Integrating Rights-Based Approaches into Community-Based Health Projects: Experiences from the Prevention of Female Genital Cutting Project in East Africa

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CARE International is one of the largest relief and development agencies in the world, working with poor and vulnerable people in underserved areas in more than 60 countries in a variety of sectors, including agriculture, income generation, water and sanitation, basic education and girls' education, and health. In 2000, CARE joined with the international development community to work towards achievement of the Millennium Development Goals, now understood to be critical for sustainable reductions in poverty. This helped concretize a fundamental reorientation of CARE's work that had begun in the late 1990s, of shifting from a needs-based to a rights-based approach (RBA) to programming. This reorientation was made in the belief that using a basic human rights framework to work with communities and other actors would address—both more systematically and more systemically—the matrix of underlying causes of poverty; this would, in turn, empower people and communities to action and sustainable improvements

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in their lives. The RBA reorientation is provoking many changes within the organization. The box below summarizes recently adopted program principles of CARE International, which reflect how CARE programs are expected to incorporate rights-based approaches. New ways of programming also imply new responsibilities for those in the organization: While international and regional human rights treaties do not define the responsibilities of NGOs and other development actors to uphold rights, CARE programs based on RBAs should now acknowledge three commonly cited responsibilities related to upholding rights—respecting, protecting, and fulfilling the rights of all community members, including the vulnerable and marginalized.

CARE International Programming Principles (2003)

1. Promote empowerment.
We stand in solidarity with poor and marginalized people, and support their efforts to take control of their own lives and fulfill their rights, responsibilities, and aspirations. We ensure that key participants representing affected people are involved in the design, implementation, monitoring, and evaluation of our programs.

2. Work in partnership with others.
We work with others to maximize the impact of our programs, building alliances and partnerships with those who offer complementary approaches, are able to adopt effective programming approaches on a larger scale, and/or who have responsibility to fulfill rights and alleviate poverty through policy change and enforcement.

3. Ensure accountability and promote responsibility.
We seek ways to be accountable to poor and marginalized people. We identify those with an obligation toward poor and marginalized people, and support and encourage their efforts to fulfill their responsibilities.

4. Oppose discrimination.
In our programs and offices, we oppose discrimination and the denial of rights based on sex, race, nationality, ethnicity, class, religion, age, physical ability, caste, opinion, or sexual orientation.

5. Oppose violence.
We promote just and non-violent means for preventing and resolving conflicts, noting that such conflicts contribute to poverty and the denial of rights.

6. Seek sustainable results.
By acting to identify and address underlying causes of poverty and rights denial, we develop and use approaches that ensure our programs result in lasting and fundamental improvements in the lives of the poor and marginalized with whom we work.

Beginning in the mid-1990s, with the passage of the International Conference on Population and Development's Program of Action, the international reproductive health community began a fundamental reorientation of its approach to reproductive health, centering it within a framework of rights in relation to sexual and reproductive health.1 Related to this, advocacy efforts began to re-frame both the female genital cutting (FGC) debate and subsequent program approaches that work with the aim of FGC abandonment, moving away from defining FGC solely as a traditional practice with serious reproductive health consequences to defining the practice also as an issue of human rights and gender violence.2 In terms of rights, FGC has been understood to compromise the rights of women and girls in a variety of ways, including rights to health and to bodily integrity, security of person, and the right of a child to develop physically and mentally.[3]

These internal and external currents coalesced to form the overarching context of the CARE multi-country FGC abandonment project and its pilot approaches to integrate RBA into on-going reproductive health projects. This article reviews and analyzes this project and its pilot approaches. It focuses on key conceptual and programmatic shifts within the project—particularly changes in the relationship with and approaches to communities that had to occur to make existing reproductive health projects more rights-based—and highlights issues that arose as more rights-oriented projects were implemented at the community level in Ethiopia and Kenya.[4]

Background: FGC and the CARE Project

FGC is practiced mostly in Africa; an estimated 130 million women and girls have been cut, and each year nearly 2 million more girls are at risk of cutting.[5] Reasons for continuing this valued, traditional practice are quite similar across the ethnic groups that practice it and include ensuring that girls are married, that boys have chaste wives, and ultimately that communities maintain their social integrity. FGC can have serious and at times life-threatening health consequences, particularly with the most invasive form of cutting—infibulation. Beyond FGC's physical ef-

fects, the practice also has serious social and economic consequences for women and girls, including limiting opportunities for education and income due to early marriage. Regardless of the type of cut, FGC marks a transition towards womanhood and initiates subsequent changes in the roles that these girls have within the family and larger society. The practice is a complex one and touches on social, sexual, and gender norms and roles that women are supposed to play in their community and society.

Given the serious reproductive health consequences of FGC, the numbers of women and girls affected, and the fact that CARE operates in 15 countries where FGC is practiced, CARE staff in several countries felt it was important to begin to include FGC in their reproductive health project portfolios. CARE's pilot FGC abandonment projects operated from 1999 to 2002. The multi-country projects were designed to allow CARE health-program and counterpart-agency staff to gain experiences in the sensitive and complicated-to-implement program area of FGC abandonment, to use these experiences to inform the larger CARE reproductive health program, and to contribute to international understanding of how to design and implement effective FGC abandonment interventions at community level. The multi-country projects were implemented in diverse settings in Ethiopia and Kenya and reached different ethnic groups (the Afar and Somalis) living in different socio-political and geographic contexts.[6] The Afar, for example, are a nomadic people who live and move with their livestock in semi-arid parts of Ethiopia, Eritrea, and Djibouti. The Afar in Ethiopia live in the eastern part of the country in one of its most impoverished areas. They have a strong sense of tradition and culture since they have been, until the recent past, quite isolated from mainstream Ethiopian society. Alternatively, the Somalis, many of whom have been living in Kenyan refugee camps for over a decade since the dissolution of their nation in the early 1990s, now live sedentary yet transitional lives in a foreign land. While they still hold many of the cultural values and traditions of Somalia, they have been exposed to ideas and norms of other cultures in Kenya. As refugees, these people live under the umbrella of international refugee conventions and thus have relatively more exposure

to international human rights dialogue than most Somalis still living in Somalia (e.g., hearing camp-based campaigns on women's and girls' rights).[7] Kenyans of Somali origin form the main ethnic group living around the camps and share a common language and elements of culture with their refugee counterparts. As such, there is interaction between these groups, which further exposes the refugees to new ideas and norms.

Yet, regardless of these differences, the people living in the various project sites had the practice of infibulation in common, with many valuing the practice for reasons of culture, tradition, a universal religion (Islam), and a strong (although erroneous) belief that their religion obliged them to cut girls. Even as most people knew about and participated in FGC, however, it was also a practice based in silence: As the CARE projects began, FGC was an unspoken subject among the Afar and was a subject only touched upon for its harmful health consequences in Kenya (by agencies in the camps working to sensitize people to reproductive health issues).

CARE, having operated in all project areas for many years, was a known actor to these communities. In partnership with local institutions, CARE helped to improve the availability of needed services in areas such as water conservation, land management, and primary health care to these populations. The FGC projects had an operations research component (conducted in collaboration with the Population Council's Frontiers in Reproductive Health Program) that included quantitative as well as qualitative research conducted at baseline and at end line. The research was designed to measure changes in women and men of their knowledge of harmful consequences of FGC, their rights awareness, and their opinions on gender equality, and to document perceptions of changes occurring in communities. Due to the relatively short period of 18 months, the projects did not attempt to measure whether there was a change in the practice—just in *intention* to change or end the practice.

Developing interventions around FGC abandonment provided very interesting program intersections—including reproductive health and social well-being, as well as gender and rights. These significant intersections pushed CARE to

move beyond a traditional project approach focused on reproductive health outcomes. Indeed, by deciding to play a larger and more direct role in facilitating social change, the organization altered and expanded its established role and relationship with partners and communities. This FGC work also challenged staff to operationalize internationally defined concepts of rights in ways that would be relevant to the receiving communities, outside of facility-level interventions, where many rights-based reproductive health programs have focused.

Moving from a Needs-Based to a Rights-Based Approach

As rights-oriented FGC abandonment activities were integrated into CARE's on-going reproductive health projects, the project designs were adjusted to address the underlying factors that encouraged the continuation of the practice (see Table 1). While reproductive rights are implicit in traditional reproductive health projects, such projects have usually been designed to address unmet needs for reproductive health information and services and, consequently, tend to focus on interventions that lead to improved knowledge and subsequent "healthy" behaviors of individuals in communities. Such projects rarely try to address the systemic and societal barriers that can stop women from acting on their reproductive choices.

The goal of the newly integrated project was to acknowledge the socio-political underpinnings of the continuation of FGC and to account for the impact of the practice not only on health but on social well-being. Likewise, changes were made in the educational messages and approaches as well as in the organizational partners with which the project worked. Advocacy activities were added, with the recognition that community-level advocates (such as religious leaders) play critical normative roles and have great influence on local values, attitudes, and beliefs. Finally, because the project was essentially working towards changing a social norm, CARE had a responsibility to "accompany" communities as they underwent change—by working, for example, to ensure protection of those brave enough to declare that they would go against the norm of cutting or by supporting collective action against FGC as it

Existing projects	Projects after integration of FGC abandonment activities	Rights rationale for adjustment
Improvement of reproductive health of women	Improve both reproductive health and *social well-being* of women.	• Recognize that the practice of FGC occurs in a context of existing gender inequalities and women's social powerlessness.
Community health education using community health volunteers	• Expand education outreach to *include social and rights messages/issues* (in addition to health messages). • Create spaces for *community discussion and debate.*	• Empower women (and raise awareness of men) with information to allow women to protect their health and claim reproductive rights. • 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 (and help further women's empowerment).
Coordination with community leaders	• Coordination continues but ***new activities are*** added. • *Community level advocacy* with religious/other leaders.	• Those who help maintain community norms can also help lead changes in norms. • Having leaders discuss FGC gives "permission" for the larger community to publicly discuss such private issues. • Promote community leaders' responsibilities for women's concerns.
Inter-organizational partnerships with Minister of Health or equivalent actors	*New partners.* 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.	• 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:* • Creation of support groups for those publicly against FGC. • Working with leaders on protection of women and girls.	• Organizational responsibility as a facilitator of change to not abandon people when they take public positions 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.

Table 1. *Comparison of community-based reproductive health project interventions prior to and after the addition of rights-oriented FGC abandonment activities.*
*See page 269 for additional information on Table 1.

emerged from the community. This latter activity was not planned in the early stages of the project; but, as communities reacted to the project's information and began debating the merits of FGC, CARE felt it had a responsibility to support communities in their change process.

Context Is Key: How Are Rights-Based Approaches Operationalized?

From the beginning, CARE had to determine how project approaches to FGC abandonment and human rights issues could become operationalized. Participatory, qualitative, community-driven research was an essential tool to increase understanding of FGC issues, as well as to begin a productive community dialogue around the subject. Done in an interactive style and often with representatives of local communities as members of the research team, this sort of research leads to a more nuanced understanding of the context within which choices are made, clarifies the development of approaches to health issues that are relevant to local communities, and comes through in language that is understood locally. Eventually, CARE incorporated rights and responsibilities into these dialogues—an important move that brought many critical issues to the forefront.

The initial round of participatory assessments, undertaken to identify the practice and community value of FGC, revealed a wide range of opinion.[8] While it was clear that a small minority of people no longer saw value in the practice, most people wanted FGC to continue. The quotes from Kenya, below, show the socio-cultural, religious, and psycho-sexual reasons why the practice was valued and elucidate the intensity of feelings that FGC produces.

> "It is our practice for the Somali people. The Somali are not two people. We are many. And we all do it. We will not change." –Elderly man

> "If you are here to stop gudniink (female circumcision), it will never happen." –Elderly woman

> "It is good. One who is not circumcised is not a Muslim." –Elderly man

> "Are you saying we leave the girls with the unlawful (hara'am) part?" –Elderly woman worried about not following the perceived religious obligation to circumcise girls

> "We do not want a girl who is easily used by every man, a girl with a big hole or opening." –Elderly woman worried that uncut girls would be sexually loose

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

> "The Pharaonic practice (infibulation) will change because men and women are having problems. Many are saying we should change to Sunna." –Woman referring to women's health and a couple's sexual problems that can be created by infibulation

When CARE began the project in Ethiopia, there had not yet been any preliminary discussion about FGC by outsiders with communities. CARE staff noted that at the outset of program activities it was difficult—sometimes even dangerous—to attempt to talk about the intimate, sexually related topic. Early on, a number of limited incidents signified the tensions involved in bringing up a publicly taboo subject. CARE staff and advocates were chased from several villages and threatened by angry mobs. Yet, even these incidents of crisis could produce fruitful ends. As one CARE staff member recalled:

> At the beginning, it was difficult, even risky, to talk about FGC. Now it's a main discussion point in the villages. Patience and dialogue are key to how CARE staff approached initial distrust from the community. . . . One Afar man was allegedly so fearful that CARE staff were coming to prevent him from circumcising his daughters that he pointed a gun at two field workers and held them hostage inside their car. The CARE staff rolled down the window and talked with the man for an hour. Then they got out of the car and talked for another two or three hours. Finally, the man gave them Afu [a ceremony of asking forgiveness]. Now he is one of the project's organizers.[9]

The initial round of assessments already revealed that people very rarely mentioned issues of rights or gender. And when

mentioned, rights and gender issues were loosely defined, such as "female circumcision was against the dignity of women" and "it is our right to practice female circumcision because it is our tradition and has been done for generations."

In another round of baseline research, focus group discussions (with different groups of community stakeholders, such as married men and women, and unmarried young men and women) on what the community defined as human rights revealed striking similarities.[10] Basic human rights—such as having adequate food, shelter, health, and being respected by others—were common to communities in both countries. The rights of boys and girls were also very similar, did not vary much by gender, and included rights to education, health, and adequate food and clothing. Notably, in Ethiopia one of the community-defined rights of both boys and girls was to be circumcised.

In both communities, which are universally Moslem, religious texts were the main "definer" of rights. Discussion participants never used language that would suggest exposure to international human rights conventions.[11] In Kenya, some people talked about rights being defined by "culture," and we interpreted this to mean that social norms helped define what rights people understand that they have.

In discussions, people mentioned responsibilities as well as rights and had well-defined ideas regarding who had the responsibility to uphold rights. For women, the responsibility rested with fathers and husbands; for children, it rested with fathers and, sometimes, with mothers.

Both sexes agreed that, while men, women, and children had specific rights, these rights were not always upheld equally. In reality, some groups' rights, particularly women and girls, were not upheld. Participants stated that women were not always well taken care of by their male partners (who were responsible for upholding their wives' rights to shelter, food, etc.); and girls were not always allowed to go to school, yet their brothers were. Participants additionally thought that children were more assured of their rights, regardless of gender. In both countries, too, participants of both sexes remarked that religion sometimes defined rights *unequally* between men and women. During disputes, for

example, when one person claimed that he/she had been wronged (in relation to a specific issue) by another party, men were compensated at 100% of the sanction for the wrongdoing while women were compensated at 50%.

Neither community spontaneously mentioned the relationship between FGC and rights, so facilitators did not probe participants to talk about whether the rights of children, women, and men were violated when FGC was practiced.

It was the discussions and conclusions from this research that informed and structured CARE's rights-oriented programming decisions. Work on the part of CARE's staff would focus on bringing together local religious leaders so that they could confer and hopefully reach consensus about the lack of religious obligation to practice FGC. In order to improve women's well-being, the project would create educational messages focusing on religious duty (or lack of duty) and duty to body (e.g., to be healthy and clean). CARE would also take an empowerment approach, creating spaces for public discussion and debate where women could publicly express their health (particularly reproductive health) needs as a community issue in the presence of men, with the intention that this sort of discussion would result in greater equality between men and women.

Challenges of Operationalizing a Rights-Based Approach

Operationalizing rights-based approaches requires making adjustments at different levels within an organization—project management and technical-assistance/capacity building structures need to change, as does a project's interface and interaction with communities.

CARE staff had to learn to do programming outside the realm of traditional community-level health programming. Staff joined with officials representing women's affairs and national networks working against harmful traditional practices to form new organizational partnerships. At the project-community interface, project staff and volunteers had to shift from playing an education role (vis-à-vis communities) to playing a facilitation role—a change that was difficult for some staff and volunteers. The staff knew how to coordinate with local structures; but once the need for ad-

vocacy became apparent, they had to develop new ways of working proactively with leaders to advocate for changes and had to learn to work with power structures in communities (such as with representatives of traditional adjudication structures). In this sense, the organization's relationship with the community shifted, and vice versa.

Some of the key issues in operationalizing an approach more based in rights are discussed below.

Gender and the Rights of Girls and Women

Gender inequality is one of the root causes of FGC. To better understand how these inequalities should be addressed in each community, CARE staff undertook the task of working with the community to analyze the gender issues at each community's foundation. Because of the different community contexts in which each project operated, staff in Ethiopia and Kenya used strikingly different strategies to address the issue.

The Afar of Ethiopia are pastoralists, still very traditional and somewhat isolated from mainstream Ethiopian culture. In Ethiopia, staff decided not to address rights in educational messages, and they never spoke directly to communities about rights that FGC potentially violates. Instead, CARE worked to reduce gender inequality more broadly through actions that would help empower women. For example, the project mandated that village health committees have women representatives. Women extension agents were selected—something never before done in the Afar community—and they began outreach activities. Establishing an awareness, in both women and men, that women could be more equal actors in their communities was the critical first step in advancing equal rights.

The Somali population in Kenya, a refugee population that has been living in Kenya for over 10 years, was at a different starting point from the Afar when it came to thinking about rights. Many refugees are quite knowledgeable both about their rights as refugees and about various dialogues on internationally defined rights. In Kenya, as a result, staff worked at several levels to address gender inequalities. Because there were already on-going efforts to sensitize the

refugee population about women's and girls' rights, almost immediately project staff felt comfortable defining the practice of FGC to the community as violence against women and an abuse of their rights. Mass communication campaigns linked to international calendar events (such as International Women's Day) discussed FGC and other practices as violations of women's rights. Education and advocacy messages spoke to the negative health and social consequences of the practice. Staff facilitated discussions with community groups on rights and their relation to FGC, and people invariably came to the conclusion that the practice violated children's rights to good health and education. They also often concluded that FGC compromised both women's rights to health and women's (and men's) sexual health rights.[12]

Still, addressing rights in the form of educational messages was not without its challenges in Kenya. CARE staff noted that women's and children's rights messages are "complicated" and "difficult to undertake in a refugee environment, when rights are difficult to uphold generally."[13] The rights-based messages that were disseminated tended to emphasize the individual rights of women and girls over the collective rights of a society. Upon reflection, one wonders whether the individualism of that approach to rights could introduce a note of dangerous discord in traditional societies that depend so much on the ordered cooperation of its members.[14] The African Charter and other African regional human rights instruments are unique because they include a stronger focus on communal obligations.[15] Perhaps the educational messages of this project would have been even more relevant had they been framed more as a societal issue (e.g., the right to change a practice that was no longer relevant).

Clarifying Roles and Responsibilities

In both countries, project staff observed a number of actions indicating that change was underway. As communities started to react to the information that was being shared by the project, more people decided that they wanted to change the practice of FGC. Some decided that they did not want their daughters to be cut and stated this publicly. In

Ethiopia, some families de-infibulated their girls. In Kenya, one family used the 2002 Child Act of Kenya and took a father to the police for trying to circumcise his daughter. Actions like these precipitated reactions: other people in the project communities, the majority of whom wanted the practice to continue, started to exert social pressure and show their disapproval of families and individuals that wanted FGC to end. Several families moved from one refugee camp to another in an attempt to escape this social pressure. Families and girls who decided not to undergo female circumcision came to CARE and other agencies to ask for help and protection.[16]

Such community-level actions led the CARE projects to refocus the dialogue on another question: Who has responsibility for upholding rights and protecting those most vulnerable—NGOs, community guardians and leaders, or the larger community? As an international NGO working to promote social change, CARE did not want to become, over the long term, *the* entity responsible for upholding the rights of disenfranchised members of communities within which it worked. Rather, we felt that the communities themselves and their leadership structures should take responsibility to uphold rights of all their members, including and especially those who were being ostracized.

Project staff thus tried to support, in various ways, individuals and families seeking assistance. One outcome of this assistance was the creation of support groups composed of people who were against the continuation of the practice. These "Circles of Friends" (as they are being called in Kenya) have provided a means for the minority viewpoint of women, men, and girls to be supported by others of like mind. Eventually, these groups may enable community members themselves to organize and make their leaders more accountable to FGC issues.

Fully recognizing that community elders and religious leaders often set and reinforce community norms (particularly in areas of gender inequalities and the protection of minority rights), CARE staff also began to raise FGC-related issues with these members of the community. The staff was particularly focused on addressing the inconsistency and inequality of the application of human rights. Both projects

used different strategies in attempts to engage traditional authorities in these discussions. In Ethiopia, project staff invited religious leaders to come together and develop a consensus on the relationship of religion and FGC. In Kenya, project staff approached elders and local religious leaders on the issue of protecting those who had publicly stated that they were against the practice of FGC. Such actions can help to make leaders more accountable to the different, and sometimes more vulnerable, members of their communities.

Some local leaders have taken action and are beginning to adjudicate on issues concerning women. It is still too early to know whether working with community leaders and traditional adjudication and communication structures is effective. We hope discussions that address issues traditionally thought to be outside the public realm, such as women's issues, will be the foundation for a crucial reworking of a structural norm. The end result, we hope, is that these sort of strategic actions enlarge leaders' responsibilities to the entire community and increase both accountability and transparency.

Catalysts or Advocates of Change? The Role for International NGOs

A guiding principle for staff in both countries was that individuals and communities had *the right to decide for themselves* whether they wanted the practice of FGC to continue or not. CARE's main priority was simply to provide as much information as possible from the variety of sources noted above and to facilitate community-level discussion and debate of the issues. This policy was a conscious choice: as an external, secular organization, we needed to respect the existing values of communities while concurrently working to get people to reflect on the value of changing a harmful, traditional practice. Staff felt that if the project could bring into these discussions how FGC relates to concepts of social well-being, religious obligation, and rights—in addition to good health—then communities would include such ideas into their discussions and debates and would eventually come to their own conclusions on the issue.

This "cultural-relativist" view was somewhat risky: communities could decide to continue their traditional

practice, thereby continuing to put women and girls at risk and in violation of many of their rights. On the other hand, a rights-based approach fundamentally changes the relationship between international NGOs and the communities where they operate. Whereas a needs-based approach can often imply a paternalistic relationship, a rights-based approach provides for a more equitable relationship in which both parties are partners in development. CARE felt that if, as outsiders, the organization had taken a bolder social activist approach, broadly proclaiming our view of what the community should do, it would have lost the respect of the community and would have effectively maintained the unequal *status quo*. Any productive discussion and exploration would have been blocked by our own attitudes and approaches. While preliminary results in Kenya are mixed in relation to attitudes about FGC, results in Ethiopia, documented in the next section, suggest that this relativist approach has merit.

Preliminary Results of the FGC Abandonment Project

After 18 months of FGC abandonment interventions, qualitative research at end line revealed significant changes in awareness and attitudes to FGC in the communities and in relations between men and women.[17] In both countries, what was once a taboo subject is now a public issue being debated by men and women in various forums. The program has been instrumental in fracturing the silently held community view of FGC as a women's issue having some health consequences. Different types of FGC have become part of the debate, as has ending or changing the practice. Members of different community-stakeholder groups—parents, girls, ex-practitioners, religious and other leaders—are saying they do not want to circumcise their daughters. Religious leaders are more clearly discerning the difference between culture and religion, and some are now advocating for the end of the practice. As powerful men in their communities, some religious leaders are becoming socially responsible for women's issues in ways they had not previously done.

A critical side benefit to advocacy and education efforts is the growing level of women's empowerment. "Women in

the Somali community never used to talk. Now they interrupt the men. They say, 'Shut up—you don't know a thing about what a woman suffers.'"[18] Afar women are now included in community debates and are even actively encouraged to speak. Customarily silent or absent during decision-making processes, Afar women now "are very much active. It was difficult to include women in the group at first. They sat at the back and on the floor. They were quiet. [Today] it's very common for everyone to discuss together. The women are near the men, sitting on the chairs (versus on the ground), they challenge the men, they confront them."[19]

At the same time, the results revealed that conflict between couples and within families had grown (presumably due to differences in opinion on FGC within the family, but perhaps also due to changing social roles between men and women). While conflict is an inevitable product of social change processes, hopefully it will lead to altered, more equitable social roles between the sexes.

Preliminary results of the quantitative survey research corroborate the qualitative research findings: Significant changes over the baseline measure have occurred in knowledge of the harmful health, social, and psycho-sexual consequences of FGC.[20] Awareness of women's and girls' rights has increased significantly in both Kenya and Ethiopia, leading us to hypothesize that rights as defined or understood internationally have begun to influence the communities' opinions. In Kenya, there was no significant increase in the number of people wanting to end the practice. In Ethiopia, on the other hand, significantly more people wanted to end the practice than prior to the pilot project. Interestingly, men were more supportive of ending the practice than women and more often said they held this view for reasons of violations of women's and girls' rights. Why were men more favorable about changed women's roles than women themselves were? This question remains and deserves further study. The answer may be related to the aforementioned increased conflict observed between couples and families and may reflect a stage in a social-change process when gender roles are readjusted.

About 12 months after the research period ended, clan leaders from 70 villages in the project area in Ethiopia met

and spontaneously declared an end to the practice in their villages. Reasons cited in the public declaration document included that 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 community. Will this ultimately lead to an end to the practice among all the Afar? We hope so.

Conclusion

CARE is in the process of adjusting the way it designs and implements programs. This experience with FGC—demonstrating that rights-based approaches can create more avenues to sustainable development and can ensure that voices of vulnerable and marginalized people are heard—has expanded the scope of the organization's work. This case study demonstrates that related adjustments need to occur at different levels, both internally, in the way that policies and programs are planned, and externally, in the way projects are implemented and in the changed relationships with communities. As NGOs move away from traditional reproductive-health projects to projects that promote social change and take more rights-based approaches to health issues, traditional community-based strategies—like those that work with volunteers and staff to educate people to adopt new "healthy" behaviors—will remain necessary interventions but will be insufficient to promote social change. In order to develop rights-oriented approaches that ring true with communities, it is essential to begin with understanding how the communities themselves think about rights and responsibilities. It is similarly crucial to understand and support pre-existing community institutions (or new groups that could play a role) in the promotion of rights. One must avoid standard program formulas for rights-based approaches and recognize that contextual factors and realities must inform the project design process.

Rights-based programming allows for new directions and new types of discussions with communities beyond those offered by traditional reproductive health programs. The power in these approaches lies in their ability to address

gender dynamics, power structures, and community capacity to mobilize for social change; indeed, such efforts can help transform the social and political structures that prevent people from fulfilling their highest potential as human beings. As this study has suggested, these new directions may prove to be very effective in supporting sustainable improvements in reproductive health at community levels. As agents of this sort of change, project staff and outreach workers will need to move into new modes of interacting with communities: from education agents to social change agents. In this new role, staff must facilitate community debates and discussions; they must also be able to analyze changes occurring at the community level and to ensure that project actions remain supportive and relevant. Communities themselves are encouraged through these processes to change the ways they relate to the staff of projects and NGOs. More importantly, within communities themselves, groups representing different stakeholders are encouraged to relate in new ways to one another and to acknowledge power and gender differentials.

As this case study also points out, change brings about conflict, at varying levels—within couples, within families, within communities. To engage in rights-based approaches for social change also requires that NGOs and donors ensure that adequate resources are secured to support efforts in communities for longer periods of time than the normal three-to-five-year project life-span. This is necessary to ensure that as conflict occurs it can be brokered in ways that lead to increasing the equity of those who are willing to go against convention or who are marginalized or vulnerable within a society. With support from donors, the projects in Ethiopia and Kenya have been able to continue their FGC abandonment efforts and will be able to continue to accompany and support these communities as they undergo fundamental changes.

*NB: Many community-based reproductive health projects, including the ones above, also have facility-based interventions to improve reproductive health services, but these are beyond the scope of this discussion and not included in the table. In the current study, in Kenya, low-level educational messages on the

health consequences of FGC had been delivered prior to the study, as part of a larger set of reproductive health messages on maternal health, family planning, sexually transmitted infections, and these activities were expanded in scope and intensity during the intervention period. In Ethiopia, FGC and reproductive health issues were new interventions that were added to on-going primary health care activities.

References

1. United Nations Population Fund (UNFPA), *The State of the World's Population: Reproductive Rights and Reproductive Health* (New York: UNFPA, 1997).

2. B. Shell-Duncan and Y. Hernund, *Female "Circumcision" in Africa: Culture, Controversy and Change* (London: Rienner Publishers, 2000).

3. E. Kirberger, K. Randolph, and N. Toubia, *Intersections Between Health and Human Rights: The Case of Female Genital Mutilation* (New York: Rainbo, 1995).

4. This case study is drawn from a larger CARE case study report published in 2002—S. Igras, 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* (Washington, DC: CARE USA, 2002)—as well as findings from the project's end-line research in 2003.

5. N. Toubia, *Female Genital Mutilation: A Call for Global Action* (New York: Rainbo, 1995).

6. The pilot project also operated in the Sudan, but most information and documentation of program experiences occurred in Ethiopia and Kenya; hence we do not present the Sudanese experiences in this article.

7. Personal communications with different CARE Kenya staff in Dadaab as the project was beginning, 1999.

8. S. Igras, M. Aden Abdi, Z. A. Ahmed, T. Kadgu, P. Kilele, J. Kinama, Y. Muhumed, N. Oigo, A. Osman, M. B. Yussuf, *Findings from Group Discussions and Exercises to Explore Issues Regarding Female Genital Cutting (FGC): Dagahaley Refugee Camp in Dadaab, Northeast Kenya* (Washington, DC: CARE USA, 1999); A. WoldeMariam and J. Muteshi, *FGC in the Awash Afar Region: Findings of a PLA Exercise* (Washington, DC: CARE International in Ethiopia, 2000).

9. G. Driscoll, *The Door: Perceptions and Perspectives on FGC Abandonment Efforts in the Refugee Camps of Dadaab, Kenya* (Internal report: CARE USA, 2002).

10. S. Igras et al. (see note 4); A. WoldeMariam, "Report on Focus Group Discussions on Rights Issues Among the Afar," unpublished draft, 2000.

11. Because many refugees are quite well-versed in internationally defined rights as refugees, we theorized that we might hear the language of international human rights conventions when discussing human rights. It did not, however, spontaneously emerge, perhaps due to the way the questions were asked by discussion leaders, perhaps because the rights

simply weren't known, or perhaps because religiously defined rights take precedence in highly religious societies.

12. One of the sexual paradoxes that existed in this community was a belief that women were expected to be passive recipients of sex while men were not. Yet, men realized that sex was more enjoyable when women were not passive, and some expressed a preference for un-cut women for these reasons, although not necessarily for *wives* that were uncut.

13. G. Driscoll (see note 9).

14. G. Driscoll (see note 9).

15. See O. Phillips, "(Dis)Continuities of Custom in Zimbabwe and South Africa: The Implications for Gendered and Sexual Rights" in this issue of *Health and Human Rights*.

16. Under recent refugee rulings, girls can be considered persecuted for not wanting to be circumcised and can consequently be prioritized for resettlement to a third country. It is, of course, impossible to know how much this factor motivated people to come to UNHCR and CARE for help.

17. N. Nuworo, *FGC: Exploring Issues of Social Change and Community Responses to Implementation of Project Activities: Findings from Focus Group Discussions* (CARE International in Kenya, 2003); A. WoldeMariam, *Results of the FGDs on FGC Abandonment, FGC Operations Research Project* (CARE International in Ethiopia, 2003).

18. G. Driscoll, *The Unwanted Way: The Afar—Ethiopia's Fierce Nomadic Tribe and Struggle to Abandon FGC* (Internal Report: CARE USA, 2002).

19. G. Driscoll (see note 18).

20. J. Chege, J. Muteshi, S. Igras, and I. Askew, *Testing the Effectiveness of Community-Based Approaches for Encouraging Abandonment of Female Genital Cutting in Ethiopia and Kenya* (Washington, DC: Population Council-Frontiers in Reproductive Health Program, in preparation).