



**At the Intersection of Health,
Social Well-being and Human Rights:**

**CARE's Experiences Working with
Communities toward Abandonment
of Female Genital Cutting (FGC)**

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Chege, Jane, I Askew, S Igras, and J Muteshi. Testing the Effectiveness of Integrating Community-based Approaches for Encouraging Abandonment of Female Genital Cutting into CARE's Reproductive Health Programs in Ethiopia and Kenya, Population Council. Frontiers in Reproductive Health Project. December 2004. http://www.popcouncil.org/pdfs/frontiers/FR_FinalReports/CARE_FGC.pdf

Figueroa, Maria Elena, D Kincaid, M Rani, and G Lewis. Communication for Social Change: An Integrated Model for Measuring the Process and Its Outcomes. Rockefeller Foundation. Communication Initiative. 2002.

Igras, Susan, J Muteshi, A WoldeMariam, and S Ali. Integrating Rights-Based Approaches into Community-Based Health Projects: Experiences from the Prevention of Female Genital Cutting Project in East Africa. *Journal of Health and Human Rights* Vol 7 (2): 251-271.2005.

INTRODUCTION

Why FGC Abandonment is Such a Challenging Program Issue

Female genital cutting (FGC) affects more than 130 million women and girls worldwide, the majority of whom live on the African continent. The term FGC refers to not one, but four differing forms of cutting, with infibulation being the most severe. Practiced for hundreds of years, the ritual of infibulation involves the excision of part or all of the external genitalia, with only a very small opening left for urine and menstrual blood. The burden of FGC cannot be laid on the shoulders of any one particular country or religion, as it is performed in a variety of social and cultural contexts and is essentially a practice frequently associated with distinct ethnic groups.

For proponents of the practice, FGC represents a thread in the social fabric that defines the individual's social standing and, ultimately, the community's identity. The wide array of favorable motivations for the practice of FGC range from: respect for and conformity to culture and tradition; religious obligation; rite of passage into womanhood; ensuring a girl's virginity and, consequently, her value and that of her family, and the increased likelihood of good marriage prospects. Underpinning these factors is another layer of reasons associated with gender roles and expressions of men and women's sexuality.

Yet this culturally sanctioned, traditional practice frequently carries with it many detrimental health and social consequences that persist throughout a woman's life. Health complications of infibulation can include chronic and severe pain, infection, prolonged and difficult labor, malodorous urine retention and difficulties with menstruation. Psychologically, cutting can result in discord between couples due to painful or difficult sexual relations. From a social perspective, cutting can reduce potential education and income opportunities for girls by making them more vulnerable to early marriage. Considered from a human rights standpoint, FGC encroaches on a number of basic human rights, compromising women's and girls' rights to good health, to have

economic independence and educational opportunities, and to attain higher standards of living. The absence of consent associated with the practice is indicative of a fundamental lack of respect for the rights of females and children. Girls who refuse the procedure, but still reside in communities embracing the tradition, face a diminished quality of life. For these girls and their immediate families, noncompliance incurs harassment and possible ostracism from their communities.





Why CARE Got Involved

Discussions during a 1998 regional health meeting for CARE staff working in East and North Africa created the momentum for CARE to begin the pilot work in the area of FGC abandonment. FGC was presented as a harmful traditional practice having a negative impact on maternal and neonatal health. Through participatory learning and action (PLA) techniques, CARE staff and local women explored the issue of reproductive health (RH) in several countries. The women themselves recognized FGC as an important, sometimes the most important, health issue they faced. At that time CARE was in the process of shifting the focus of its RH programs, which had previously been predominantly based on addressing needs, to also address underlying social, gender and rights factors that influenced health outcomes. With the realization that CARE had a presence in 15 countries where FGC was practiced, an extraordinary possibility surfaced for a multi-country FGC abandonment pilot project and related study.

The project would allow CARE to gain experience and assess the effectiveness of rights-based approaches (RBA) when applied in a health context, and contribute to the growing body of FGC literature that could help advise the design of future FGC abandonment programs at

the community level. It is CARE's belief that using a basic human rights framework when working with communities would more effectively address the matrix of underlying causes of poverty and poor health. In turn, people would be empowered to take action for sustainable improvements in their lives. CARE staff in Ethiopia, Kenya and Sudan, working collaboratively with the health unit staff at CARE USA headquarters in Atlanta, developed a pilot project focusing on integrating activities that would lead to the abandonment of FGC within community-based health projects.

Working in Partnerships to Achieve Change

The FGC abandonment project was realized with the help of several international and local partners including PATH (assisting with development of behavior change communication [BCC] messages) and the Population Council Frontiers in Reproductive Health Project (primary provider of technical assistance in research). At national and local levels, partners included Sudan's National Committee Against Harmful Traditional Practices and the Sudanese and Ethiopian MOH/Social & Women's Affairs. In Kenya, partners included the National Council of Churches, Médecins sans Frontières and UNHCR. Financial support was provided by the CARE USA Africa Fund, private CARE donors and the USAID Special Initiatives Fund from the Office of Population/RH.

PROJECT OVERVIEW Goals and Objectives

Past health programs in a variety of countries and settings attempted to eliminate FGC by focusing largely on the serious health effects that stemmed from the procedure, while neglecting the underlying social currents that governed the perpetuation of the practice. Consequently, these programs were only marginally successful at reducing FGC and often were met with strong resistance from communities. Drawing from past experiences, CARE understood that in order to motivate a community to consider abandoning a

deeply ingrained and culturally sanctioned practice such as FGC, interventions would have to extend beyond the realm of traditional community-level health programming. The scope would have to be expanded to address the social norms, beliefs and attitudes of the communities as a whole, as well as those of the individuals who reinforced the continuation of the practice.

The goal of the FGC abandonment project was to improve the health and social well-being of young girls and women in the project areas by initially decreasing and eventually eliminating the practice of FGC, and so, two core project objectives were identified. First, CARE hoped to increase the interest and ability of communities, nongovernmental organizations (NGOs), ministries of health and other local actors to appropriately and effectively address FGC issues. Simultaneously, through its research component, CARE hoped to contribute to the body of evidence on the effectiveness of different community-based interventions aimed at reducing the practice of FGC.

Description of Project Sites

The multi-country FGC abandonment project operated in three countries where CARE already managed community-based health projects and where staff were interested in integrating FGC abandonment activities into their ongoing health projects. The projects reached the Afar people in Ethiopia, Somalis in the Dadaab refugee camps in Kenya and the Arabic Dar Hamid people in Sudan. Although ethnically diverse, these communities shared three defining links: a common religion (Islam), belief of an association between FGC and Islam and an almost universal practice of infibulation.

Ethiopia

In Ethiopia, CARE piloted FGC abandonment activities in the Afar region, which baseline surveys indicated had the highest rate of FGC in Ethiopia, 94.9 percent compared to a country wide rate of 73.6 percent. The Afar region is home to one of Ethiopia's major ethnic groups, the Afar, with a population of approximately 1.1 million. Nomadic pastoralists, they are dependent on

animals for their livelihood. Highly mobile in search of water and grass, the Afar's movements are dictated by the rainy seasons. CARE chose to work in the Awash-Fental Woreda (district) of the Afar region, where it already had an ongoing primary health care project that reached approximately 18,000 people. Prior to the FGC pilot study, previous exposure to FGC-related education topics was non-existent. CARE partnered with the Ethiopian ministries of health and social affairs to add FGC abandonment and other RH information and services, including family planning, HIV/AIDS and maternal health, to existing primary health care services.

Kenya

The Dadaab refugee camps, in operation since the early 1990's in northeast Kenya, were selected as the second FGC project site. Comprised of three camps, Dagahaley, Ifo and Hagadera, Dadaab serves about 120,000 refugees. Ninety-eight percent of the camp's population is of Somali origin. At the onset of the project, the refugees in the Dadaab camps were already aware of international doctrines on human rights and were familiar with their rights as refugees. Camp residents also had prior education on FGC and its harmful health effects, chiefly through the work of the National Council of Churches of Kenya (NCCK), which was subcontracted by UNHCR to provide RH and anti-FGC information. CARE's role was to provide camp management and social services, including a program to reach vulnerable women and children. CARE joined with NCCK to expand the

For projects to motivate

a community to consider abandoning a deeply ingrained and culturally sanctioned practice such as FGC, interventions would have to extend beyond the realm of traditional community-level health programming ... to address the social norms, the beliefs and attitudes of the communities ... [and] individuals who reinforce the ... practice.



intensity and scope of FGC abandonment activities into the existing community-level RH activities.

Sudan

In Sudan, the localities of Um-Garfa and Um-Sayala, located in North Kordofan state, were chosen as the third project site for CARE's pilot anti-FGC project. The 67,300 people occupying the study region share a similar culture and means of livelihood, employing farming as their main occupation, and principally belong to the Awlad Agoyi, Bagada and Maramra branches of the Dar Hamid tribe. Like in Kenya, the residents

of communities where CARE was conducting FGC abandonment activities had already been exposed to a low level of education on FGC and its harmful health effects. However, they had limited exposure to internationally defined human rights concepts. CARE partnered with the Sudanese Ministry of Health to implement anti-FGC activities.

Moving from Needs to Rights-Based Project Approaches: Necessary Changes

CARE's recent shift toward RBA meant that its more traditional RH programs also needed to be modified. Historically, much of CARE's RH work had been focused on improving knowledge (through health education outreach using community educators) and on improving the quality of RH clinical interventions (through interagency partnerships with MOH and equivalent agencies). However, with the addition of a social and rights-oriented FGC component, project designs and activities had to be adjusted to reach individuals with education and information while systematically building more supportive social environments to sustain change (Table 1). Health education outreach was expanded to include education and awareness of social and rights issues. Public discussions with women and men were facilitated to encourage community debate, and community-level advocacy activities involving religious and other influential people began with the hopes of creating support for grassroots actions combating FGC. As the project progressed, an operational framework (Figure 1) gradually emerged, steering the direction of overall project activities. Reflected in this framework was the realization that nurturing change of a socially condoned practice would require addressing the physical, health, psychosexual and social realities that influenced individuals and the larger community in their decision to continue or abandon the practice. Or to say this using public health terms: The framework reflected a need to focus systematically on the enabling environment as much as on the individuals directly involved in the FGC behavior.

TABLE 1: COMPARISON OF COMMUNITY-BASED RH PROJECT INTERVENTIONS PRIOR TO AND AFTER THE ADDITION OF THE FGC ABANDONMENT COMPONENT

(Source: Igras et al, 2005)

Existing projects	Projects after integration of FGC abandonment activities	Social and rights rationale for changes
Goal: Improve RH of women	NEW Goal: Improve RH and social well-being of women	<ul style="list-style-type: none"> Recognize that the practice of FGC occurs in a context of existing gender inequalities and women's social powerlessness
Health education using community health volunteers	<p>Expand education outreach to include social and rights messages/issues (in addition to health messages)</p> <p>Create spaces for community discussion and debate</p>	<ul style="list-style-type: none"> Empower women and raise awareness of men with information to allow women to protect their health Encourage women to play new social roles - e.g., in Ethiopia women became community health workers and members of health committees Allow women, men and community leaders to address FGC as a public issue
Coordination with community leaders	Coordination continues but NEW ACTIVITY added: community-level advocacy with religious/other leaders	<ul style="list-style-type: none"> Those who help maintain community norms can also help lead changes in norms Having leaders discuss FGC and give "permission" for the larger community to publicly discuss such private issues Promote community leaders' responsibility for women's concerns
Inter-organizational partnerships with MOH or equivalent actors	Work continues with existing partners but NEW ones include: Ministry of Social/Women's Affairs, Committee Against Harmful Practices, community groups/institutions such as "Circles of Friends" support groups, national FGC networks	<ul style="list-style-type: none"> New partners outside of traditional health sectors are needed to address social and political issues Partnerships form at different levels (e.g., locally, nationally, internationally), to address micro-operational, macro-systemic and global advocacy issues
	NEW ACTIVITY: Support for individual and collective actions against FGC - e.g., the creation of support groups of those publicly against FGC; working with leaders on protection of women and girls	<ul style="list-style-type: none"> Organizational responsibility as a facilitator of change not to abandon people when they take a public position against the community's norms that put them at risk Promote recognition by and responsibility of those in positions of power/influence to have obligations to women

NB: Many community-based RH projects, including the ones above, also have facility-based interventions to improve RH services, but these are beyond the scope of this discussion and not included in the table.

Measuring Effectiveness of Community-Based Education and Advocacy Models: Research

An operations research (OR) component to the project was designed to answer the question: To what extent could 18 months of community-based FGC abandonment interventions, integrated into ongoing health projects, reduce people's intended practice of FGC? CARE postulated that BCC approaches coupled with community-level advocacy would be more effective in reducing people's intentions to cut their daughters than BCC interventions alone, and even more so when compared to an absence of interventions. Furthermore, those communities exposed to BCC approaches and community-level advocacy would have an increased knowledge of negative health, psychological and social effects associated with FGC, would be more aware of human rights as they relate to FGC, and would express less often their intention to cut their daughters. Each project site took slightly different approaches to their research, but a core set of questions was used in all countries to look at changes across countries. (CARE-Sudan participated in piloting FGC abandonment activities in its project area but did not conduct related research.)

A final round of surveys, using essentially the same questionnaire as at baseline, was conducted during the last six months of 2002.

FGC Abandonment Study General Research Hypothesis

Those populations exposed to BCC and advocacy interventions (compared to populations exposed to BCC activities alone or to no interventions) will have:

- Greater knowledge of negative health, social and psychological effects of FGC
- Increased awareness of human rights as they relate to FGC
- Be more supportive of FGC abandonment
- Will express less often their intention to cut their daughters

Community and Individual Realities

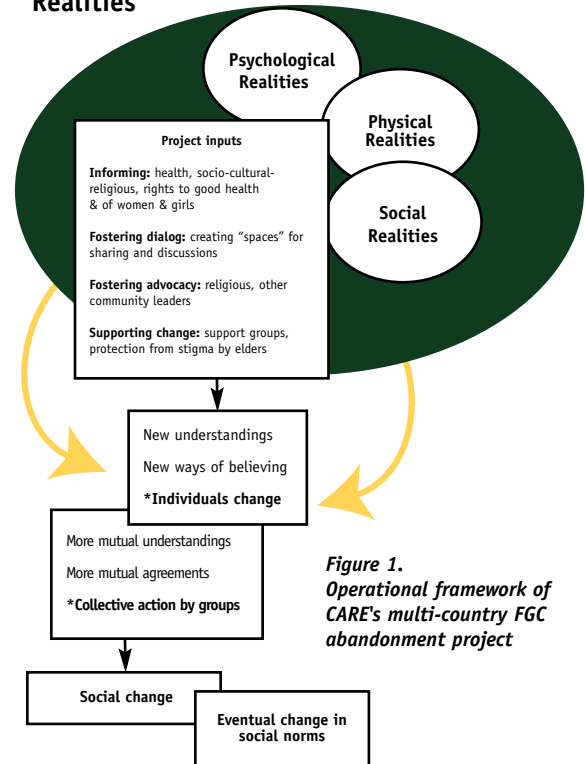


Figure 1.
Operational framework of
CARE's multi-country FGC
abandonment project

Focus group discussions with men and women were also conducted at the end of the 18-month study period to gain a better understanding of what social changes were occurring within families and communities. Readers wanting more details should contact CARE or the Population Council for the full research report.

PREPARING TO BEGIN

Working on a socially entrenched issue such as FGC was new to health staff working in the three CARE offices. Historically, most work on FGC was approached from an RH and individual behavior change standpoint, with its social and religious undertones largely overlooked. To reaffirm the importance of a rights-based, holistic approach to this pilot project, CARE staff from the three participating countries developed a project position statement to reflect the shared vision and philosophy of action on how the project would approach FGC abandonment. That is, communities would be approached with respect and all decisions on the practice would be the communities' decisions to

make (see box to the right).

Through a series of workshops, CARE staff laid the groundwork for the project. During this period, participants were given the opportunity to clarify their own values regarding FGC and reflect on the possible influences these values may have on the project. In anticipation of the need to understand the context (values, beliefs and traditions) in which communities practice FGC, a first workshop, held in the Dadaab refugee camps in Kenya, was conducted to develop a common participatory approach to the planned, qualitative research. Participating staff would later return home to replicate the process with colleagues, partner agencies and community representatives.

A final preparatory workshop signified the official start of the project. Partnering with staff from the Population Council Frontiers in Reproductive Health project, CARE co-hosted a workshop in September 1999 to allow participants from all three country offices to further define proposed interventions using behavior change communication and community-level advocacy approaches. Participants took this opportunity to define the general study hypothesis as well as more specific study hypotheses for each country project. They also identified a set of core knowledge, attitudes and belief variables that would be used across countries to measure change.

HIGHLIGHTS OF PROJECT ACTIVITIES

Understanding the Context of the Practice through Discussion and Dialogue

At the onset of the project, participatory research was undertaken in each country to elicit a comprehensive understanding of the socio-cultural perspectives governing targeted communities, particularly in relation to the link between social and individual values of FGC as well as linkages to gender issues and rights awareness. Each ethnic group and community was unique, and FGC abandonment strategies would have to be tailored to local contexts.

Excerpts from the Project Position Paper, 1999

Problem statement:

Female genital cutting (FGC) is a widespread and culturally important practice in a number of countries where CARE operates. Women and girls who undergo this operation often suffer long-term health and psychological problems, and this practice leads to the poor health status of women and girls' in these countries. In addition to negatively affecting women and girls' health status, this practice can have an adverse effect on communities as a whole.

Vision statement:

We envision communities in the three participating countries free from the problems and complications related to FGC.

Position statement:

As reproductive health and population planners, we believe that FGC is a practice that violates the health, emotional well-being, educational and economic opportunities and the basic human rights of women and girls. We recognize that FGC is a deeply rooted, culturally sanctioned practice and that its abandonment will take time and effort. We therefore resolve to work closely with communities to determine the most appropriate models and approaches to be used to increase knowledge and debate that will positively influence attitudes and behaviors that will lead to the eventual total abandonment of the practice.

Therefore, initial research focused on better understanding these contexts, especially in regard to the practice of FGC.

CARE utilized several different methodologies and participatory tools to better understand FGC issues from within the communities. One-on-one interviews complemented information gleaned from group discussions with different stakeholders, including: men, women, boys, girls, community elders, religious and other leaders, circumcisers/traditional birth attendants and community health workers. Using participatory learning and action (PLA) exercises proved most valuable in fostering substantive discussions of FGC issues and practices, and in



beginning to break the silence around a “women’s” issue. The PLA exercises included social mapping, RH life lines (Figure 2) and the causal flow analysis of the reasons for and effects of FGC. By seeking to create an environment where local knowledge was respected and utilized as a launch pad for program action, these participatory methodologies strove to cultivate a more balanced relationship between development workers and community members.

In addition to the overall community context, the timing of when to begin talking

about FGC had to be defined by the community’s stage of readiness to talk about this secretive subject. In Ethiopia, where no previous discussion by outsiders of FGC had occurred, staff proceeded with caution and vigilance to gain the trust of the communities. Preliminary participatory assessments began with broad discussions of traditional practices around marriage, divorce, childbearing and related social norms. As the assessment progressed and the tradition of FGC was mentioned, staff then had “permission” to learn about this practice. In contrast, in Kenya and Sudan, where residents had already been exposed to some degree to FGC health messages, staff and communities were able to comfortably hold discussions about FGC issues at early meetings.

Different Approaches Were Required with Different Communities

ETHIOPIAN CONTEXT

Communities had no prior exposure to RH/FGC topics or rights as defined in international conventions.

- **Approach** Begin discussions on traditional practices in community - e.g., marriage customs. As FGC is brought up, begin discussions on this traditional practice.

KENYAN CONTEXT

Refugee site with community having prior exposure to RH/FGC education, particularly on the harmful health effects of FGC. People informed of refugee rights and related international conventions.

- **Approach** Discussions begin immediately to learn from communities about the practice of FGC.

SUDANESE CONTEXT

Communities had prior exposure to RH and FGC education, particularly on the harmful health effects of FGC. Rights as defined in international conventions were considered potentially provocative for the country context.

- **Approach** Begin discussions on critical women’s health issues and, as FGC is mentioned, begin discussions on this health issue.

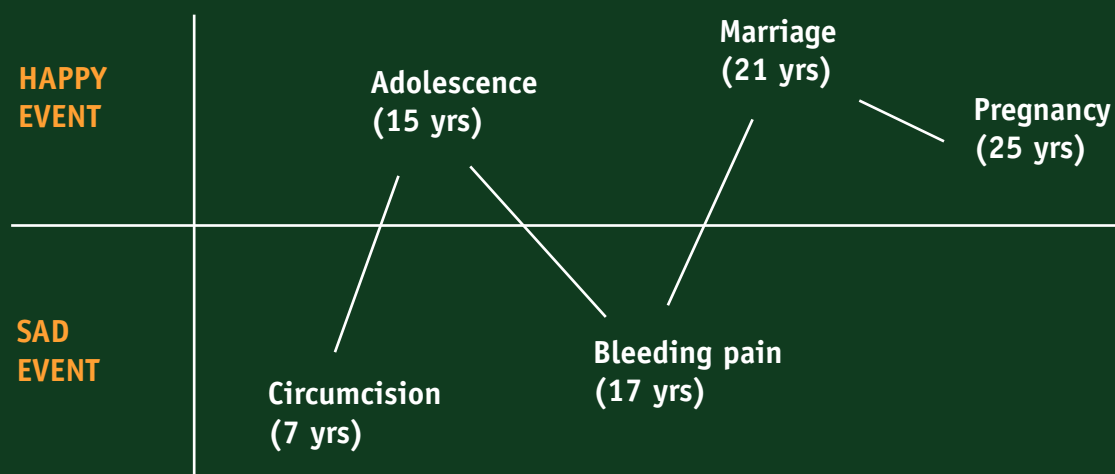


FIGURE 2: REPRODUCTIVE HEALTH LIFELINE OF A 34-YEAR OLD WOMAN, SUDAN

RH lifelines were used to solicit people’s views on reproductive events that occurred throughout their lives and how these events affected their sense of well-being. As the lifeline example above indicates, FGC was the first reproductive event in most women’s lives and was also often considered one of the saddest events in their reproductive lives. In the above example, the woman considered FGC to be both a happy and sad event - happy because there were parties and gifts from relatives and friends, but sad because the FGC operation was the most painful thing that she has experienced throughout her life.

What We Learned: Some Critical Findings

The Practice of FGC

Findings from the initial series of participatory assessments revealed and/or confirmed striking similarities between the three project sites in regard to the practice of FGC, most notably the almost universal practice of infibulation. Cutting occurred when girls were young, generally between the ages of 4 and 12. The cutting was performed by a circumciser, a highly respected position that is generally held by a traditional birth attendant and/or midwife in the community. After the cutting, the girl’s legs were bound and she remained home in bed to give the cut time to heal. A small, family-oriented celebration was held to commemorate the cutting that included the girl, her mother, the circumciser and a few neighboring women.

Beliefs, Values and Attitudes Surrounding FGC

There was a very significant majority of people who felt the practice of FGC should continue and a small minority that spoke about

wanting the practice to end or change. When asked why they felt the tradition of FGC should be continued, participants expressed concepts that centered on duty, particularly to religion and cultural preservation, on sexual pleasure of self and one’s partner, and on social responsibility to daughters and family.

As with the findings related to FGC practice and procedure, reasons cited for the continuation of the practice were similar across the three countries. Religious obligation was frequently cited as the defining reason for performing FGC. According to community residents, a girl from a “proper” Muslim family would cleanse and purify herself according to the laws of Islam. She would undergo circumcision to remove the haraam (unclean) part of her, thereby distinguishing herself from a non-Muslim. Although this was the prevailing belief among the majority of residents, there was a minority presence that argued that the religious obligation associated with circumcision was only for men and that circumcision was an optional practice for women.

FGC was seen as an ancestral cultural

Learning Themes that Guided Participatory Assessments

Round 1- Qualitative Research: Community views on FGC

Understanding the practice and context of FGC:

- Details (where, when and how the cutting occurred)
- Celebrations and ceremonies attached to the cutting.
- Beliefs, values and attitudes towards female circumcision and its continuation.

Round 2- Qualitative Research: Community views on rights

- Defining rights and responsibilities for a good life (highest standard of living) and good health.
- Understanding who has responsibility to uphold rights for men, women and children.
- Understanding human rights and their relation to FGC; whether FGC violated human rights.

practice, passed down from generations. Women in particular saw themselves as the custodians of their traditional practices, bestowed with the duty to preserve and ensure the survival of cultural rituals. But sense of duty was more complex: In Kenya and Ethiopia, men said that they wanted the practice to continue because the women did; women said they wanted the practice to continue because their men did.

Much discussion also centered on issues of sex and sexuality and, linked to this, a belief that FGC ensured that a girl would remain a virgin until married. Once married, FGC would ensure that she remains faithful to her husband. Underneath these concerns was an underpinning of socially acceptable gender roles of men and women. In all three sites, there was a strong association between infibulation and virginity. FGC was proof of a girl's virginity, thus her value. FGC served as a deterrent for males trying to engage in pre-marital sex, as men would be hesitant about engaging in sex with

a circumcised girl. A girl who was not circumcised was perceived as a prostitute or loose woman and ostracized by the community. In essence, by symbolizing proof of virginity, FGC improved the marriage prospects for young, unmarried, circumcised girls.

Women and men also spoke of how FGC resulted in increased sexual pleasure for men. FGC made a woman more sexually desirable and women were often re-infibulated after childbirth to tighten loose vaginal walls. The smooth appearance of a woman's genitalia following circumcision was considered sexually attractive. Additionally, some men stated that penetrating a circumcised girl during the first nights of marriage reaffirmed their masculinity and gave them a sense of achievement. Yet there were other men who were conflicted by the pain they caused their new wives.

Baseline Survey Findings from Intervention Sites Confirmed Participatory Assessment Findings

Ethiopia

- 66% of male and female respondents did not know any negative effects of FGC (health, psychosexual, social)
- 8% agreed that FGC violated women's rights
- 22% supported FGC abandonment by community
- 8% did not intend to cut their daughters in the future

Kenya

- 43% of male and female respondents did not know any negative effects of FGC (health, psychosexual, social)
- 4% agreed that FGC violated women's rights
- 23% supported FGC abandonment by community
- 14% did not intend to cut their daughters in the future

Source: Population Council, 2004

The fear of being socially ostracized was also recognized. The negative social consequences that arise from noncompliance with the circumcision tradition are often severe. They include insults, shame, stigmatization, a decrease in marriage prospects, rejection if married without being first cut, possible ostracism of the girl's family and the inability to participate fully in community activities. A number of women claimed that mothers circumcised their daughters out of fear that men would not marry their daughters and their daughters would be abused and insulted by girls who were circumcised.

Awareness of FGC-related Health, Social and Human Rights Consequences

Knowledge about the negative health effects of the practice was limited and uneven. Women were more knowledgeable than men; adolescent boys and girls had the least amount of knowledge. Knowledge linked to more immediate post-cutting problems, such as excessive bleeding, was more often recognized than chronic issues like prolonged labor.

Rights-related issues pertaining to the effects of FGC on the dignity of women, a girl/woman's right to an education and the increased susceptibility of a circumcised girl to early marriage were rarely mentioned during discussions. What did surface in Ethiopia was the belief that circumcision was a right of boys and girls.

Later, discussions were held with different community groups to explore the concepts of rights to health and to a high standard of living. These meetings revealed a good understanding of what constituted basic human rights. Definitions of rights in all study communities were heavily influenced by religious texts. According to both men and women, the Koran defined the man as the head of the household, therefore responsible for upholding rights. Women's rights, including health rights, were accessed through their fathers or husbands. Men and women also recognized that rights were not always upheld equally between males and

Why Does the Practice of FGC Continue?

Quotes from discussions with community members reveal the complex reasons and values behind the practice

We are going to perform salot (infibulation) even though we are dying. Our mothers and grandmothers did it, we did it and our daughters will do it.

– Woman in Ethiopia commenting on the cultural history of FGC

Circumcision preserves a girl for marriage. A girl who is circumcised in the new way (Type 1 circumcision) is said to have been used before, that she was a prostitute; men are not interested in an open lady.

– Schoolgirl in Kenya referring to how FGC ensures virginity before marriage

It is good. She (the girl) has no value if she is not circumcised.

– Man in Kenya commenting on how FGC confers status

Gudniink (infibulation) is a religious practice done to restrict girls from being promiscuous and doing things contrary to religion.

– School boy in Kenya commenting on sexuality and religious obligation

The elders tell people not to marry an uncircumcised girl because she cannot control herself.

– School girl in Kenya

How can I marry an uncircumcised girl? My peers will insult me.

– Young, unmarried man in Sudan referring to social consequences of deviating from a social norm

Some people think that eating food prepared by an uncircumcised girl is haram (against Islamic law).

– Elderly woman in Sudan

It is good. One who is not circumcised is not a Muslim.

–Elderly man in Kenya

females. (These logical linkages between the violations of rights and the practice of FGC could be explored at a later date with communities.) The linkage of rights with religious texts highlighted the importance of working with religious

leaders to clarify misconceptions surrounding religion and FGC.

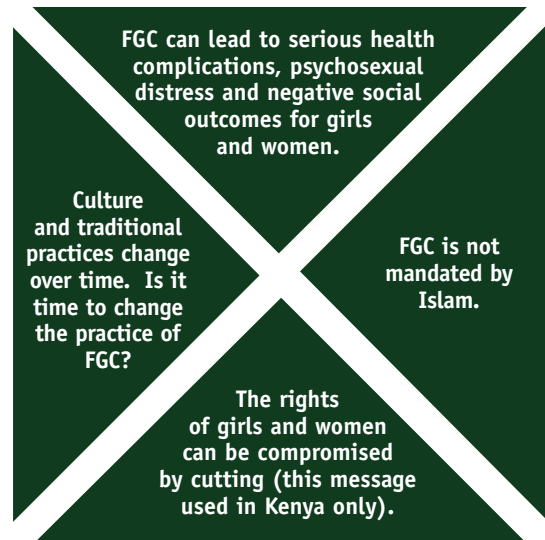
The complexity of physical, psychological and social reasoning for the continued practice – touching on history, tradition, religion, sex and sexuality, prescribed gender roles, community continuity, being respected and included in community affairs, girls’ opportunities to become wives and mothers – became apparent during discussions with community members. Project work with communities would have to address not just health issues but the social determinants of the practice.

Education and Advocacy Activities *Educational Messages and Approaches to Sharing Information and Fostering Discussion and Debate*

Using the information gathered from community discussions as a guide, CARE identified issues and an appropriate language that could be used to develop educational messages and advocacy approaches. Assessments revealed knowledge gaps in areas concerning harmful health effects and awareness of the human rights issues related to FGC. Although culture and tradition were critical elements in the continuation of the practice, minimal links were made to social and rights consequences. Furthermore, even as religious influences dominated the persistence of the FGC practice, religious leaders and the community itself had widely varying interpretations of the role of FGC as a religious obligation.

Understanding the value of the practice and its significance in social and religious norms made it clear that to advocate for change, the project had to focus on working with influential people, such as religious and other leaders. Given the shroud of secrecy surrounding the topic, that men and women did not discuss the practice together and hence could not understand different viewpoints, efforts were concentrated on placing the subject of FGC in the public forum to allow men and women to discuss the practice and examine its social value. Educational messages were developed to address issues raised during the qualitative baseline

KEY EDUCATIONAL MESSAGES



assessment, including erroneous associations of FGC with Islam, the changing nature of culture and social consequences (see box above).

To disseminate information about the negative health and social effects of FGC, CARE identified key change agents that could act as credible sources of information (education and information) and offer new opinions and beliefs (advocacy and information) to different target groups. These agents included: community leaders, religious leaders and elders who were influential and highly respected people involved in upholding customary social laws and addressing individual and community disputes and rights. As these people acted as guardians of community norms, their support for anti-FGC measures was essential.

Community health workers, traditional birth attendants and others providing health and social services in communities were individuals who could disseminate information on the clear health and social risks associated with FGC.

Training was provided to all change agents to facilitate a common understanding of FGC issues and communications approaches that could lead to community discussions and debates, as well as to disseminate educational messages related to FGC abandonment. Training themes included the health, social and

**TABLE 2:
SUMMARY OF THE PROJECT'S COMMUNITY EDUCATION AND ADVOCACY ACTIVITIES**

Country	Education and Advocacy Interventions	Change Agents Involved
ETHIOPIA	<ul style="list-style-type: none"> • Discussions with elders and community leaders on FGC • Four-day seminar series with 12 local religious leaders to discuss FGC issues within religious texts • Religious leaders deliver anti-FGC messages in mosques • Use of songs, role-play, stories and radio cassettes to pass messages • FGC and health education campaigns in collaboration with local government and community institutions • General community discussions on FGC 	<ul style="list-style-type: none"> • Religious leaders • Community elders • Traditional birth attendants • Primary health care workers • Extension workers • Ministry of Health workers
KENYA	<ul style="list-style-type: none"> • Participatory education theatre performances to inform and create debate on health effects of FGC and issues of human rights • Religious leaders (some) deliver anti-FGC messages in mosques • Community seminars and group discussions • Counseling sessions at community centers, health posts and hospitals • Home visits • Public debates on FGC • Anti-FGC messages included in mass media campaigns linked to major calendar events - e.g., World Refugee Day • Group discussions and counseling sessions on human rights and gender rights • Camp-wide mass media campaign focusing on anti-FGC issues 	<ul style="list-style-type: none"> • Religious leaders • Local camp leaders • Community leaders • Traditional birth attendants • Community development workers/volunteers • RH motivators • Youth • Ministry of Health workers
SUDAN	<ul style="list-style-type: none"> • Public speeches by religious leaders • Mobile theatres to depict religious views on FGC and its related harmful effects • Mixed media event: video depicting religious/FGC views by a famous imam and presentations on FGC medical issues and drama-tragedy acted by famous Sudanese actors • Village health committees hold community meetings to deliver key health messages on FGC • Staff hold public discussions on FGC 	<ul style="list-style-type: none"> • Community leaders • Religious leaders • Teachers • Community health promoters • Traditional birth attendants • Village midwives



psychosexual consequences of FGC, the lack of religious obligation for FGC and the changing nature of culture with respect to the significance and value of the practice of FGC in present times.

To ensure educational messages were reaching the entire community, and recognizing that different people would be influenced by different messengers, messages were delivered through a variety of channels and by a variety of people (Table 2). To promote individual reflection on the information, sessions were designed in a participatory way to engage community members in discussion and debate.

Conflict and Other Challenges as FGC-Related Work Began

While great care was taken to demonstrate that CARE staff were not out to eradicate the practice of FGC and that they would respectfully offer information and facilitate debate on the practice and whether it should change as other

cultural practices had changed in the past, there were still some violent reactions that had to be managed at the onset of the project. In Kenya, as the baseline survey was being launched and people in the camps were informed that a survey on FGC would take place, religious leaders in one camp vehemently disagreed with conducting a survey on FGC issues and the idea of having FGC abandonment activities in their midst. Riots ensued and after several days of discussion and negotiation between CARE senior staff and leaders in all three camps, a new camp was chosen as an intervention site. National Council of Churches of Kenya staff recounted obstacles they encountered during earlier efforts to discuss the negative health effects of FGC, such as people throwing stones or chasing education agents as they moved throughout the camps. Staff continued to meet and talk with people, and gradually the incidents stopped.

In Ethiopia, CARE staff were initially

confronted with distrust and suspicion from community members. As one CARE staff member recalled: “At the beginning, it was difficult, even risky, to talk about FGC. One Afar man was so fearful that CARE staff were coming to prevent him from circumcising his daughter that he pointed a gun at two field workers and held them hostage inside their car. The CARE staff rolled down their window and talked to the man for an hour. They then got out of the car and talked for another two to three hours. Finally, the man gave them Afu, a ceremony of asking for forgiveness.”

Conflict was also observed as a by-product of people’s reactions to information and debate about FGC. As people began to respond to education and advocacy activities, a backlash against those who took a minority viewpoint to end the practice began to emerge. These circumstances prompted several individuals to seek help and protection from CARE in the refugee camps. This story is discussed in further detail in the section on collective action found later in this article.

Roles of CARE staff had to change from being predominantly education - oriented to being facilitators supporting a community’s change process.

Addressing the Belief that Religion Mandated FGC

Baseline research uncovered the existence of a strong link between FGC and religion among study communities. A significant portion of the study populations at all three sites considered the practice of FGC to be a religious obligation, yet among religious leaders there also existed a lack of consensus about the issue. It was critical to work with willing religious leaders as advocates for change. During the initial phase of the project, CARE took a crucial first step with this group of potential advocates by clarifying and building consensus that FGC was not a religious obligation.

Reflected in this framework was the realization that nurturing change of a socially condoned practice would require addressing the physical, health, psychosexual and social realities [influencing people]...

In Ethiopia, CARE worked extensively with religious leaders to address the relationship, or lack of, between FGC and Islam. Project staff organized a four-day seminar for 12 local religious leaders to review the Koran and other teachings in relation to FGC. The meeting was convened under the respected religious leader of Awash (who was known to be an advocate of RH issues). A district representative from the Afar Women’s Affairs Office was on hand as a resource regarding the health and social consequences of FGC. In their role as catalysts of a change process, CARE staff members were present only as observers. Clerics reviewed the Koran, Sunnas and Hadiths for scriptures that could potentially refer to female circumcision. At the conclusion of the meeting, the religious leaders reached a general consensus that there was no religious recommendation related to the practice of FGC. As a group they committed to re-informing communities about the lack of association between FGC and Islam. During subsequent community activities, more than 58 imams advocated for abandonment of FGC.

In Sudan, religious leaders recruited to deliver messages to the community came from both inside and outside the community. CARE recruited Sheikh Mohammed Ahmed Hassan, a nationally famous religious educator and proponent of FGC abandonment, to conduct a religious discussion on FGC abandonment. The discussion was filmed and the subsequent video – which also included a presentation on medical issues by the CARE FGC officer and a drama-tragedy acted by famous Sudanese actors – was shown to the communities. After viewing the video, village religious leaders led public discussions and answered questions on FGC.



Although it was planned, the Kenyan project site did not systematically work with religious leaders. The use of these key change agents in any concerted action did not materialize significantly during the intervention period.

Creating Awareness: FGC Issues in Relation to Gender and Human Rights

As the project was beginning, there was a lack of awareness of a possible linkage between the practice of FGC and how it could compromise the rights of women and girls. As the contexts in which FGC was practiced differed between project sites, intervention messages and the resulting strategies to address the issue of FGC and human-rights were developed.

In Ethiopia, public discussions about FGC and human-rights issues (as defined in international treaties and conventions) were new to the Afar communities. Since the Afar were unfamiliar with the concept of internationally defined human rights, addressing such notions would be irrelevant as long as women's status remained so disparate to that of men. Thus, CARE chose not to address rights in educational messages. Instead, CARE chose to work to reduce gender inequality through actions that would empower women. The project encouraged women to participate in roles traditionally designated for men. Women were recruited as project extension

agents, something that never occurred before, to conduct outreach activities, while village health committees were mandated to include women representatives. CARE hoped that through these actions, the status of women would be elevated to a level that would allow them to participate in the political and social decision-making processes of their communities.

In contrast, Somali refugee populations in Kenya were well aware of their own rights as refugees. Staff members were able to address gender and human rights directly in public discussions and media campaigns. Due in large part to the earlier work of the National Council of Churches of Kenya, the staff faced no impediment when encouraging communities to discuss whether FGC was a violation against women and an abuse of their rights. Invariably, such small group discussions led people to conclude that the practice compromised women's rights and rights to health. Occasional camp-based media campaigns, linked to events such as International Women's Day, incorporated messages on FGC and women's rights.

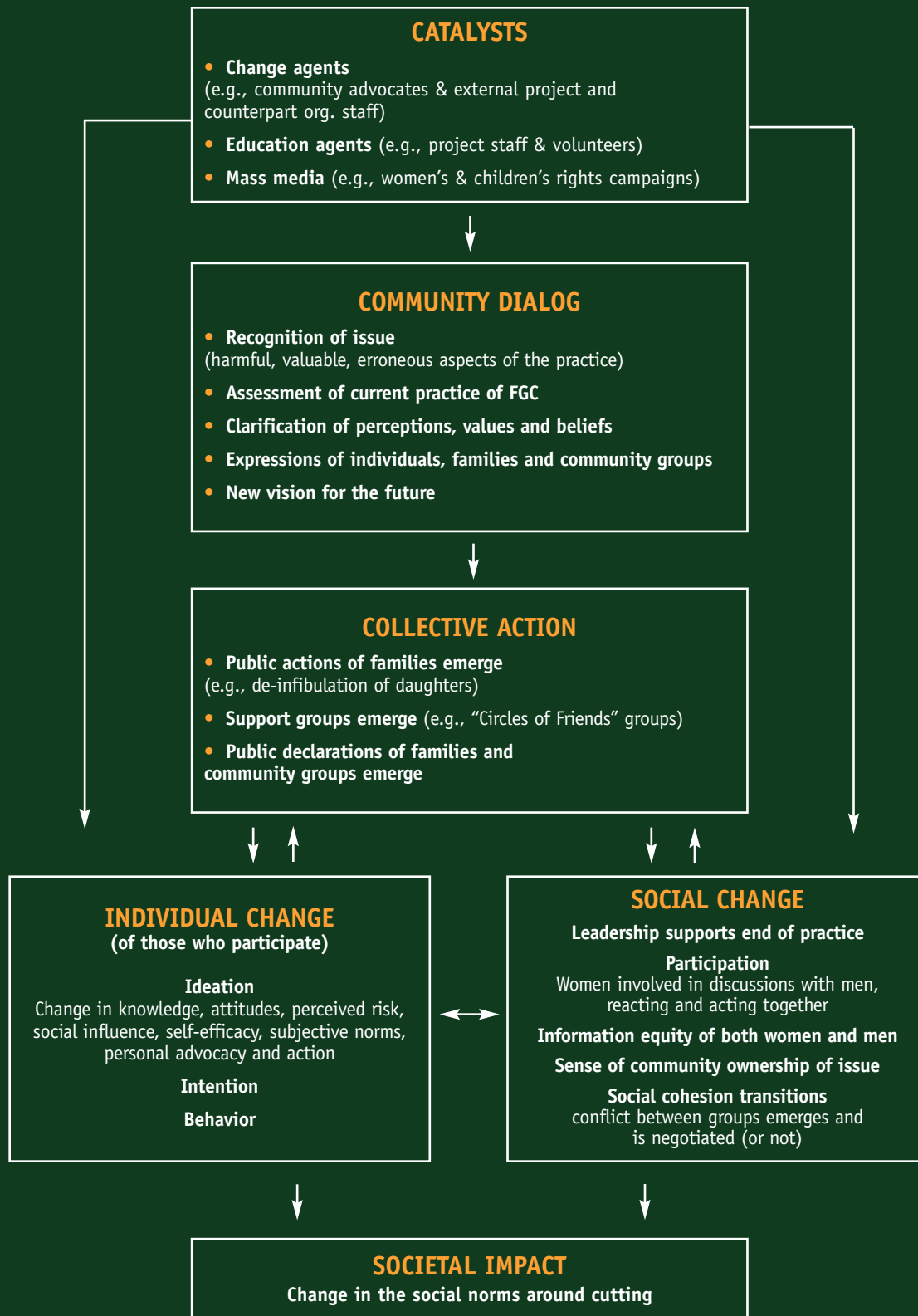
In Sudan, engaging people in discussions on rights in an environment where such discussions were not welcomed by authorities could have harmed both staff and community members. As a result, rights-based messages were not used.

Supporting Individual and Collective Actions for Change

As multi-country FGC abandonment activities and information dissemination progressed, and FGC was being publicly debated, signs indicating that changes were taking place at individual and collective levels began to emerge. These individual and collective actions took the project staff by surprise; change was occurring sooner than expected!

Some families with girls who had not yet been cut stated publicly that they did not want their daughters to be cut. In Ethiopia, some families even de-infibulated their cut girls. In Sudan, a village declared that it would not cut its daughters and thought of ways to ensure that daughters could be married even if not cut.

FIGURE 3. DIAGRAMMATICAL REPRESENTATION OF THE PROJECT'S INDIVIDUAL AND SOCIAL CHANGE MODEL
(adapted from 2002 Figueroa's et al "Communication for Social Change Model")





prompted several people to seek help and protection from CARE and other service agencies.

Although in retrospect such reactions appear predictable, staff were caught unprepared. To help support these individuals whose actions signaled the beginnings of collective change, CARE offered temporary protection in Dadaab by establishing “safe houses.” Individuals decided to band together to form support groups, which CARE supported with minimal materials and moral support from staff. These support groups, known as “Circles of Friends,” provided a haven for men, women and girls to share their minority viewpoint with those of like mind. Yet, it was clear that eventually, long-term support for people discriminated against for taking a minority position would have to originate from community institutions. CARE recognized that engaging the support of community elders and religious leaders was critical to sustaining social change. Consultations began between staff and community leaders in Kenya and Sudan to consider expanding the scope of their traditional adjudicating roles to include greater protection of women, girls and families that chose to declare themselves against FGC. In Ethiopia, the meeting of religious leaders to develop a consensus on the link, or the lack of one, between FGC and religion ultimately helped dismantle discrimination based on religious grounds and provided a new avenue for the minority viewpoint to feel more protected.

A Social Change Model: Guiding Education and Advocacy Efforts and Support of Early Adaptors

Through these experiences and learning from others organizations involved in FGC abandonment efforts, CARE’s earlier model of social change became more fleshed out (Figure 3). The social change model adapted by the project is centered on public discussion and dialog and the precept of “people coming together to decide who they are, what they want, and how they will obtain what they want”

However, many of the individuals and families who had publicly committed to abandoning the practice of FGC began to feel intense social pressure from those who wanted the practice to remain. In Kenya, for example, a number of families moved from one camp to another to escape the social pressure and marginalization that was occurring as a result of their stand against FGC. These circumstances

(Figuroa et al, 2002:4). It involves a process with parallel and interacting strands of action by individuals and groups, which begins with the identification of a community's concerns and cumulates with a series of actions taken to address those concerns. The stages of this process consist of recognition of the issue by communities, identification and involvement of leaders, clarification of perceptions, expression of individual and shared needs, visions of the future and assessment of current status.

In this model, external and internal agents serve as catalysts for individual and social change processes, providing information and creating spaces for dialogue for different community groups. In the case of the CARE Multi-Country FGC project, catalysts included CARE and counterpart organization staff, external advocates such as representatives from the Ministry of Social Affairs and nationally respected religious leaders. Staff and outreach workers provided information and created spaces for public discussion and debate that would lead to supportive environments for change and, ultimately, abandonment of FGC. Part of this work entailed identifying and working with leaders in communities who would take on advocacy roles and speak publicly on FGC abandonment issues. While there were efforts to inform and improve knowledge and awareness of individuals about the practice and its effects, there were concurrent efforts to engage community members, men as well as women, in public dialog on FGC-related issues. This led to community ownership of the issues. It also led to individual change and public "early adopters" wanting to end or change the current tradition and practice. As collective action began to emerge, external agents and local institutions provided critical support to those willing to embrace change and stop practicing FGC.

As conflict arose and the social cohesion of communities was strained, efforts were made to mitigate conflict by external and internal institutions. A social change process was underway.

RESEARCH RESULTS: SUCCESS OF THE INTEGRATED MODEL

After 18 months of FGC abandonment interventions, there were significant changes in knowledge, awareness and community attitudes toward FGC. Both men and women in all countries displayed increased knowledge of the negative health, psychosexual and social effects of FGC. Attitudes and beliefs were starting to shift. Once unimaginable, men and women were now having public debates and discussions about alternatives to FGC. Communities from all the countries were debating support for less severe forms of FGC, although CARE did not promote the lesser forms. Significantly, a positive benefit to advocacy and education efforts was a growing level of women's empowerment. In both Ethiopia and Sudan, where gender roles were particularly defined, women were taking more active roles in discussions and

Endline Study Results in Ethiopia and Kenya showed:

- Public discussion by women and men of the practice increased in both settings
- Increased knowledge of the adverse health, social and psychosexual effects of FGC
- Increased awareness of how women's and girls' rights were compromised by the practice
- Women were more resistant to changes in the practice than men
- In Ethiopia, support for abandonment more than doubled in the intervention site
- In Ethiopia, the proportion of respondents saying they would not cut their daughters in the future more than doubled
- In Kenya, the intervention had little effect on intended behavior related to FGC

Source: Population Council, 2004

decision-making processes.

In Ethiopia particularly, increased knowledge of negative health and social effects related to FGC translated into significant increases in intentions not to cut daughters in the future and support for FGC abandonment. (This shift was negligible in Kenya.) Overall, men and women exhibited more positive attitudes toward FGC abandonment.

With change around a social norm in debate at a community level, endline qualitative research also revealed growing tensions between couples and families. This tension may be due in part to differing attitudes on FGC within a family and perhaps even the result of changing social roles between men and women.

As a testament to the project's success in Ethiopia, six months after the end of the study period, Ethiopian clan leaders from 70 villages in the project area united to declare an end to the practice of FGC in their villages. They cited such reasons as: FGC was not supported by religion; was in contradiction with human rights; was a brutal and inhuman tradition; had severe health complications for women and children; and was a development stumbling block to their communities.

CONCLUSIONS AND SOME LESSONS LEARNED

The multi-country project has demonstrated that traditional, community-based RH programs – with some adjustments in design and approaches – can successfully introduce into the public domain discussions on culturally condoned practices such as FGC that negatively affect RH. Often, the voices of men and women who are affected daily by such sensitive issues as FGC are silenced. Public discussions allow these voices, the voices of all community members, to be heard. These new approaches can greatly increase the relevance and power of efforts – facilitated by either external agents or by

Each ethnic group and community was unique, and FGC abandonment strategies would have to be tailored to local contexts.

community members and institutions – to improve RH outcomes.

Looking back over the course of the multi-country study, several points emerged as key to the success of community-based approaches to combat FGC in the context of health projects.

- In this project, **FGC abandonment activities were integrated into projects that had a wider scope of improving reproductive and women's health.** If FGC had been tackled as a stand-alone issue and not within a project context of health and social well-being, communities might have viewed the project with suspicion. **Because CARE had worked for years in all project areas and was recognized as a neutral actor,** trust existed when staff began activities to address this particular social issue among other programming issues.

- In addition, there was a **conscious effort to clearly define to both CARE staff and the community that any decision to change the practice must come from the community alone.** Organizations such as CARE could provide the necessary information and facilitate public discussions and debates of the issue in order to allow communities to make more informed decisions. However, the organization must take a back seat to the process, guided by the belief that decisions to change a valued, traditional practice reside within the community.

- While education and information are critically important interventions to inform individuals, **advocacy and the creation of spaces for public dialog and debate are needed to make the issue one shared by the larger community.** Having influential people speak to the secretive issue of FGC opened a public space that gave permission to individuals to act publicly on their beliefs.

- The **roles of CARE staff had to change from being predominantly education-oriented to being facilitators supporting a community's change process.** The changed role also allowed for more open and bi-directional relationships to develop between external project staff and intended beneficiaries. When communities themselves guide project activities, they are



compelled to share a greater responsibility in sustaining actions and outcomes.

- To address the issue of FGC effectively, **issues of gender and rights need to be addressed.** Tackling gender dynamics and power structures requires focusing on underlying social currents that influence a community's attitudes, practices and beliefs. One often assumes that providing information and education is the only means of addressing gender and rights; by understanding the local context sometimes it is more effective to address gender and rights through actions to demonstrate that women can play important roles in the development process.

- **Rights-based approaches must be grounded in socio-cultural-politico contexts of communities.** Understanding context is critical. Developing interventions that are specific and appropriate to each community and learning how communities themselves think about rights and responsibilities will allow for more successful and sustainable outcomes.

- Finally, a plea for donors and development organizations: **Expect and commit to longer timeframes for projects that engage communities on social rights and power issues.**

As this study shows, initial changes bring about conflict. At the end of the 18-month study period, social roles were being renegotiated and readjusted in communities. In the pilot areas of Kenya and Ethiopia, projects continued after the study phase, but abrupt ending of supportive project activities could have led to a push back into more restrictive roles for women.

Future Directions

CARE considers the work already undertaken in the area of FGC abandonment as a critical learning for future project directions. Thus, CARE will continue to build its FGC abandonment program in Africa, with the addition of Somalia, Eritrea and Mali, while continuing projects in Ethiopia, Kenya and the Sudan.

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