of key informants

ICRW conducted key informant interviews, and/or conducted meetings where programing details were discussed, with the following individuals:

- Charlotte Feldman-Jacobs, Population Reference Bureau, Washington, DC
- Ole Lelein Kanunga, Nasaru Eselenkei Emaa, Kenya
- Salma Abou Hussein, Population Council Egypt
- Omar Nsateh, Youth Anti-FGM Network Kenya
- Karanga Muraya, SOWED-Kenya
- Hadditajou Ceesay, Safe Hands for Girls, USA/The Gambia
- Angela Peabody, Global Women P.E.A.C.E. Foundation, USA/Liberia
- Fred Yego, Rural Women Peace Link, Kenya
- Kakenya Ntaiya, Kakenya Center for Excellence, Kenya and the USA

Reviewed program documentation for, or exchanged correspondence with:

- Samson Nyangaluk, Umoja Development Foundation, Kenya

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