Call for proposals: research on Female Genital Mutilation and Female Sexuality

Summary
WHO’s Department of Reproductive Health and Research is calling for proposals to examine and evaluate the role of female sexuality in women’s continued support of FGM. The study duration is 12-17 months. The deadline for submission of concept papers (3-5 pages), or full proposals (12-20 pages) for a first selection is Wednesday, 28 June 2006. The deadline for full applications of selected projects is 31 August 2006, with projects beginning in January 2007 and concluding by May 2008. The project is funded by the European Commission.

Introduction
WHO defines female genital mutilation as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or non-therapeutic reasons. The practice is widespread in 28 African countries, concentrated around the belt of the Sahel. FGM is also practiced in some countries in the Middle East and Asia. The practice is also found among immigrants from these areas in Europe, North America, and Australia.

Among groups where FGM is a cultural tradition, the practice is associated with a variety of socio-cultural meanings and is often considered necessary for social acceptability. But FGM is also a tradition that involves severe pain and health risks, both immediate and long term, and that violates women’s fundamental human rights. FGM violates human rights treaties and resolutions assuring the rights of physical integrity and freedom from all forms of torture, inhumane, degrading treatment and discrimination. FGM was explicitly condemned in the UN International Conference of Population and Development (ICPD) Programme of Action, Cairo 1994, and reinforced the condemnation in Beijing 1995 at the Fourth World Conference on Women. In 1997 WHO, UNFPA and UNICEF published a joint statement against the practice (1), and it has since been maintained as a topic on the international agenda. Many countries have also outlawed FGM and taken various steps towards an abolition of the practice (2).

Given 25 years of national and international efforts to eradicate FGM, the prevalence is relatively unchanged in countries where it is practiced. Only a handful of countries have documented a decline in the practice (3). Evidence from countries in which laws have been passed banning FGM, show that outlawing the practice can push the practice underground and/or lead people to practice different forms of FGM (4). While laws prohibiting FGM are an initial step, legal change on its own is insufficient. The efficacy of health interventions is mixed. They are predominantly rooted in a biomedical perspective focused mainly on adverse health consequences associated with FGM, not sociocultural reasons why communities, particularly women, support the practice (5). In recent years, the fact that countries have responded to health education messages by medicalizing FGM has highlighted the limitations of health education interventions. In the midst of medicalization, FGM persists and human rights violations of bodily integrity continue to be committed (6). The WHO condemns medicalization of FGM and only supports efforts to eliminate the practice (1).

Major gaps in knowledge regarding the sociocultural underpinnings of FGM hinder the efficacy of future interventions. Specifically, women’s decision-making regarding their continued support of FGM is not well understood.
understood. While the practice of FGM involves many agents including religious leaders and men, few studies and interventions have specifically examined women’s agency with regards to continuing and ending the practice. Women involved in practicing FGM include grandmothers, aunts, village elders, health care workers and ritual specialists. Though FGM is conceptualized by the international community as a violation of women’s rights, in countries where FGM is widely practiced more women than men support the practice and the majority of women also support continuation of the practice (7). The complexity of women’s involvement in FGM is highlighted by the fact that (a) in contexts where FGM is almost universal, women still report it should be stopped; and (b) women who do not support FGM still indicate their daughters have undergone the practice (7). In northeastern Africa where the prevalence of FGM is between 80 to 97 percent, the proportion of women indicating that the practice should stop ranges from 13.3% in Egypt to 44.2%, in Eritrea (7). However, mothers reporting the practice should end also report that their daughters have undergone the practice. In Eritrea, for instance, 60.3% of women supporting discontinuation of FGM stated that their eldest daughter had been cut (7).

Further research is necessary to develop explanations as to why women in various roles continue practicing FGM. While a variety of factors are believed to influence women’s decision-making, sociocultural beliefs regarding the relationship between female sexuality and women’s decisions to continue practicing FGM have not been systematically examined. Research has lacked rigorous study designs utilizing survey methods, in-depth ethnographic analyses, or a combination of both. In addition, despite a multitude of intervention models that have been proposed and implemented in communities to stop the practice of FGM, few have addressed underlying reasons why women support FGM, such as those related to female sexuality. Until further research on the topic of FGM and female sexuality is conducted and interventions to stop the practice are implemented and evaluated, social change among women and the communities they belong to will be difficult to achieve.

Call for proposals

WHO’s Department of Reproductive Health and Research is calling for proposals to examine and evaluate the role of female sexuality in women’s support of the practice; specific aim 2 is to evaluate the efficacy of interventions to change women’s attitudes regarding supporting FGM when underlying factors related to female sexuality are addressed.

With regards to specific aim 1, the research question of interest is as follows:

- How is desire for sexual morality, proper sexual behaviour, and femininity associated with women’s decisions to practice or stop FGM?

With regards to specific aim 2, the research question of interest is as follows:

- Are intervention models to reduce FGM that address underlying factors related to female sexuality effective in changing women’s attitudes regarding the practice?

The study duration is 12-17 months. To examine specific aim 1, survey and/or ethnographic methods should be utilized. The research questions of interest should be applied across a range of diverse ethnic groups. Specific aim 2 may be carried out as a supplement to an existing intervention or as an original intervention. The intervention should take place in communities where female sexuality is an important reason why women support the practice of FGM. The intervention should take place among groups that practice various types of FGM. Evaluation of the interventions should include use of quantitative and/or qualitative process indicators. Quantitative indicators should measure change in attitudes regarding women’s support of FGM (8). Ethnographic data should be collected analysing women’s reactions and responses to the intervention messages (9). The research proposals must describe how the following ethical principles will be ensured for all study participants: (a) autonomy (i.e., the study respects the right for individuals and communities to make decisions for themselves); (b) beneficence (i.e., the study maximizes potential benefits to individuals and society); (c) non-maleficence (i.e., the study minimizes any potential harms including physical, social, and psychological to individuals and society); and (d) justice (i.e., the study treats all subjects equally and disadvantaged community members do not bear a disproportionate burden of a study from which all members of a community will benefit) (10).

Specific aim 1

FGM and sociocultural beliefs regarding female sexuality

- How is desire for sexual morality, proper sexual behaviour, and femininity associated with women’s decisions to practice or stop FGM?

Research proposals or concept papers should focus on the role played by desire for sexual morality, proper sexual behaviour, and femininity in women’s decisions to support FGM. In the literature, the dominant claim is that desire for sexual morality and proper sexual behaviour plays a major role in women’s support of FGM (11-17). The finding, though, is not unequivocally substantiated by evidence across practicing groups. Studies among certain groups in Northern Sudan and Somalia suggest that desire for sexual morality and proper sexual behaviour are the main reasons women support the practice of FGM (11;12;15;17). On the other hand, studies among different groups in Sierra Leone, the Gambia, and Kenya suggest that FGM is not practiced to maintain sexual morality, but rather as a rite of passage, for marriage, and/or to enhance women’s fertility (11;14-16;18).

In conjunction with beliefs that FGM maintains sexual morality and proper sexual behaviour, research suggests that FGM is an expression of women’s femininity (11;13;19;20). However, the degree to which women in different ethnic groups associate FGM with femininity is unclear, including the extent to which femininity is linked to women’s own desire to be sexually controlled and “pure”. Ethnographic reports suggest that the association between FGM and femininity arises from women’s beliefs that the female genitalia are unattractive and masculine (13). Therefore, women associate FGM with feminine expression such as personal aesthetics, womanhood, and female power having removed male features of their genitalia (19). Based on a study in Egypt, for example, it has been found that younger girls request FGM in order to be more “beautiful” (20).

With respect to female sexuality, the study findings on the reasons women support FGM are suggestive but incomplete. Limited information is available on the roles played by the desire for sexual morality, proper sexual behaviour, and femininity in women’s decision-making across a comprehensive range of groups that practice FGM (9). Most studies have also not examined the interplay between desire for sexual morality, proper sexual behaviour, femininity and
other factors argued to be related to women’s decisions to support FGM such as sexual pleasure, religion, marriage, and fertility (9).

**Specific Aim 2**

Efficacy of interventions that address reasons women decide to practice FGM that are related to female sexuality

- Are intervention models to reduce FGM that address underlying factors related to female sexuality effective in changing women’s attitudes regarding the practice?

In addition to significant knowledge gaps in the area of women’s decision-making and FGM, research is also limited regarding the efficacy of interventions for reducing FGM. Intervention models that have been implemented in the field and described in the literature are legal measures, health education programmes, alternative approaches such as the harm-reduction approach have arisen from communities themselves in response to other interventions such as health education programmes (21-24). Most interventions to eliminate FGM have not been designed with reference to a proposed intervention model, much less evaluated (8). Certain intervention approaches such as the harm-reduction approach have arisen from communities themselves in response to other interventions such as health education programmes (24). The harm-reduction approach has been increasingly questioned in public health regarding its sustainability, whether it adequately addresses underlying causes of adverse health outcomes, and its viability from a human rights and ethical standpoint (25). The harm reduction approach claims to eliminate FGM via intermediate steps that offer safer “solutions” in the process of change by either medicalizing the procedure and/or encouraging communities practicing Type III to shift practice to Type II or Type I (24). Both intermediate “solutions” are documented to be occurring in more and more communities (7). Some governments and researchers even suggest the harm-reduction approach is appropriate. Apart from the ethical and human rights dimensions, a major limitation of the harm-reduction strategy though is that it does not address underlying sociocultural reasons why women continue supporting the practice of FGM (1).

Hence, research is being called for to examine the efficacy of interventions that address female sexuality as one of the reasons why women may support the practice of FGM. The intervention should be conducted in communities in which female sexuality is a prominent reason why FGM is supported by women. The study should take place among groups that practice various types of FGM. This research may be carried out as a supplement to an existing intervention or as an original intervention. An original intervention study should explore various intervention models proposed in the literature that are ethical and appropriate to the target community. Such models include women’s education and empowerment interventions (5,22); the proclamation approach (26); and the stages of change approach (23). The intervention research should have a sufficient sample size and include matching control groups, if possible (8). Evaluation of the interventions should take place at multiple time points utilizing quantitative and/or qualitative process indicators. Rigorous quantitative indicators of change in attitudes such as statements of intention to discontinue the practice should be utilized (8). Meaningful qualitative indicators should include ethnographic exploration of women’s reactions and responses to the intervention with respect to their local context and the impact this has on their decision-making.

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### Practical Information

**Potential partners**

Researchers from developing countries are invited to submit concept papers or full proposals addressing any of these issues. Investigators should be researchers living in, working for, and coming from communities/countries in which FGM is prevalent.

Proposals may be submitted in collaboration with other national researchers and international partners. However, financial support for a western-based partner should be obtained elsewhere.

**Format**

We accept both concept papers (3-5 pages) and full proposals (12-20 pages). The acceptance of full proposals is for the benefit of applicants who may have already developed a proposal, whereas a concept paper is sufficient for being included in the selection procedures.

Submissions should contain the following:

- Name, institution, address, telephone, fax number, email, title of project page
- Objectives of the proposed study and their justification
- Summary of study design and conceptual framework
- Fieldwork location and study population
- Methodology
- Analytical procedures proposed
- Time frame and budget

**NB! The duration of the project should not exceed 17 months.**

Deadline for submission for proposals: Wednesday, 28 June 2006

**The review process**

Proposals (both shorter concept papers and more detailed proposals) will first be screened by an internal committee at WHO. The group will decide which proposals should be further developed. Researchers selected for further development are expected to present a full proposal following the WHO guidelines by mid-August 2006, to give time for final revisions. These projects will then be submitted to the Specialist Panel for Social Science and Operation Research at their September 2006 meeting. The Panel will recommend one or two projects to be processed further. This entails submission to the Programme’s Scientific Ethical Review Group (SERG) and the WHO Research Ethics Review Committee (ERC). During the review process the researcher will be requested to respond to all the queries and amendments requested by these committees.

The final decision on funding is expected by December 2006, and the selected project(s) expected to start in early 2007. The duration of the project can be from 12-17 months, depending on when the project processing is concluded and ready to start, as the final report have to be presented to WHO by May 2008.

**Submission address**

R. Elise B. Johansen
E-mail: johansene@who.int
Copy to: cottinghamj@who.int, bathiah@who.int

**Postal address:**

R. Elise B. Johansen,
Department of Reproductive health and Research (RHR)
World Health Organization (WHO)
20, Avenue Appia, 1121 Geneva 27, Switzerland
Reference List

(7) Yoder PS, Abderrahim N, Zhuzhuni A. Female Genital Cutting in the Demographic and Health Surveys: A critical and comparative analysis. DHS Comparative reports No 2004; 7.
(10) Abdel-Tawab N. Ethical issues in conducting interventions research on FGC. Conference on Advancing Research on Female Genital Cutting, Bellagio, Italy 2002; 29.