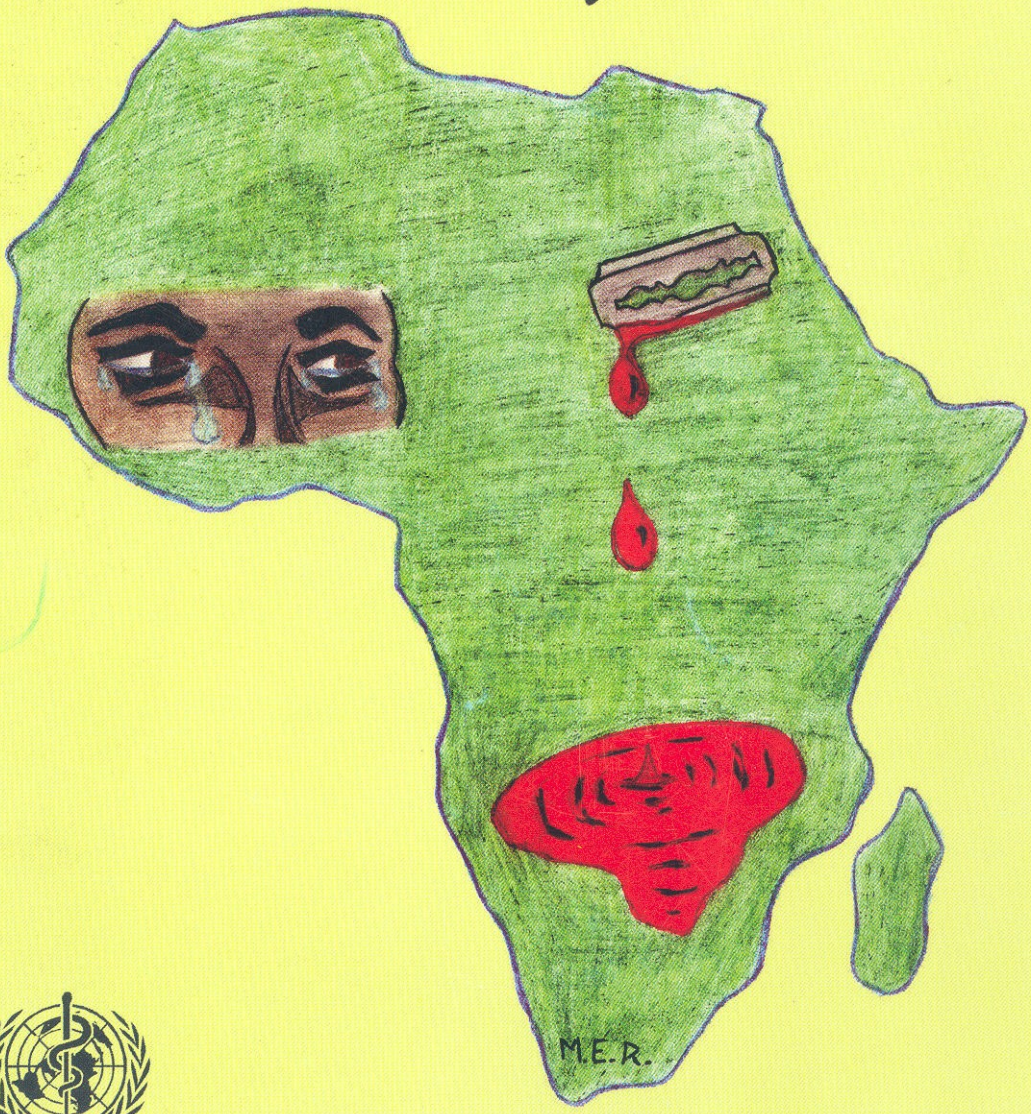
Regional Plan of Action to Accelerate the Elimination of Female Genital Mutilation in Africa



World Health Organization

Regional Plan of Action to Accelerate the Elimination of Female Genital Mutilation In Africa

WORLD HEALTH ORGANIZATION
Regional office for Africa
Brazzaville

Printed at the WHO Regional Office for Africa

CONTENTS

ANNEXES

Page

ACKNOWLEDGEMENTS

The World Health Organization Regional Office for Africa wishes to thank the following persons for their valuable contributions to the Women and Adolescent Health (WAH) Unit in the preparation of the Regional Plan of Action: Dr E. E. Ekanem (Temporary Consultant), Dr (Mrs) Olayinka A. Koso-Thomas (Temporary Consultant), Dr (Mrs) V. Ndiki Ngcongco (Temporary Consultant), Mrs Sheila M. Poole (Editor) and Mrs Safiatu K. Singhateh (Temporary Consultant).

Thanks are also due to the many others who have provided useful comments.

Foreword

Female genital mutilation, commonly referred to as female circumcision, is a grievous and harmful practice which has long existed on the African continent. Girls are constantly at risk of undergoing this deeply rooted traditional and cultural practice and it is known to be prevalent in 27 of the 46 countries of the African Region of the World Health Organization. While there are some good reasons for recognizing and respecting the initiation of girls into womanhood, eliminating their mutilation certainly has many advantages.

Over the years, the negative consequences of female genital mutilation have resulted in a heavy burden for us in the African Region. Quite a number of activities have sprung up over the last decade aimed at changing behaviour among the providers and beneficiaries of this practice but we seem to be trapped in a vicious circle.

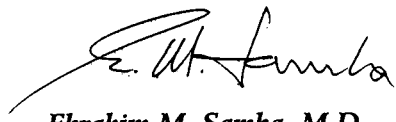
Whatever the justifications are for maintaining the practice, there is no doubt that female genital mutilation is an obstacle to the attainment of the goal of health, development and human rights for not only girls and women, but for all members of our society. The practice continues to have serious adverse effects on the health of girls and women and is detrimental to development. We will therefore be shirking a major moral responsibility if we shy away from the problem. Our primary commitment is to help the populations of our Region to enjoy a better quality of health.

Until there is leadership that will put together a concrete plan of action and take it to African governments, there will be no marked progress towards the elimination of female genital mutilation. The WHO Regional Office for Africa is committed to assuming this leadership and coordinating role as WHO's campaign against the practice of female genital mutilation cannot be compromised. This is why we have developed the *Regional Plan of Action to Accelerate the Elimination of Female Genital Mutilation*.

The Regional Plan of Action demonstrates how working in close collaboration with *all* partners in the interest of liberating girls from the victimization of this practice can be accelerated. It reflects a multisectoral and multidisciplinary approach to the elimination of the practice and management of its health complications within existing primary health care programmes and other initiatives in the areas of women's health and development, reproductive health and safe motherhood, child survival and development and HIV/AIDS and other sexually transmitted diseases. It has been developed as a broad strategy to support and coordinate the planning of implementation of country activities for the prevention and elimination

not only of female genital mutilation but also of other harmful traditional practices which affect the health of women and children in the Region.

It is our hope that some day soon, using the *Regional Plan of Action to Accelerate the Elimination of Female Genital Mutilation* as a vehicle, we will be able to derive tangible action-oriented solutions to this problem thereby improving the quality of life of girls and women in the WHO African Region.



Ebrahim M. Samba, M.D.
Regional Director

1. Introduction

Female genital mutilation, commonly referred to as female circumcision, is a deeply rooted traditional practice. However, it is a form of violence against girls and women that has serious physical and psychosocial consequences which adversely affect health, and it is a reflection of discrimination against women and girls. The World Health Organization (WHO) is committed to the abolition of all forms of female genital mutilation and condemns the involvement of health professionals in any form of the practice in any setting, including hospitals and other health establishments.

Despite the fact that female genital mutilation is practised in many societies with diverse cultures and religions, there is no religion that requires it and neither the Bible nor the Koran prescribes it. In Africa, female genital mutilation is reported among followers of some Islamic sects and local religions and among some Protestants, Catholics, Orthodox Christians and Jews. It is not known when or where the tradition originated, but a variety of reasons (sociocultural, psychosexual, hygienic, aesthetic, religious) are given for maintaining it.

1.1 Definition[1]

Female genital mutilation comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons.

1.2 Classification and distribution

The different types of female genital mutilation known currently to be practised are as follows:

Type I Excision of the prepuce with or without excision of part or all of the clitoris

Type II Excision of the prepuce and clitoris together with partial or total excision of the labia minora

Type III Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)

Type IV Unclassified:

[1] In July 1995, WHO convened a Technical Working Group on Female Genital Mutilation in Geneva, Switzerland, which recommended the adoption of this definition and classification (*1*).

- pricking, piercing or incision of the clitoris and/or labia
- stretching of the clitoris and/or labia
- cauterization by burning of the clitoris and surrounding tissues
- scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina
- introduction of corrosive substances or herbs into the vagina to cause bleeding, or with the aim of tightening or narrowing the vagina, respectively
- any other procedure that falls under the definition of female genital mutilation given above.

The procedures described above are irreversible and the damage done to the female sexual organs and their function is extensive. Excision (types I, II) is common from the west coast of Africa to the east, from Mauritania to Ethiopia. Infibulation (type III) is widespread and has been reported in Eritrea, Ethiopia, northern Kenya, northern Nigeria and some parts of Mali.

Female genital mutilation is one of a number of harmful traditional practices that are still prevalent in many African countries and constitute a major public health problem for health services that are already overburdened and frequently deficient. These harmful practices affect the health of women and girls, who already carry the heavy responsibility of caring for the family (*2*).

1.3 Health consequences

The health consequences depend on the type and the severity of the genital mutilation performed and are divided into two broad categories:

- immediate
- long-term.

The immediate health complications include: pain, shock, bleeding, acute urine retention, injury to adjacent tissues, risk of transmission of blood borne diseases such as hepatitis B and HIV/AIDS from the use of unclean cutting instruments during group mutilations, and other infections leading to fever, tetanus, gangrene, septicaemia, failure of the wound to heal and in some cases, death.

The long-term health complications include: difficulty in urination, recurrent urinary tract infections, dysmenorrhoea (painful menstruation), clitoral neuroma, dyspareunia (painful sexual intercourse), sexual dysfunction, risk of transmission of blood borne diseases such as hepatitis B and HIV/AIDS from repeated cutting and stitching during labour and the higher incidence of wounds and abrasions during vaginal intercourse associated with type III, chronic pelvic infection and vaginal discharge,

infertility, vesico-vaginal fistulae, recto-vaginal fistulae, vulval cysts and abscesses, prolonged and obstructed labour, keloid formation, and psychological and social consequences.

1.4 The social dimension

Female genital mutilation of girls and women is deeply rooted in many cultures and, in those cultures, is socially binding. Although it is generally performed by women, male barbers are the sole practitioners in some communities. Regardless of who undertakes the procedure and what form it takes, female genital mutilation has important gender[2] implications in all its aspects. It deprives the victim of an essential part of her body and of control of her sexuality. It is also closely associated with marital status – a significant aspect of African society – since it is seen as a means of preserving virginity in the female until she is given away in marriage.

Family members who grow up in communities where female genital mutilation is practised usually believe that they are doing a "social good" to a female member by putting her through this ordeal.

Studies reveal that the decision to send a girl child to undergo genital mutilation is taken by female members of the family, whereas all other major decisions, including those relating to the marriage of a family member are taken by the male spouse, father or eldest male in the family. This seems to be the greatest irony in the history of decision-making within the African family unit, and the question remains as to what is responsible for this major difference from the patriarchal trend

Female genital mutilation entails far more than the mutilation itself. It is usually associated with the rites of passage of girls into adult womanhood, involving training, grooming and the provision of values that maintain domestic stability within the community and enable future mothers to nurture their children in ways that prepare them to live meaningful lives in their societies. It also plays a part in the establishment of women's networks within society which provide a forum for women to share their personal experiences and discuss matters pertaining to their sexuality.

[2]While "sex" is used to refer to the biological attributes of men and women, "gender" is understood here as a social construct, referring to the distinguishing characteristics of men and women. Gender can be seen as the full range of personality traits, attitudes, feelings, values, behaviours and activities that society ascribes to the two sexes on a differential basis.

1.5 Economic and political implications

As indicated in section 1.3, female genital mutilation can have serious consequences for women's health, both physical and mental. This in turn affects their productivity: ill-health, lack of concentration and poor output reduce their ability to participate effectively in decision-making, in productive activities and in the care and nurture of children who are the future generation and leaders of the society. It is a cycle of diminishing returns.

On the other hand, practitioners (circumcisers) generate significant additional income from this activity. While some may regard this as exploitation, both practitioners and their clients are convinced that it is the obligation of the family of the circumcised to offer a gift in cash or kind for the service. The practitioners will not readily relinquish the practice unless they can see alternative sources of income.

Furthermore, female genital mutilation cannot be discussed without considering the important role of practitioners and their level of influence in the communities in which they live. The practice places them in a position of considerable power, commanding respect among members of the community. They are invariably community leaders and leading political militants, and the hands that cut the clitoris are also those that deliver the babies. Any attempt to eliminate female genital mutilation must take this into account if it is to be successful. Otherwise there is a danger of forcing the practice underground as has been in the case in countries where legislation has been passed to prohibit it (Egypt, Sudan).

2. Situation Analysis

Female genital mutilation is known to be prevalent in 27 of the 46 countries of the WHO African Region (Annexes 1 and 2). In some countries, the practice is widespread, while in others, it is limited to a few ethnic groups. Unfortunately, data on the practice are often lacking or unreliable. The veil of privacy and some of the norms, traditions and beliefs that surround the procedures in various ethnic groups only compound the uncertainty. Nevertheless, on the basis of information available from small-scale studies, it is estimated that over 100 million girls and women in Africa have undergone some form of female genital mutilation. Each year, at least a further 2 million girls are at risk of undergoing the practice; most of them live in Africa, with some in the Middle East and Asia and in immigrant communities in Australia, Canada, European countries, New Zealand and the United States of America (*3, 4*). Since 1994, four countries in the Region (Central African Republic, Côte d'Ivoire, Eritrea and Mali) have included questions on female genital mutilation in their national Demographic and Health Surveys. A module for the investigation of the practice has been developed and is now available for use in national Demographic and Health Surveys.[3] This module could be used by countries to generate reliable data on incidence and prevalence in the future.

A summary of the US State Department's *Country reports on human rights practices for 1993* outlined the status of female genital mutilation worldwide, including prevalence and interventions initiated to eliminate the practice in 27 African countries (*5, 6, 7*). A worldwide survey of female genital mutilation based on a literature search and fieldwork in Africa prepared for a WHO seminar on Traditional Practices Affecting the Health of Women and Children held in Khartoum, Sudan in 1979, revealed the prevalence of the practice, with procedures ranging from excision to infibulation, in a number of African countries (*8*). While this report does not provide exact information in quantitative terms, it gives a sound indication of the extent of the practice in Africa. Similarly, national studies conducted in Sierra Leone, Sudan and Nigeria have established that female genital mutilation procedures were being undertaken in those countries (*9, 10*).

While immediate and long-term health consequences have been observed in various health care institutions in a number of countries in Africa, there are no systematically documented studies that enable health care providers to bring out the direct association or linkage between the observed complications and female genital mutilation. Current scientific data on the

[3] The national Demographic and Health Surveys are prepared and organized by Macro International, Inc., Calverton, MD, USA.

impact cannot be assessed with any creditable level of accuracy. Anecdotal reports, observations by midwives and obstetricians, and scattered testimonies by girls and women who have undergone genital mutilation are, however, widespread, and provide some insights into the situation (*11*).

In 1984, WHO co-sponsored a major seminar on Traditional Practices Affecting the Health of Women and Children, held in Dakar, Senegal. This seminar led to the creation of the Inter-African Committee (IAC) on Traditional Practices Affecting the Health of Women and Children. IAC now has national committees established in 24 African countries (*12*). In 1985, IAC presented a report by nongovernmental organizations on workshops on harmful traditional practices during the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace (*13*).

In 1987, WHO collaborated with UNICEF and other organizations in bringing together, in Ethiopia, 29 African countries to participate in a Regional Seminar on Traditional Practices Affecting the Health of Women and Children in Africa. Participants drew up a plan of action aimed at addressing the following harmful practices: early childhood marriage and teenage pregnancies, female genital mutilation and related hazards, practices related to delivery and child spacing, and nutritional taboos (*14*).

In 1989, the Safe Motherhood Conference held in Niamey, Niger, called for the elimination of harmful traditional practices including female genital mutilation. In the same year, the WHO Regional Committee for Africa adopted resolution AFR/RC39/R9, which called for concerned Member States to adopt appropriate policies and strategies to eliminate female genital mutilation (Annex 3).

In September 1993, the WHO Regional Committee for Africa adopted resolution AFR/RC43/R6, which requested the Regional Office to accelerate routine collection of data on female genital mutilation (Annex 3). This was reinforced during the Forty-seventh World Health Assembly in May 1994, when the Assembly adopted resolution WHA47.10, which urged Member States: to assess the extent to which harmful traditional practices affecting the health of women and children constitute a social and public health problem in any social community or sub-group; to establish national policies to abolish female genital mutilation and other harmful traditional practices; and to collaborate with nongovernmental groups active in this field, draw on their experiences and expertise and, where such groups do not exist, encourage their establishment. The resolution also requested WHO to strengthen its technical support to and cooperation with Member States in implementing the measures specified and to continue global and regional collaboration with networks of nongovernmental organizations, United Nations bodies and other agencies in order to establish national, regional and

global strategies for the abolition of harmful traditional practices. The need to mobilize additional extrabudgetary resources in order to sustain the action at national, regional and global levels was recognized (Annex 3).

In July 1995, WHO convened a Technical Working Group on Female Genital Mutilation in Geneva, Switzerland to begin the process of developing standards and norms related to the practice and to make recommendations for further activities (*1*).

WHO has also actively participated in many national and regional meetings arranged by different organizations. The most recent were the United Nations Human Rights Commission Seminar on Traditional Practices held in Ouagadougou, Burkina Faso in May 1991 and two sponsored by IAC in Addis Ababa, Ethiopia in 1990 and 1994.

In spite of the various resolutions adopted and recommendations made by WHO, other United Nations bodies and nongovernmental organizations, and of the various initiatives undertaken in countries in an effort to prevent and eliminate the practice, millions of girls continue to be at risk of genital mutilation, particularly in the African Region. The slow progress towards elimination can be partly explained by the lack of planned coordinated programmes, lack of monitoring and evaluation of activities, inadequate documentation and limited investments.

3. Background to the Regional Plan of Action

Female genital mutilation is not only an important issue in its own right, but it is also relevant in the context of the Convention on the Elimination of All Forms of Discrimination Against Women (1979), the Convention on the Rights of the Child (1989), the Goals of the World Summit for Children (1990), United Nations Economic and Social Council resolution 1992/251 on traditional practices affecting the health of women and children, the Declaration and Programme of Action of the World Summit for Social Development (1995), and in Africa, the African Charter on the Rights and Welfare of the Child adopted by the Organization of African Unity (OAU) (1990), and the OAU Declaration on the African Plan of Action concerning the Situation of Women in Africa (1995), which covers violence against women (*15–21*).

The Declaration and Programme of Action of the International Conference on Population and Development (Cairo, 1994) included recommendations in regard to female genital mutilation, which commit governments and communities to take urgent steps to stop the practice and to protect women and girls from all such similar unnecessary and dangerous practices (*22*).

The Platform for Action of the Fourth World Conference on Women (Beijing, 1995) included a special section on the girl child and urged governments, international organizations and nongovernmental groups to develop policies and programmes to eliminate all forms of discrimination against the girl child, including female genital mutilation (*23*). More recently, WHO has expressed deep concern over women's health, particularly as to how inequalities between the sexes contribute to the poor health of women. WHO's Safe Motherhood Initiative and emphasis on reproductive health translate this concern into programmes.

While some governments have made statements condemning female genital mutilation and a few have passed laws banning it, many have not considered it a priority and have taken no action on the issue, despite its devastating effects on the quality of life of women. In many countries where it is prevalent, national nongovernmental organizations have been active for over a decade, sensitizing the population as to its health consequences. In spite of continuous constraints (community harassment, alienation, lack of financial and moral support from governments), these activities have helped in bringing the practice into the open and creating an atmosphere of political support for its elimination, and some local projects against female genital mutilation have been relatively successful. In some countries, knowledge, attitude and practice surveys have been carried out. A study on the social, economic and health implications of female genital mutilation in Gambia

(*24*) provided important insights. Information from this and similar studies in other countries have culminated in the development of new initiatives for combatting the practice such as restructuring of the rites of passage of girls (undertaken in Gambia by BAFROW, and in Kenya by Maendeleo ya Wanawake and the National Family Planning Association). This concept promotes the enhancement of a specific cultural tradition by eliminating genital mutilation while building upon empowerment aspects to promote knowledge and attitudes that will help girls to develop the capability to improve the quality of their lives and to participate effectively and take decisions in community matters. The primary educators and trainers are "converted" practitioners.

To link with the health-related implementation initiatives of international and regional conferences, such as the first Regional Congress of Medical Women's International Association (Nairobi, 1993) and the Fifth African Regional Conference on Women (Dakar, 1994) and in response to the Beijing Platform for Action, the WHO Regional Office for Africa will provide support to countries for the elimination of female genital mutilation within the context of WHO's Ninth General Programme of Work.

A well designed, well coordinated campaign against female genital mutilation, with appropriate technical expertise and consultation, and adequate levels of funding, should bring about major declines in the practice within 10 to15 years (*25*). It is within this context that the WHO Regional Office for Africa is embarking on a Regional Plan of Action to Accelerate the Elimination of Female Genital Mutilation. The Regional Office is aware of the wide variations between individual countries in their orientations towards and efforts to eliminate or modify the practice. It is therefore envisaged that while the Regional Plan of Action will serve as a guideline in setting out the broad parameters for programme planning by countries, it is the countries themselves that will determine the most appropriate combination of strategies to use and set priorities for implementation.

There are a number of different harmful traditional practices, which are deeply rooted in ancient traditional, cultural and religious rituals and which are passed down from generation to generation. Many of these practices have negative effects on the psychological, physical and social well-being of girls and women. They can be grouped into three main categories: those related to reproductive health – female genital mutilation, childhood marriage and early pregnancy, etc.; those related to nutrition – food taboos, forced feeding, etc.; and those associated with human rights – discriminatory inheritance and property laws, bride price, widowhood practices, male child preference, unequal access to education and health care, etc. The elimination of all these harmful traditional practices is desirable. However, the Regional Plan of Action will focus initially on the elimination of female genital mutilation.

4. Regional Plan of Action

The Regional Plan of Action covers a 20-year period (1996 to 2015), and consists of three phases, starting with a three-year short-term plan (1996–1998), followed by an eight-year medium-term plan (1999–2006), and lastly by a nine-year long-term plan (2007–2015) which will be developed on an ongoing basis, reaching a sharp focus towards the end of the year 2005, when a comprehensive evaluation of the first and second phases has been made (see section 6).

4.1 Goal

The goal is to accelerate the elimination of female genital mutilation in order to improve the health and quality of life of women and girls in countries in the Region.

4.2 Objectives

The **overall objectives** of the Regional Plan of Action are:

(*a*) to reduce the proportion of girls and women aged 1–20 years who have undergone any type of genital mutilation in countries where intervention programmes for the elimination of the practice have been implemented;

(*b*) to increase the number of countries that have implemented intervention programmes, formulated policies and/or guidelines, and legislated against female genital mutilation;

(c) to increase the number of countries reporting a decrease in the number of excised and/or infibulated girls in the age group 1–20 years among countries that have implemented intervention programmes;

(*d*) to increase the proportion of communities (within targeted countries) reporting positive changes in the attitudes, beliefs, behaviours and practices of decision-makers within families (i.e. partners, husbands, fathers, mothers, aunts, grandmothers) with respect to female genital mutilation;

(*e*) to increase the proportion of primary, secondary and tertiary health facilities that provide care, counselling and support to girls and women presenting with physical and psychological problems associated with female genital mutilation;

(*f*) to reduce the incidence of other forms of harmful traditional practices;

(*g*) to raise awareness on the need for an increase in the enrolment of girls in formal education at primary and secondary schools.

4.3 Targets

To achieve these objectives, the following specific targets are set:

(i) the proportion of females in the age group 1–20 years undergoing female genital mutilation to be reduced by 40% by the year 2015;

(*ii*) the number of countries that have implemented intervention programmes, formulated policies, and/or guidelines and legislated against female genital mutilation to increase by 55% by the year 2015;

(*iii*) the number of countries reporting a decrease in the number of excised and/or infibulated girls in the age group 1–20 years to increase by 60% by the year 2015;

(*iv*) the proportion of communities (within selected targeted countries) reporting case studies reflecting positive changes in the attitudes, behaviours, beliefs and practices of decision-makers within families to increase to 30% by the end of 2015;

(*v*) the proportion of primary, secondary and tertiary health facilities that provide care, counselling and support to girls and women presenting with physical and psychosocial problems associated with female genital mutilation to increase to 50% in targeted countries;

(*vi*) the incidence of other forms of harmful traditional practices to be reduced by 40%;

(*vii*) the proportion of girls enrolled in primary and secondary schools to increase by 20% and 15% respectively by the end of 2015.

4.4 Short-term plan (1996–1998)

The **general objectives** are to strengthen advocacy and mobilization initiatives, and further develop institutional capacity for planning, implementation, monitoring, training and coordination of activities aimed at accelerating the elimination of female genital mutilation and other harmful traditional practices.

The **specific objectives** for this period are:

(*a*) to collect baseline data necessary for determining strategies and for planning and implementing programmes and activities that are socioculturally appropriate;

(*b*) to strengthen the role of governments and relevant nongovernmental organizations in the elimination of female genital mutilation;

(c) to establish a regional advisory body or interagency task force that will monitor the implementation of the Regional Plan of Action, intensify interagency collaboration and cooperation, and provide guidance in the prevention of female genital mutilation and other harmful traditional practices and management of their consequences;

(*d*) to develop guidelines for the planning, implementation, monitoring and evaluation of activities, in collaboration with Member States, in countries where female genital mutilation and other harmful traditional practices are prevalent;

(*e*) to develop training modules and outline approaches for the training of trainers in strategies for the prevention of female genital mutilation and in the management of its health consequences;

(*f*) to plan, implement, monitor and supervise educational training programmes for health workers, women and men's groups, adolescents and youth, traditional birth attendants, practitioners of female genital mutilation, and religious and other community leaders;

(*g*) to develop appropriate activities for the mobilization of relevant partners (e.g. community leaders, political groups, women's and men's groups, traditional birth attendants, health workers, adolescents and youth) in support of the acceleration of the elimination of female genital mutilation and other harmful traditional practices.

Broad strategies will include: mobilizing the support of governments, relevant nongovernmental organizations and United Nations partners for accelerating the elimination of female genital mutilation in the Region; promoting the integration of prevention of the practice and management of its consequences into ongoing regional and national initiatives, programmes and activities; and strengthening national capacity for planning, implementing and monitoring programmes for the elimination of female genital mutilation and other harmful traditional practices.

Broad activities will include: establishing a regional advisory body or interagency task force; developing training modules and packages for the training of trainers; supporting countries in planning, implementing, monitoring and evaluating appropriate training activities for health care providers and other relevant groups on the prevention of female genital mutilation and management of its consequences; mobilizing technical and financial support for countries to facilitate the establishment of policies, legislation, guidelines, procedures and mechanisms for monitoring the implementation of activities aimed at eliminating female genital mutilation and other harmful traditional practices affecting women and girls; and conducting operational research aimed at strengthening the design and development of appropriate programmes and interventions.

4.5 Medium-term plan (1999–2006)

The **general objective** is to strengthen and sustain achievements and gains realized during the three-year short-term period through the provision of technical support for the implementation of social mobilization, advocacy, formulation of policy and legislation, training, research and programme management in order to consolidate national and community-based activities for the prevention of female genital mutilation and the management of its consequences.

Outcome objectives will be determined by the impact indicators used for monitoring and evaluation of progress during the short-term plan. They will be developed accordingly towards the middle of the short-term plan period.

Broad strategies will generally be consistent with the main strategy of the Regional Plan of Action. However, modifications will be made on the basis of meaningful progress review statements.

Broad activities will be outlined towards the end of the short-term plan period on the basis of the information and data collected through monitoring and evaluation. It is anticipated that some short-term activities will overlap with those of the medium-term plan.

5. Major Components

The Regional Plan of Action consists of five interrelated components which will be implemented through a variety of strategies and activities undertaken in collaboration with other partners in health development at the national, regional and international levels. These five components are:

- programme development and management;
- research for intervention development, monitoring and evaluation;
- advocacy at the regional, national and community levels;
- education and training of human resources for health to promote capacity-building at all levels;
- development of education and training materials.

5.1 Programme development and management

The main activities under each of these headings are listed below.

- Planning, implementing, monitoring and coordinating activities for the prevention of female genital mutilation and management of complications, and for rehabilitation and health promotion at the national level.

- Promoting the integration of activities for the prevention of female genital mutilation and management of its consequences in district health packages and other primary health care programmes.

- Integrating a module on female genital mutilation in obstetrics, gynaecology, nursing and midwifery and other health and health-related training programmes.

- Developing plans for social mobilization, advocacy and training activities to support nongovernmental organizations at the grassroots level in integrating health messages into existing activities.

- Outlining mechanisms for multidisciplinary and multisectoral collaboration at the district, intermediate and central levels.

- Integrating the prevention of female genital mutilation in the activities of district development committees, district health committees and district health teams.

5.2 Research for intervention development, monitoring and evaluation

- Establishing baseline epidemiological data, which will include prevalence and incidence of different types of female genital mutilation and the consequences of the practice, testing the usefulness of information obtained, and setting targets and indicators for monitoring.

- Integrating operational research activities in selected services provided at the district, intermediate and national levels.

- Developing a system for the collection of data on obstetric and gynaecological complications arising from female genital mutilation.

- Collecting data on factors associated or linked with female genital mutilation, including information on the perceptions of women, men and youth groups regarding the practice.

- Involving communities in identifying physical, psychosocial and emotional problems associated with female genital mutilation.

- Collaborating with regional, national and international institutions (e.g. nursing, midwifery, medical) involved in health and socioeconomic development research.

- Establishing a regional database on women's health and development, and adolescent and reproductive health.

5.3 Advocacy at the regional, national and community levels

- Mobilizing political support for the development of national policies, guidelines and mechanisms for the prevention and management of female genital mutilation.

- Encouraging countries which have not already done so to include the female genital mutilation module in their Demographic and Health Surveys and other national health surveys.

- Establishing alliances and partnerships between health development, human rights and women's health groups at the district, intermediate and central levels.

- Supporting initiatives for the elimination of female genital mutilation by national governments, nongovernmental organizations, pressure groups, women's associations and clubs, etc.

- Promoting awareness-raising workshops for health care providers to train and encourage them to be advocates for the elimination of female genital mutilation.

- Supporting Member States in integrating activities for the prevention of female genital mutilation and management of its consequences in national plans of action developed for the follow-up of the Fourth World Conference on Women and regional conferences and initiatives.

- Networking with women's advocacy groups at the national, regional and international levels.

- Soliciting support from traditional leaders and other influential community groups.

- Supporting programmes to assist girls and women to acquire skills for communicating with elders on the reproductive and health implications of female genital mutilation for girls and women.

- Advocating the education of girls in both the formal and informal sectors.

5.4 Education and training of human resources for health to promote capacity-building at all levels

- Sensitizing and training WHO representatives and their country teams on the integration of action to eliminate female genital mutilation in ongoing and future activities.

- Supporting the sensitization and training of staff within national authorities, particularly ministries of health, on integrative and participatory approaches to the elimination of female genital mutilation.

- Training WHO regional and country staff in the operation of national databanks on the health of women and adolescents that include information on female genital mutilation.

- Promoting training in and the development of norms and standards in activities for the prevention of female genital mutilation.

- Training health workers at all levels in the reproductive health services skills, including those related to HIV/AIDS and other STDs, needed to engage in female genital mutilation elimination activities.

- Focusing on country-level training, seminars and workshops on female genital mutilation which are beneficial and cost-effective.

- Networking with institutions of higher learning to promote training and the provision of health information (including information on female genital mutilation) to health care providers.

- Training of reproductive health care providers to win their support for the prevention of female genital mutilation and management of its consequences and to use them as goodwill ambassadors in this regard.

- Using national and local expertise on female genital mutilation issues through technical cooperation among developing countries (TCDC).

- Networking with WHO headquarters, WHO representatives and other United Nations organizations, e.g. UNESCO, in the use of education and training materials on female genital mutilation.

5.5 Development of education and training materials

- Developing a simple manual on the creation and operation of a database on female genital mutilation which could be extended to other programmes including reproductive health.

- Developing appropriate information, education and communication (IEC) materials to help break the silence on female genital mutilation.

- Designing and producing culturally appropriate information materials and programmes designed for specific target groups

- Using the "bottom-up" approach to the development of appropriate IEC messages, ensuring that they are formulated in a clear, adaptable, consistent and simple manner at the local level, in collaboration with those concerned.

- Promoting cross-cultural experiences and exchanges of already tested and adaptable materials within countries of the Region where female genital mutilation is prevalent.

- Networking with youth and women's groups at all levels of the health care system on methodologies used in health education concerning female genital mutilation.

6. Implementation

6.1 Time frame

As indicated in section 4, the Regional Plan of Action will be implemented in three consecutive phases, over a period of 20 years as follows:

- three-year short-term plan (1996–1998);
- eight-year medium-term plan (1999–2006;
- nine-year long-term plan (2006–2015).

An operational plan of action for the short-term plan has been outlined (section 4). A comprehensive evaluation is scheduled to begin at the end of the second quarter of 1998. The results and findings will be used to consolidate activities planned for the first four years of the medium-term plan. The activities for the second half of the medium-term plan will be developed during the year 2002 and will take into consideration the results and findings from research and evaluation studies conducted between 1997 and 2002. It is anticipated that trends in the incidence of female genital mutilation and other harmful traditional practices and the prevalence of associated complications will be better defined by the end of the medium-term plan (2006). Information and data collected through monitoring and evaluation will be used to review progress, revise long-term objectives and elaborate in more concrete terms operational aspects of the long-term plan.

The Regional Plan of Action provides for the formation of a multidisciplinary regional advisory body or interagency task force on the elimination of female genital mutilation during the first phase, to be constituted by the Regional Director.

6.2 Main strategies

While the overall goal is to target all countries where female genital mutilation is prevalent, the approach is to work with ministries of health, WHO country offices and national teams in a phased manner, so that success stories in one set or group of countries can be used to benefit the next group of countries assisted under the plan.

During the short-term plan (1996–1998), 10 to 15 countries will be selected and will be targeted with a combination of strategies and activities developed in collaboration with the countries themselves in line with the broad objectives, strategies and activities outlined in the Regional Plan of Action. Intensive focused work will be carried out in three to five countries and the lessons learned, together with expertise developed in these countries, will be applied accordingly to other countries as part of the medium-term plan. As countries may be at different levels of awareness and openness

about the prevalence or status of the practice in their communities, priority areas for intervention development and action will be identified.

Countries not targeted for intensive focus during this initial period will be sensitized through awareness-raising workshops with health care providers and other health-related partners, dialogue and consultation, to build consensus and prepare them to be advocates on issues related to the prevention and elimination of female genital mutilation and other harmful traditional practices and to the health and well-being of girls and women. Appropriate points of entry for programme development and integration will be identified. Similarly, focused rapid assessment studies, surveys and decision-linked research will be conducted at the community and national levels to facilitate objective planning of elimination activities to be implemented in the next set of countries during the medium term.

WHO country offices, the Regional Office and WHO headquarters will collaborate with national teams in the training of trainers in the three to five countries targeted during the period 1996–1998 to support the implementation of strategies and activities in accordance with national and regional plans of action.

WHO representatives and their country teams, national focal points for women's health and development, reproductive health and adolescent health and relevant national authorities, particularly ministries of health, will be sensitized and trained on integrative and participatory approaches to the elimination of female genital mutilation in ongoing and future health and health-related activities.

During the medium-term phase, technical support will also be provided by national trained teams drawn from countries in which elimination activities have been implemented as part of the short-term plan.

Collaboration with governments, nongovernmental organizations, United Nations partners notably UNFPA, UNICEF, UNDP, UNESCO and the United Nations Economic Commission for Africa, reproductive health service providers, national, regional and international associations for health professionals will be a key factor in the realization of the Regional Plan of Action. Appropriate technical support will be obtained from relevant WHO divisions and programmes, such as those concerned with family and reproductive health; from external sources such as regional research networks, health institutions, including research units in health ministries; from national, regional and international associations for health care providers; and from WHO collaborating centres for nursing, midwifery, women's health and reproductive health research.

At the regional level, emphasis will be placed on providing technical and managerial support to countries to facilitate the effective implementation of

activities in the five programme components of the Plan. Implementation will be guided by the objectives and the combination of strategies and activities outlined for all five components. Programme activities will be integrated in selected primary health care activities and in other programmes and initiatives at the regional and national levels such as the Regional Plan to Accelerate Reproductive Health and regional HIV/AIDS/STD initiatives.

Multisectoral, multidisciplinary and interagency collaboration will be promoted at the regional, national and community levels to ensure optimum use of resources and effort. Collaboration in planning and regular exchange of information will be promoted to assure coherence between the regional and national action plans.

In order to foster collaboration between countries and to maximise the use of resources, several intercountry activities will be planned and criteria will be selected to guide organization within countries.

Qualitative and quantitative indicators will be developed by countries for monitoring and evaluating change (section 7). Core indicators have been developed (Annex 4); a consensus to use these indicators will be required so as to enable appropriate scientific review of progress.

Operational research for intervention development will emphasize capacity-strengthening in relation to research already under way and the promotion of new operational health, sociocultural, behavioural and social research that will provide information to aid the development of appropriate strategies for interventions against female genital mutilation, for example, to convince individuals and communities at large of the need to eliminate the practice. Indicators will be developed as a means of monitoring and evaluating interventions. The Regional Office will provide research support to the Plan through its regional experts; the Special Programme on Research Development and Research Training in Reproductive Health at WHO headquarters will provide technical, financial and material backup. Activities will focus largely on creating an understanding of the linkage between female genital mutilation and its consequences for the health and well-being of girls and women.

Advocacy, social mobilization and training activities will be implemented to ensure national capacity-building and to solicit consensus on and support from community groups and political leaders for the prevention of female genital mutilation. Nongovernmental organizations that have already initiated activities for the elimination of the practice in 24 countries of the Region during the past decade are included in the implementation plan as partners. Special assistance will be provided to youth groups engaged in advocacy against female genital

mutilation and for peer group education and counselling. Attention will be focused on advocating the education of the girl child.

Education and training for human resource development will be provided by national trainers of trainers, with support from regional institutions, and from relevant divisions and programmes at the Regional Office and at WHO headquarters. The emphasis will be on participatory approaches to learning through problem-solving and action for planned change. Training support for relevant nongovernmental organizations, particularly at the grassroots level, in strategic planning, advocacy and social mobilization, provision of counselling and social support to women seeking care for the complications of female genital mutilation will also be provided. Relevant indigenous groups and other nongovernmental organizations will be included for training in the following: strategic planning, advocacy and social mobilization, and the provision of counselling and social support to women seeking care for complications of female genital mutilation.

Appropriate education and training materials for use in training health care providers, multidisciplinary teams, women, men, youth, community leaders and other groups and for the training of trainers will be developed. Existing training materials on female genital mutilation for different target groups will be evaluated as part of this activity.

6.3 Responsibilities of WHO Regional Office for Africa

To facilitate the integration of activities for the elimination of female genital mutilation into the various regional programmes and to support implementation, an interprogramme/inter-divisional working group on female genital mutilation will be formed consisting of regional advisers from the Regional Office divisions and programmes on nursing and midwifery, reproductive health and safe motherhood, health education, women's health and development, adolescent health, child health, rehabilitation, mental health, traditional medicine and HIV/AIDS/STDs.

Further, it is proposed that a multidisciplinary action-oriented regional advisory body/interagency task force on the elimination of female genital mutilation and other harmful traditional practices should be formed, bringing together a wide range of participants, including experts in the field and representatives of nongovernmental organizations involved in research and advocacy on behalf of women, and representatives of United Nations organizations already active in the area of women's health, including female genital mutilation. Their involvement at an early stage will facilitate cooperation and collaboration at regional and at country levels for the implementation of the Regional Plan of Action and for the integration of activities against female genital mutilation in relevant ongoing programmes and initiatives. The Regional Office should play a strong coordinating role

in this partnership for success, which should avoid any elements of a vertical approach, rather advocating a participatory, consultative methodological approach at country level, complementing the integrated and comprehensive concept of reproductive health.

Regional Office responsibility for the coordination of these two new bodies will lie with the Women and Adolescent Health unit. To support the implementation of the Regional Plan of Action, the Regional Office will, through the same unit, undertake the following activities:

Immediate activities

- conduct on-site assessments of the countries targeted in the first phase of implementation of the Regional Plan of Action;
- assist in the translation of the Regional Plan of Action into national plans of action.

Other activities

- support countries in advocating for the development of a national policy and legislation on the elimination of female genital mutilation;
- provide technical support for the development of training programmes;
- promote resource mobilization in support of country activities
- promote multisectoral and multidisciplinary collaboration in intervention development research and programme planning;
- promote interagency collaboration at the regional and national levels;
- coordinate, monitor and evaluate activities for the prevention of female genital mutilation and management of its consequences, in collaboration with countries;
- assist countries in developing appropriate indicators for monitoring the effectiveness of activities implemented at community and national levels.

6.4 Responsibilities of Member

(a) Immediate activities

- with support from the Regional Office, through its Women and Adolescent Health unit, develop national plans of action based on guidelines developed in the Regional Plan of Action;
- develop national programmes on female genital mutilation;
- identify potential nongovernmental organizations for collaboration in the implementation of programmes;

(b) Other activities

- implement policies and activities for sensitization, orientation, and education of health care providers, community leaders, traditional birth attendants, youth leaders and other concerned activists on female genital mutilation;
- integrate activities for the prevention of female genital mutilation and management of its consequences in primary health care district health packages and education programmes for health care providers and others;
- promote community participation in advocating the elimination of the practice and management of its consequences;
- establish mechanisms for multisectoral and multidisciplinary collaboration at all levels of the health care system;
- integrate a module on female genital mutilation in their national Demographic and Health Surveys or other national surveys and conduct operational research for strengthening interventions at all levels;
- develop and implement health care and social support activities to reduce the physical, psychological and social effects of female genital mutilation on girls and women;
- implement training activities to mobilize support and gain political and community consensus on the elimination of female genital mutilation;
- develop appropriate indicators for monitoring the effectiveness of activities implemented at community and national levels.

7. Monitoring and Evaluation

7.1 Monitoring

General monitoring indicators will focus on measurement of progress and effectiveness in line with the targets set in national and regional plans as follows:

1. The proportion of targeted countries that have reported a reduction in the incidence of female genital mutilation over the three phases of the Regional Plan of Action.

2. The proportion of females in the age group 1–20 years who have not undergone female genital mutilation between 1998 and 2015 in communities where the practice is prevalent.

3. The proportion of countries that have formulated policies and guidelines or legislated against female genital mutilation.

4. The the proportion of countries reporting a decrease in the number of excised females in the age group 1–10 years.

5. The proportion of health care institutions that have included prevention of female genital mutilation and management of its consequences in reproductive health and other primary health care programmes.

Specific indicators (quantitative and qualitative) may be developed from some or all of these general indicators.

In the process of developing programmes and specific activities, each country will develop its own indicators for monitoring and evaluation. However, in order to compare situations among countries and to monitor progress scientifically, **core indicators** have been elaborated; these are listed in Annex 3.

Mechanisms for monitoring progress and the effectiveness of the targets set within national and regional plans may include some or all of the following:

(*a*) establishing baseline values for female genital mutilation practices in selected communities to be targeted with prevention and elimination activities prior to the implementation of those activities;

(*b*) conducting follow-up spot checks on girls attending child welfare or paediatric clinics in the age group 0–5 years at specified periods, and keeping accurate records;

(*c*) reviewing records in health and social welfare institutions over specified periods of time;

(*d*) including questions on the practice and prevalence of female genital mutilation in national Demographic and Health Surveys, population censuses and other household surveys;

(*e*) developing check lists and flow charts to record progress in the process and impact of activities;

(*f*) developing criteria for measurement of indicators and assessment of progress towards the attainment of targets;

(*g*) developing community, district and national reporting procedures which can be used by various community groups and different levels of health providers;

(*h*) conducting community and household visits and holding focus group discussions with individuals, families and community groups;

(*i*) assisting communities and groups to suggest relevant and practical tools for monitoring progress and the effectiveness of their activities, and for recording and reporting;

(*j*) involving community groups, women, men, youth and traditional birth attendants in data collection activities so that they participate effectively in monitoring and evaluation activities.

7.2 Evaluation

Continuous in-built and summary evaluation will be conducted to assess progress toward the achievement of national and regional objectives. The following methods of evaluation may be used:

(*i*) Operational and evaluation research in local, district, regional and national health and social welfare institutions.

(*ii*) Rapid assessment studies, small community group testimonies and observation reports on the progress made toward the attainment of national objectives.

(*iii*) Small- and large-scale surveys, carried out as part of other household, demographic and family health surveys.

(*iv*) Evaluation tools and instruments suggested by community groups and community-based health and community development workers, developed and presented in the most appropriate format and language for use by the community groups concerned.

(*v*) Quarterly, six-monthly and annual review of charts and other reporting procedures and records to assess progress and evaluate performance.

(*vi*) Evaluation of training, advocacy and social mobilization activities conducted and the skills that communities have acquired, through observation, participant observation and other forms of testing.

Internal and external evaluations will be conducted to assess progress towards the attainment of objectives. The initial short-term plan will be evaluated internally within 18 months of its commencement and an external evaluation may be conducted toward the end of the third quarter of 1998. Similarly an internal evaluation of the medium-term plan will be conducted during 2001 followed by an external evaluation during the third quarter of 2006.

Countries may invite outside agencies and evaluation experts to work with them during their internal mid-term evaluation to assure the quality of the evaluation process and results, as well as to raise the capacity of nationals in evaluation techniques and procedures. The Regional Office may provide technical support in this regard.

Experts in evaluation will involve nationals in the planning and design of external evaluation exercises or, where necessary, include them in the evaluation activities. The Regional Office and WHO headquarters will provide technical support to national evaluation teams and facilitate consultation and discussions on the findings, results and recommendations of the evaluation.

8. Budget

It is estimated that the net total required for the implementation of the short-term plan (1996–1998) will amount to approximately US$ 2 114 230. Additional budgetary and extrabudgetary funds will have to be sought to meet this requirement. A summary of the estimated budget for this period is provided in Annex 5.

At the end of the first year of the short-term plan an estimate of the required budget for the medium-term plan (1999–2000) will be made. It is expected that while more countries will be involved during this period, some of the regional, technical and material resources developed during the short-term plan can be used and more resources will be mobilized. Similarly, partnerships for collaboration with national, regional and international institutions will facilitate exchange and sharing of technical, material and other resources.

As far as possible national, intercountry and regional resources will be used. The plan is to integrate activities to eliminate female genital mutilation into existing primary health care and other programmes at the community, district, national, regional and international levels. When additional staff are required, nationals will be engaged, wherever possible, as temporary advisers or on special services agreement arrangements.

It is estimated that the net total for the long-term plan will amount to far less than the costs likely to be incurred during the first and second phases, as most countries will either be strengthening, reviewing, evaluating, redirecting or reassessing rather than starting up their programme activities at this stage.

A list will be developed of possible sources of extrabudgetary funds, which will include United Nations organizations, nongovernmental organizations, bilateral agencies and others interested in collaborating in the implementation of the Regional Plan of Action.

References

1. *Female genital mutilation; report of a WHO Technical Working Group, Geneva 17–19 July 1995.* Geneva, World Health Organization, 1996 (unpublished document WHO/FRH/WHD/96.10).

2. *Female genital mutilation, a Joint WHO/UNICEF/UNFPA Statement,* Geneva, World Health Organization, 1996 (unpublished document).

3. Hosken FP. *The Hosken report: genital and sexual mutilation of females,* 4th ed. Lexington, MA, Women International Network News, 1993.

4. *Female genital information: information kit,* Geneva, World Health Organization, 1996 (unpublished document)

5. Toubia N. *Female genital mutilation. A call for global action,* 2nd ed. New York, NY, Rainb, 1995.

6. *Women, health and development for the 1990s; report of the Regional Director,* Brazzaville, WHO Regional Office for Africa, 1993 (unpublished document AFR/RC43/16).

7. *Country reports on human rights practices for 1993.* Washington, DC, US Department of State, 1994.

8. *Traditional practices affecting the health of women and children.* Alexandria, WHO Regional Office for the Eastern Mediterranean, 1979 (unpublished document).

9. Koso-Thomas O. *The circumcision of women: a strategy for eradication,* 2nd ed. London and New Jersey, Zed Books Ltd, 1992.

10. *Female circumcision in the world of today.* Alexandria, WHO Regional Office for the Eastern Mediterranean, 1979 (unpublished document EM/SEM.TR.AFF.HTH.WM/II).

11. Adebajo CO. *Female circumcision and other dangerous practices to women's health: women's health issues in Nigeria.* Zaria, Tamaza Publishing Co., 1992.

12. *Report on the Seminar on Traditional Practices Affecting the Health of Women and Children in Africa.* Dakar, Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, 1984.

13. *Report on Workshops of NGO Inter-African Committee held in Geneva on Traditional Practices Affecting the Health of Women and Children in Africa,* Nairobi, World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, 1985.

14. *Report on the Regional Seminar on Traditional Practices Affecting the Health of Women and Children in Africa: 6–10 April 1987, Addis Ababa, Ethiopia 1987.* Addis Ababa, Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, 1988.

15. *Convention on the elimination of all forms of discrimination against women.* New York, NY, United Nations, 1979 (United Nations General Assembly resolution 34/180).

16. *Convention on the Rights of the Child.* New York, NY, United Nations, 1989 (United Nations General Assembly resolution 1386 (XIV)).

17. *Report of the World Summit for Children.* New York, NY, 1990.

18. *Traditional practices affecting the health of women and children.* New York, NY, United Nations, 1992 (United Nations Economic and Social Council resolution 1992/251).

19. *Report of the World Summit for Social Development*, Copenhagen, 1995.

20. *African Charter on the Rights and Welfare of the Child*, Addis Ababa, Organization of African Unity, 1990.

21. *Declaration on the African Plan of Action concerning the Situation of Women in Africa*, Addis Ababa, Organization of African Unity, 1995.

22. *Declaration and Programme of Action.* Cairo, International Conference on Population and Development, 1994.

23. *Platform for Action.* Fourth World Conference on Women, Beijing, 1995.

24. Singhateh SK. *Female circumcision, the Gambian experience. A study on the social, economic and health implications.* Banjul, The Women's Bureau, 1985.

25. *Traditional practices affecting the health of women and children.* Addis Ababa, Inter-African Committee Traditional Practices Affecting the Health of Women and Children, 1993 (Newsletter, No. 15).

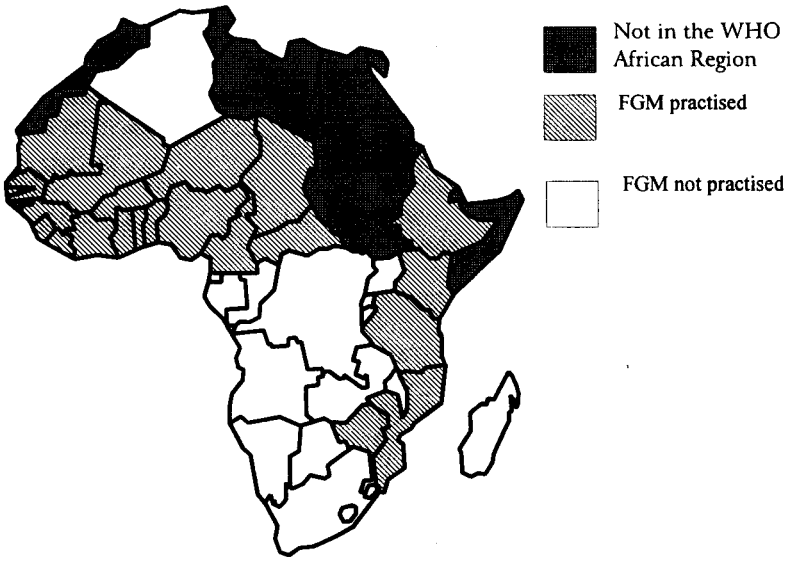
ANNEX 1

COUNTRIES OF THE WHO AFRICAN REGION

French-speaking	English-speaking	Portuguese-speaking
Algeria	Botswana	Angola
Benin	Eritrea	Cape Verde
Burkina Faso	Ethiopia	Guinea-Bissau
Burundi	Gambia	Mozambique
Cameroon	Ghana	Sao Tome and
Central African Republic	Kenya	Principe
Chad	Lesotho	
Comoros	Liberia	
Congo	Malawi	
Côte d'Ivoire	Mauritius	
Equatorial Guinea	Namibia	
Gabon	Nigeria	
Guinea	Seychelles	
Madagascar	Sierra Leone	
Mali	South Africa	
Mauritania	Swaziland	
Niger	Uganda	
Rwanda	United Republic	
Senegal	of Tanzania	
Togo	Zambia	
Zaire	Zimbabwe	

ANNEX 2

COUNTRIES IN THE WHO AFRICAN REGION WHERE FEMALE GENITAL MUTILATION IS PRACTISED[1]



[1]Sources: *Women, health and development for the 1990s; report of the Regional Director*, Brazzaville, WHO Regional Office for Africa, 1993 (unpublished document AFR/RC43/16); *Country reports on human rights practices for 1993*. Washington, DC, US Department of State, 1994; *Female genital mutilation: information kit*, Geneva, World Health Organization, 1996 (unpublished document).

Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Malawi, Mali, Mauritania, Mozambique Niger, Nigeria, Senegal, Sierra Leone, Togo, Uganda, United Republic of Tanzania, Zaire and Zimbabwe.

ANNEX 3

RELEVANT RESOLUTIONS OF THE WHO REGIONAL COMMITTEE FOR AFRICA AND THE WORLD HEALTH ASSEMBLY

(a) Regional Committee for Africa

Resolution AFR/RC39/R9 Traditional practices affecting women and children

The Regional Committee,

Considering the adverse effects on maternal and child health in certain traditional practices such as female circumcision, early marriage, nutritional taboos and other such practices;

Considering the high priority given by WHO and Member States to maternal and child health;

Convinced that the World Health Organization has an important role to play in the control of traditional practices affecting maternal and child health;

1. RECOMMENDS that the Member States concerned:

(I) adopt appropriate policies and strategies to eliminate female circumcision;

(ii) organize educational and informational activities, bearing in mind local cultural contexts, in order to:

- create awareness among women and men of the dangers of female circumcision, early marriage, nutritional taboos and similar practices;

- inform the general public of the possible relationship between the propagation of infectious diseases, including AIDS, and female circumcision;

(iii) prohibit the medicalization of female circumcision and discourage health personnel from performing this operation;

(iv) include in training programmes for health personnel and traditional birth attendants relevant information on the dangers of female circumcision;

(vi) take the steps necessary to put into practice the various recommendations made at the national and international levels in this area;

2. REQUESTS the Regional Director:

(i) to provide appropriate support to Member States in the implementation of this resolution;

(ii) to include this topic on the agenda of a future session of the Regional Committee.

Eleventh meeting, 13 September 1989

Resolution AFR/RC43/R6: Women, health and development

The Regional Committee,

Recalling previous World Health Assembly resolutions on women's health and development, in particular resolutions WHA40.27, WHA42.42, WHA43.10 and WHA45.25;

Noting with concern that despite the appreciable efforts made by the Member States the level of schooling of young girls still remained low, particularly in the rural areas;

Considering Regional Committee resolutions AFR/RC39/R9 (1989) on traditional practices affecting women and children and AFR/RC40/R2 (1990) on literacy programmes and viable and sustainable income-generating activities;

Recognizing the central role played by women in Africa in undertaking responsibilities for family members in health care and the important place they occupy in the socioeconomic development of the continent;

Bearing in mind that women's health is a fundamental human right, and should be made a priority area for investments;

Noting with great dismay the lack of feedback on results of implementation of these resolutions, lack of gender-segregated statistics, unacceptably high maternal mortality rates, and the low socioeconomic position of women which have been highlighted in the Regional Director's report;

Considering that Member States have endorsed the African Health Development Framework for accelerating the achievement of HFA/2000;

1. THANKS the Regional Director for his concise and comprehensive report;

2. REGISTERS appreciation for initiating data collection and presentation on female genital mutilation;

3. CALLS upon Member States to:

   (i) develop an enabling legal framework for women to play their role in every sphere of development;

   (ii) reiterate Regional Committee resolutions AFR/RC39/R9 on traditional practices affecting women and children and in particular, the practice of female genital mutilation; AFR/RC40/R2 on accelerating literacy programmes and promoting viable and sustainable income-generating activities in all communities as a means of enhancing women's full participation in health and development;

   (iii) make women's health a priority area for appropriate investment in education and income-generating activities;

   (iv) mobilize local and external resources for women, health and development activities;

   (v) review their respective country budgets (AFROPOC) with a view to making appropriate allocations to the various components of their women, health and development programme;

   (vi) undertake to empower women through greater access to information, knowledge development resources and decision-making;

   (vii) encourage the development of local technologies in collaboration with WHO and other agencies in order to facilitate women's domestic activities;

   (viii) create a secretariat or similar structure, or where possible ministries or commissions to promote and monitor the implementation of resolutions on women, health and development;

(ix) integrate women, health and development activities into primary health care;

4. CALLS upon international, governmental and nongovernmental organizations and private voluntary foundations to support WHO activities concerning women, health and development in the African Region;

5. REQUESTS the Regional Director to:

(i) ensure continuous efforts in mobilizing resources and increase budgetary allocations in support of the women, health and development programme;

(ii) accelerate routine collection of data on female genital mutilation, give appropriate technical advice to Member States and report regularly at Regional Committee meetings on progress made;

(iii) give the necessary technical support to Member States in the formulation and implementation of women, health and development activities, including the development of a database on women's issues;

(iv) organize national, technical and management training activities for women leaders as well as intercountry seminars and workshops to facilitate the exchange of experiences and the promotion of the programme at national and regional levels.

6. FURTHER REQUESTS the Regional Director to report to the forty-fifth session of the Regional Committee on progress made in women, health and development programmes in the Region.

Eleventh meeting, 7 September 1993

(b). World Health Assembly

Resolution WHA47.10: Maternal and child health and family planning: traditional practices harmful to the health of women and children

The Forty-seventh World Health Assembly,

Noting the report by the Director-General on maternal and child health and family planning: current needs and future orientation;

Recalling resolutions WHA32.42 on maternal and child health, including family planning; WHA38.22 on maturity before childbearing and promotion of responsible parenthood; and WHA46.18 on maternal and child health and family planning for health;

Reaffirming its support for the United Nations Convention on the Rights of the Child, and United Nations Economic and Social Council resolution 1992/251 on traditional practices affecting the health of women and children;

Recognizing that, although some traditional practices may be beneficial or harmless, others, particularly those relating to female genital mutilation and early sexual relations and reproduction, cause serious problems in pregnancy and childbirth and have a profound effect on the health and development of children, including child care and feeding, creating risks of rickets and anaemia;

Acknowledging the important role that nongovernmental organizations have played in bringing these matters to the attention of their social, political and religious leaders, and in establishing programmes for the abolition of many of these practices, particularly female genital mutilation,

1. WELCOMES the initiative taken by the Director-General in drawing international attention to these matters in relation to health and human rights in the context of a comprehensive approach to women's health in all countries, and the policy declarations to the United Nations Special Rapporteur on traditional practices by governments in countries where female genital mutilation is practised;

2. URGES all Member States:

(1) to assess the extent to which harmful traditional practices affecting the health of women and children constitute a social and public health problem in any local community or sub-group;

(2) to establish national policies and programmes that will effectively, and with legal instruments, abolish female genital mutilation, childbearing before biological and social maturity, and other harmful practices affecting the health of women and children;

(3) to collaborate with national nongovernmental groups active in the field, draw upon their experience and expertise and, where such groups do not exist, encourage their establishment;

3. REQUESTS the Director-General:

(1) to strengthen WHO's technical support to and cooperation with Member States in implementing the measures specified above;

(2) to continue global and regional collaboration with the networks of nongovernmental organizations, United Nations bodies, and other agencies and organizations concerned in order to establish national, regional and global strategies for the abolition of harmful traditional practices;

(3) to mobilize additional extrabudgetary resources in order to sustain the action at national, regional and global levels.

Twelfth plenary meeting, 10 May 1994

ANNEX 4

CORE INDICATORS FOR MONITORING PROGRESS TOWARDS THE ELIMINATION OF FEMALE GENITAL MUTILATION

Core indicators developed for monitoring progress towards the elimination of female genital mutilation are listed below. They include input, process and impact indicators. Explanatory notes are provided below each list for input and impact indicators; process indicators are self-explanatory. These indicators can be used at regional, national and district levels. Appropriate adjustments in terminology should be made to make the indicators applicable to a particular level. For example, in the first input indicator, "national advisory body" can be substituted for "regional advisory body".

INPUT INDICATORS[4]

1. Formation of a regional advisory body/interagency task force (RAB/ITF) for monitoring the implementation of the Regional Plan of Action.

2. Development by the RAB/ITF of strategies and approaches for mobilizing political support from national governments for the formulation of policies and legislation for the elimination of female genital mutilation.

3. Financial support (amount in US dollars) given to countries for activities for the elimination of female genital mutilation and other harmful practices.

4. Technical support (mobilization of appropriate human resources) given to countries.

5. Existence of guidelines for the planning, implementation, monitoring and evaluation of activities for the elimination of female genital mutilation and other harmful traditional practices.

6. Existence of training manuals on strategies for the prevention of female genital mutilation and management of its consequences.

Explanatory notes on input indicators

1. This is a qualitative indicator which seeks to ascertain whether activities for the elimination of female genital mutilation have been given the necessary start-up impetus and attention as proposed in the Regional Plan of Action.

2. *This qualitative indicator seeks to measure the functioning and activities of the proposed body.*

3. *The amount of financial support can be used as an indicator of the level of commitment by the Regional Office to activities for the elimination of female genital mutilation in the countries concerned.*

4. *This is another indicator of the level of Regional Office commitment to elimination activities. It could be assessed in terms of human resources mobilized for training, programme management and research.*

5. *This qualitative indicator seeks to ascertain whether this particular activity has been executed as planned.*

6. *This indicator also seeks to ascertain whether this particular activity has been executed as planned.*

PROCESS INDICATORS

1. Number of research projects on female genital mutilation and other harmful traditional practices supported.

2. Proportion of supported projects that have been undertaken.

3. Number of countries that have included a module on female genital mutilation in Demographic and Health Surveys and/or other national health surveys.

4. Number of countries in which mechanisms for involving nongovernmental organizations and communities in activities for the elimination of female genital mutilation and other harmful traditional practices have been introduced or strengthened.

5. Number of training sessions on the prevention of female genital mutilation and management of its consequences conducted at national, intercountry and regional levels:

   (a) number of participants involved in the training
   (b) number of countries covered by the training
   (c) proportion of trainees who are involved in elimination activities in their places of work.

6. Number of advocacy meetings, seminars and workshops for the elimination of female genital mutilation held with staff of the central level of ministries of health, other related bodies, nongovernmental organizations and WHO Representatives.

7. Existence of a regional databank covering women's health and development, adolescent health and reproductive health.

IMPACT INDICATORS

1. **Prevalence of female genital mutilation (FGM):**

$$\frac{\text{Number. of females who have undergone FGM}}{\text{Total female population}} \times 10^{n}$$

(where n = integer)

2. **Incidence of female genital mutilation**

(*a*) Overall incidence:

$$\frac{\text{Number. of females undergoing FGM over a specified period}}{\text{All females who have not previously undergone FGM prior to the period in question}} \times 10^{n}$$

(*b*) Age-specific incidence:

$$\frac{\text{Number. of females in a particular age group who have undergone FGM in a given period}}{\text{Number. of females in the same age group who have not previously undergone FGM prior to the period in question}} \times 10^{n}$$

(c) FGM type-specific incidence:

$$\frac{\text{Number. of females undergoing a particular type of FGM in a given period}}{\text{Total female population}} \times 10^{n}$$

(*d*) Incidence of other harmful traditional practices:

$$\frac{\text{Number. of females undergoing a particular practice in a given period}}{\text{Total female population}} \times 10^{n}$$

3. Country compliance rate:

(*a*) Number. of countries that have formulated policies and/or guidelines on FGM elimination × 100

Total number. of targeted countries

(*b*) Number. of countries that have formulated legislation against FGM and other harmful traditional practices × 100

Total number. of targeted countries

(c) Number.of countries that have implemented legislation × 100 against FGM and other harmful traditional practices

Total number. of targeted countries

(*d*) Number of countries with a declining number of excised and/or infibulated females.

4. District compliance rate

(*a*) Number. of districts with reported changes in attitudes, beliefs and practices related to FGM × 100

Total number. of districts where FGM is known to be practised

(*b*) Compliance improvement rate:

Number. of districts - no. of districts with reported positive changes in attitudes, beliefs and practices related to FGM × 100

Total number. of districts where FGM is known to be practised

5. Health facility involvement index

Number of health facilities providing care and counselling to those affected by female genital mutilation.

6. Female genital mutilation integration index

(*a*) Whether health facilities display information education and communication materials on female genital mutilation and other harmful traditional practices.

(*b*) Whether health talks in health facilities include prevention of female genital mutilation and other harmful traditional practices.

Explanatory notes on impact indicators

1. *Prevalence is expressed as the proportion of the total female population at any point that have undergone female genital mutilation. This indicator measures the burden of female genital mutilation within the country, province, district or community and can be used to estimate medical care needs for individuals with related complications. It does not, however, distinguish between "old" and "new" events.*

2.(a) *The number of females undergoing female genital mutilation in a specified period is not readily available from routine data sources. It can be obtained from Demographic Health Surveys, other national surveys or special surveys on female genital mutilation and other harmful and traditional practices. A question or set of questions can be asked about the respondents' history of female genital mutilation, including the age at which it occurred. The number of new events that take place within a given period should be used as the numerator, while the number of respondents at risk (i.e. those who have not previously undergone the procedure) should be used as the denominator.*

2(b) *The information obtained for indicator 2(a) can be disaggregated by age to permitthe assessment of the risks of female genital mutilation at a particular age. Such information can be useful for intervention purposes. If, for example, the risk is known to be high in girls under five years of age, interventions can be aimed at pregnant women and nursing mothers. If it is high in the age group 15–19 years, interventions can be directed at school children through school health programmes.*

2(c) *Incidence computed for different types of female genital mutilation indicates the relative magnitude of the risk of undergoing a particular type of procedure in a given country, province or district. However, collecting the necessary information may be culturally unacceptable as it would entail physical examination. In such cases it could be limited to very young children, say under five years of age, who might be examined while presenting at health services for other services.*

3. *Country compliance is a qualitative indicator which can be assessed by enquiring about the availability of policy of policy statements and guidelines in the countries concerned. The quantitative indicator, country compliance rate, measures the proportion of targeted countries in which prevention of female genital mutilation is being addressed. Countries that haveformulated legislation show a higher degree of commitment than those with policy statements alone. The number of excised and/or infibulated females may indicate how policy statements and legislation affect the practice at the district and community levels.*

4. *It must be emphasized that changes in attitude and behaviour are not easy to measure and such data are not readily available. The number of districts with positive changes in attitudes and practices can only be determined through surveys or rapid ethnographic assessment techniques. This information indicates the degree of success at the district level. Compliance improvement rate will measure change from one point in time to another rather than absolute levels.*

5. *This indicator seeks to determine the proportion of health facilities that are involved in providing care and counselling to those affected by female genital mutilation.*

6. *This is a qualitative indicator which seeks to determine whether the elimination of female genital mutilation and other harmful traditional practices is integrated into other health services. Possible ways of assessing it include determining whether health facilites display information education and communication materials on female genital mutilation and whether health talks in public health facilities include prevention of this and other harmful traditional practices. This information can be collected through simple surveys.*

ANNEX 5

ESTIMATED SUMMARY BUDGET FOR THE SHORT-TERM PLAN (1996–1998)

The net total for the estimated budget for the short-term plan (1996–1998) amounts to US$ 2 114 230. In order to focus on WHO's clear, realistic and traditional mandate of support for countries, activities for the elimination of female genital mutilation will require the appointment of one full-time professional staff member, whose main responsibilities will be to develop and the Regional Plan of Action further and to implement it intensively in 3–5 countries, with support from the Women and Adolescent Health unit at the Regional Office and from consultants.

COMPONENT	Estimated amount required (US$)		
	Year 1	*Year 2*	*Year 3*
Personnel (1 full-time professional staff member, grade P5)	157 000	157 000	157 000
Consultants	90 000	90 000	90 000
Travel	30 000	30 000	30 000
Regional advisory body/inter-agency task force on FGM	40 000	40 000	40 000
Development of advocacy, information and training materials and guidelines	60 000	120 000	60 000
National team meetings	50 000	50 000	50 000
Collection and dissemination of data (5 countries)	60 000	60 000	60 000
Support to countries, training workshops, etc.	80 000	80 000	40 000
Evaluation and dissemination of findings	20 000	20 000	110 000
Subtotal	587 000	647 000	637 000