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INTEGRATING RIGHTS-BASED APPROACHES INTO COMMUNITY-BASED HEALTH PROJECTS: EXPERIENCES FROM THE PREVENTION OF FEMALE GENITAL CUTTING PROJECT IN EAST AFRICA

Prepared by
Susan Igras, MPH, CARE-USA
Jacinta Muteshi, PhD, consultant to CARE-USA
Asmelash WoldeMariam, MA, CARE-Ethiopia,
and
Saida Ali, BSW, CARE-Kenya

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1-Introduction

As CARE moves to incorporating rights-based approaches (RBA) into its programming, project staff are beginning to experiment with operationalizing RBA in terms of designing and implementing projects.

In the field of reproductive health, the idea of framing health in a context of women's and men's rights to sexual and reproductive health (S/RH) was debated and adopted by many governments at the International Conference on Population and Development (ICDP) in 1994. The Cairo Programme of Action fundamentally changed how we view reproductive health, moving away from an approach that focused on women as bearers of children to an holistic approach that acknowledges gender equity and equality, sexuality in addition to reproduction, a lifecycle approach to men and women's sexual and reproductive health needs, and standards of care and services to address those needs. This shift in definition is framed within a set of sexual and reproductive health rights. (A summary of these new RH directions post-Cairo is found in Appendix A).

Box 1: Characteristics of a rights-based approach to programming *(Source: CARE, Nov 2001)*

1-Being in solidarity with poor and marginalized people
2-Supporting the poor and marginalized to take control of their lives
3-Holding others accountable for fulfilling responsibilities towards the poor and marginalized
4-Opposing any discrimination based on sex/gender, race, ethnicity, caste, etc
5-Examining and addressing the root causes of poverty and rights denial.
6-Promoting non-violence in the democratic and just resolution of conflicts
7-Working in concert with others to promote the human rights of poor and marginalized people

Since 1994, governments and other entities have worked to incorporate S/RH rights into *facility-based* services and programs. For the most part, these efforts have neglected the role of the community or civil society in assuring access to quality services, and indeed, in playing a key role in maintaining and protecting the community's reproductive health. As such, there are relatively few documented *community*-based initiatives that use rights to frame issues of access to quality health services and information and/or to frame community responsibilities to ensure good health of all. Since the ICDP, some NGOs have started placing RBA more into the hands of civil society actors. CARE, for example, has begun work to guide programming practices by identifying seven characteristics of programming that acknowledge rights and responsibilities (see Box 1 and a fuller description of the characteristics in Appendix B). How does one operationalize a rights-based approach in a community-based project context? The *purpose* of this case study is to demonstrate and discuss how reproductive health project staff in two countries (Ethiopia and Kenya) are working to develop a rights-based approach that is community-based.

The paper:

1) Explains the participatory process that staff took with communities to learn how rights and responsibilities were defined by communities themselves;
2) Provides examples of how staff planned and then actually used this new knowledge in designing strategies and educational messages to help communities to address issues related to rights and specifically to female genital cutting; and then,
3) Discusses lessons learned and questions raised by project staff when taking an inductive approach to rights in community-based health projects.

2-Background to this case study

In the late 1990s, in response to concerns raised at a CARE regional Africa workshop on maternal mortality and the role of FGC (female genital cutting, also known as female genital mutilation or FGM, or female 'circumcision) in contributing to poor maternal health outcomes, CARE began a multi-country FGC abandonment project in Ethiopia, Kenya, and the Sudan. The project was initially viewed as a 'traditional' RH project (that is, a project based on addressing information needs and promoting healthy behaviors using targeted educational messages about the harmful health effects of FGC). It became apparent in talking with others involved in FGC programming, though, that a more multi-faceted approach to FGC was in order if the project was to have any significant impact.

Why was a multi-faceted approach necessary? FGC is a deeply ingrained and culturally-sanctioned practice valued by men and women, yet has harmful and at times life-threatening sexual and reproductive health consequences (particularly for the most severe form of cutting, infibulation). As the project began working in Ethiopian, Kenyan, and Sudanese communities, girls were usually cut between the ages of seven and 12 years. The practice was essentially universal and represented a 'behavior' that had been practiced over hundreds of years. Anecdotal evidence pointed out that projects which focused only on negative health consequence of FGC tended to result in communities adopting less severe forms of cutting with less severe health consequences. Thus, staff felt that working with communities to understand only the negative *health* effects of the practice, without framing the issue in a larger context of social well-being of girls and women, would not be very effective in helping community members think through and eventually decide to abandon the practice. (See Appendix C for a brief description of the multi-country FGC project and a discussion of the negative health and social consequences of FGC.)

While there was agreement on the need for a more holistic sexual and reproductive health approach, it was not clear how to integrate 'social well-being' activities into on-going community-based RH activities. FGM activists, for example, were arguing that FGC program designers had to include the violation of rights and women's empowerment as part of FGC-abandonment activities. As the project was beginning, staff were unclear how appropriate and relevant a discussion of rights was at a community level. Indeed, it was unclear what communities themselves believed about rights.

3-Experiences with incorporating rights-based approaches into the multi-country FGC project strategies

A-Initial questions on how the project should include rights within a context of existing community values, beliefs, and reflections for change. The FGC abandonment activities were to be integrated into existing RH projects that were largely community-based and used outreach workers and volunteers to provide information and education on RH issues to target communities. We could and would train staff and volunteers on the social and rights issues related to RH and FGC, to help them have a broader conceptual basis for their actions in the field. To what extent, though, should we educate *community members* on rights issues (as defined in international treaties and conventions), violations of rights, and community responsibilities to uphold certain rights? Would such an approach be too top-down and too Western-dominated?

An initial round of participatory assessments with communities by CARE staff to learn how communities thought about FGC – their values and beliefs around FGC, knowledge of negative consequences of the practice, and reasons why the practice should or should not continue – revealed that people very rarely mentioned issues of rights or gender. 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.' How did people in communities define their rights? Did they think about rights in relation to FGC? Could we as outsiders even bring up the issue of rights in relation to FGC, given the extremely sensitive nature of FGC, which as the project was beginning was a taboo subject and not discussed openly in communities where CARE worked? On a more practical level, would we need to move beyond traditional education activities and include community-level *advocacy* activities as a way to sensitize local leaders to engage communities in debates about the practice?

B-Whose 'rights' are being defined? As the project was beginning, we thought about rights in the more traditional sense of adherence to international conventions. Because of this thinking, and based on information gleaned from the qualitative assessments, we discussed which rights issues should be included in educational outreach and community-level advocacy efforts. In a pre-intervention baseline survey that was conducted as part of the operations research component of the project,[1] we measured men and women's awareness of human rights, health rights of women and girls, and the relation of rights to FGC.

As Box 2 indicates, below, survey results in both Ethiopia and Kenya corroborated the qualitative research findings, indicating that there was already a small proportion of people in the project communities who were thinking about violations of rights in relation to FGC. With the above information we had a plan - based on both qualitative and quantitative research - of general information that we would include in our

[1] The multi-country FGC prevention project included an operations research component designed to test the effectiveness of different combinations of community-based activities (education and advocacy efforts) that would be implemented to help people decide to change their future intentions to practice FGC. As this paper was being written, end-of-project research was being conducted to measure the effects of the project interventions.

education and advocacy efforts. Yet we were still unclear how to proceed, particularly given the extreme sensitivity to having public discussions on FGC issues.

Box 2: Findings from the Multi-Country FGC Prevention Project Operations Research Component - Baseline Survey Measurement of Rights, 2000		
	Ethiopia (n=819)	**Kenya (n=1,440)**
Human Rights Variable: Awareness of the human and health rights of women and girls and the relation of rights to FGC.		
Indicators – rights in relation to FGC		
Proportion of men and women (combined responses):		
♦ Who believe that FGC goes against the rights of girls (any rights)	**5%**	**25%**
♦ Who believe that FGC goes against the rights of women (any rights)	**8%**	**26%**
♦ Who choose not to circumcise their daughters *and* mention as reason an awareness of any rights of women (by category of rights, eg, health, women's dignity, etc)	**11%**	**TBD at endline**
NB: While this box highlights selected human rights indicators that were included in the study, other variables in the study included general rights, gender inequalities, health, social, and religious knowledge, attitudes, beliefs, and intended behaviors associated with female 'circumcision.'		

Sources: Baseline Survey on FGC in Awash Fentale and Amibara Woredas of Affar Region, CARE-Ethiopia, June 2000, and Baseline FGC Survey on Knowledge, Attitudes, Beliefs, and Practices of Refugees in Ifo and Hagadera Camps, CARE-Kenya, December 2000

C- Defining the issues more precisely: learning from communities how they defined rights and responsibilities. In order to build on beliefs and knowledge already existing at the community level and to define more relevant educational messages on rights in relation to FGC, we wanted to understand better how communities themselves viewed rights. Consequently, staff began to hold discussions with communities about their rights. All communities were Moslem and had a 'rights' knowledge of sorts in various religious texts, which defined responsibilities that husbands, wives, neighbors, etc, had towards others with whom they had relationships. It was felt critical to understand how people defined their rights and responsibilities and where these rights were not being upheld well. We needed to understand better what social norms existed that ensured that rights were upheld and what mechanisms existed (or did not exist) to ensure that rights of different groups in the community were upheld. Programmatically, this was logical: Taking a community-based approach to an assessment of rights mirrored other community-based approaches to FGC/RH used by the project, where the health, social, and cultural issues and contexts – both positive and negative – needed to be understood before any interventions were undertaken by staff.)

Conducting participatory assessments with communities to define and understand how well rights were upheld. How does one begin to look at rights at the community level? The legal language of international treaties and conventions is generally not used in daily conversation. Such language is not meaningful to people in the rural, isolated settings were the projects were operating. These assessments allowed staff to develop a relevant language on rights that was used and understood by communities with which the project worked. The assessment sought to answer the following questions:

- Did words exist in local languages that reflected the idea of rights and responsibilities to uphold rights?

- What rights (to a good life and good health) existed within communities served by the project?
- Did rights differ between different community groups – women, men, and children?
- Who was responsible to uphold rights and to protect the rights of community members?

Staff and volunteer facilitators discussed which groups might have different perspectives on rights in order to determine which groups to speak with, eg, married men and women, adolescent girls and boys. Facilitators agreed upon the words to use for 'rights.' It was decided beforehand that if groups did not spontaneously mention the issue of FGC, then the facilitators would not broach this subject. It could be taken up in later discussion sessions.

4-Main findings and discussion on community-defined rights

Findings of the focus group discussions on rights in Ethiopia and Kenya are presented and compared in this section.[2] (Please refer to Appendix D for a complete discussion of findings and lessons learned from both country sites.)

A-Definitions of rights and tenor of discussions. Both local languages had words for 'rights' and we were pleasantly surprised at the tone of discussions in Ethiopia and Kenya. People liked to talk about their rights and discussions were lively. Although there were basic rights common to both countries, such as having adequate food, shelter, health, to be respected by others, both ideal life situations and rights of people seemed to be defined practically in slightly different ways between the two countries, which was expected. Rights of boys and girls in both countries were very similar, did not vary much by gender, and included rights to education, health, adequate food and clothing. Notably in Ethiopia, one of the rights of both boys and girls was to be circumcised.

B-How rights were defined and who had responsibility for protecting rights of community members. In both communities, the main 'definer' of rights was religion and the Koran, Hadiths, and Sunnas were instruments that defined rights. In Kenya, some people also talked about 'culture' as defining rights (and we interpreted this to mean that social norms helped define what rights people have). People had well-defined concepts regarding who had the responsibility to uphold rights. For women it was fathers and husbands, for children it was fathers and sometimes also mothers.

C-Were rights upheld equally for men, women, and children?[3] In both countries, men and women agreed that, while men, women and children had specific rights, these rights were not always upheld equally. In reality, some groups' rights (women and girls) were not upheld as well as rights of other community members.

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[2] The work in Sudan had not been completed as this paper was being written and thus was not included in the discussion.

[3] In human rights literature, three responsibilities related to rights are frequently cited: respecting, protecting, and fulfilling rights. In our discussions with communities we used a more general term of 'upholding' rights, focusing on responsibilities to ensure that rights were protected, for the most part.

Participants thought that children were more assured of their rights, regardless of gender.

In both countries, too, participants 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% while women were compensated at 50% of the sanction for the wrongdoing.

D-FGC as a violation of specific rights. In both communities, FGC was not spontaneously mentioned as a right that had been violated, so facilitators did not probe participants to talk about whether the rights of children, women, and men were violated when FGC was practiced.

5-Implications for programming: Main issues that the project has faced when working to operationalize a rights-based approach with communities around FGC-related issues

After discussions with community members, staff now had a much better understanding of rights issues as defined by the communities themselves. Yet, even when rights *issues* were defined, a rights-based *approach* to FGC programming still needed definition and in fact, we have learned that approaches will vary with different situations. Staff had a lot of difficulty at first in deciding how we could actually operationalize a rights-based approach. But, as the project developed it became clearer what approaches we could and should use to ensure that rights were integrated into the project's conceptualization and activities. Some of the main issues that staff confronted and their reflections on these issues are discussed below.

A-To what extent should community-based projects depend on international standards to guide rights-based programming? In communities in Ethiopia and Kenya, there was general concurrence between international standards and community-defined standards of rights to good life. Would this hold true in different situations? It would be prudent to look at rights programming from both international and local perspectives, letting each serve a 'checks and balance' function of the other. Clearly though, in order to develop approaches that ring true with communities with which we work, we must understand how communities think about rights and responsibilities and what community institutions exist to promote rights equally among its membership.

B- What are the implications and responsibility of CARE in supporting a social change process? This question was in the minds of many staff as the project was beginning. The project was going to engage communities in a social change process, moving beyond traditional RH project activities that were limited to improving education and service delivery responses. We were going to be asking communities to reflect on some very difficult issues, and we needed to understand the ramifications of CARE's actions before we began the process. As changes began to be observed in communities, eg, girls started declaring that they did not want to be cut, some mothers had their daughters de-infibulated, this was reaffirmed - CARE needed to make a long-

term commitment to 'accompany' communities as they went through a process of change. As one staff-person so succinctly summarized the changes being observed: 'We never thought that it would go this far.' As another staff person noted: 'If we stop the FGC abandonment activities now (when the project ends), the communities may well slip backwards in their reflection and may never be able to move forward again.'

If CARE is to shift its programming to be more based in rights approaches, then we must be sure that we can find resources to support efforts in communities for longer periods of time than the normal three to five year project life-span. If not, we risk creating more harm than good in communities where we work. All projects engaging in social change efforts should conduct a harms-benefits analysis before they begin activities, and then should review the potential harms and benefits of our actions periodically throughout a project's duration.

C-The chicken and the egg dilemma: gender inequalities and how they should be addressed. Staff in Ethiopia and Kenya took quite different strategies to address a root cause of the practice of FGC, eg, gender inequality, in large part because of the different community contexts in which each project operated. The Afar of Ethiopia are pastoralists, still very traditional, and somewhat isolated from mainstream Ethiopian culture. The Somali population in Kenya, on the other hand, is a refugee population that has been in living in Kenya for over 10 years. Some traditions still exist in these communities but living as refugees, the population has been exposed to ideas and norms from outside their traditions, and in fact are both informed and quite politicized. The Somalis were quite knowledgeable about their rights as refugees, for example, and were at a different starting point than the Afars in terms of discussions on rights as defined by international conventions and treaties.

In Ethiopia, staff decided to not address rights directly and instead worked to reduce gender inequality *indirectly*, thereby helping to empower women. The project mandated that village health committees have women representatives on them. Women extension agents were selected, never before done in the Afar community, and began outreach activities. Taking women to a certain level of awareness was viewed as a critical step before talking about rights issues related to FGC. Staff facilitated discussions with local religious leaders to encourage them to reach a common decision on the position of Islam vis-à-vis FGC and to encourage leaders to advocate for the abandonment of the practice. In fact, the project never spoke directly to communities about rights that were violated with the practice of FGC.

In Kenya, on the other hand, staff worked at several levels to *directly* address gender inequalities. Because there had been on-going efforts to sensitize the refugee population about women's and girl's rights, staff almost immediately defined the practice of FGC as violence against women and an abuse of their rights. Mass communication campaigns linked to international calendar events such as women's day and refugees days, spoke of FGC and other practices as violations of women's rights. Education and advocacy messages spoke to negative health and social consequences of the practice and dis-associated the idea that women had a religious obligation to undergo circumcision. At the community level, staff facilitated discussions with communities on rights in general and then asked people to think about whether any rights of children

and women were violated due to the practice of FGC. People invariably came to conclusions that children's rights to good health and education were violated. They also often concluded that women's rights to health were compromised by FGC and that women's (and men's) rights were compromised in terms of sexual health.

Very importantly, in both countries the projects always stressed that individuals and communities had *the right to decide for themselves* whether they wanted the practice to continue or not, based on information from the variety of sources noted above and community-level discussion and debate of the issues that were facilitated by the project. This re-affirmation that communities make their own decisions was a conscious one taken by the project staff in all countries - to respect the existing values of communities relating to the practice of FGC while concurrently working to engage people in reflections on the value of changing a harmful traditional practice, which the reader should recall was an almost universal practice, highly valued by men, women, and children for social-cultural and religion reasons in communities (even though it could have very serious RH consequences). It was felt that if the project could bring into these discussions ideas of social issues and rights of children, women, health, etc, as they related to FGC then communities would include such ideas into their discussions and debates and eventually come to their own conclusions on the issue. (This was somewhat risky in the sense that communities could decide to continue the practice, thereby continuing to put women and girls at risk and in violation of many of their rights. But the approach was deemed the best way in the long run to accompany communities in their reflections, while concurrently actively supporting those groups and individuals that wanted to change the practice, thereby creating a critical mass of people in the community that would eventually help change the social norm of cutting.)

D-Clarifying roles and responsibilities: who is responsible to uphold rights – the project staff, community institutions and adjudication structures, or community members? 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. As a result, other people in the project communities, the majority who still wanted the practice to continue, started to exert social pressure on and show their disapproval of families that wanted the practice to end and of girls that did not want to be cut. In Kenya, families and girls who decided not to undergo female circumcision came to CARE and UNHCR staff to ask for help and protection from those in the community who wanted the practice to continue. In Ethiopia, families also came to CARE for help.

CARE, as an international NGO working to promote social change, did not want over the long term to become the entity responsible for upholding the rights of disenfranchised members of communities in which it worked. Rather, we felt that it should be the *communities* and leadership structures that took responsibility to uphold rights of all its members, including those who were being ostracized. In response, project staff tried to support individuals and families seeking assistance. They also began to bring up this issue at the community level and initiated discussions with village elders and religious leaders on who should take responsibility to protect those being persecuted. In Ethiopia, the traditional *dagu* communication system, an oral tradition used to pass

information between clans in different part of country, is being 'expanded' so that that individual concerns come to be seen as issues/ subjects for community discussion and reflection. Note, also, that because the elders and other community leaders had been involved in the project since its inception, they had already taken on a certain level of responsibility even prior to seeing some of the more negative effects / social changes at the community level.

While it is still too early to know whether working with community leaders and traditional adjudication and communication structures is effective, we hope that by beginning discussions with such leaders to address issues that are traditionally seen as outside the public realm, such as women's issues, there may be a crucial re-working of a structural norm. This is strategic, as it potentially enlarges leaders' responsibilities to the larger community and increases both accountability and transparency.

E-Changing roles of CARE staff and volunteer: being facilitators as well as educators, deepening critical analysis skills at all levels of the project. One other issue became apparent as the project moved away from a traditional RH project to a project promoting social change: As we moved towards a rights-based approach, more traditional strategies based on educating people in order for them to adopt a new 'healthy' behavior began to be viewed as a necessary intervention but insufficient by itself to promote social change.

This 'changing roles' issue is highlighted when addressing a traditional practice such as FGC. Changing the practice requires more than education and information. Communities themselves have to make decisions to change a traditional practice and project staff, as agents of change, have to move into new modes of interacting with communities – from education agents to social change agents – facilitating community debates and discussions on issues. This is true with FGC and is true with any discussion on health that also includes discussion on rights and responsibilities. There is no simple educational message that will lead to social change.

This was a challenge for project staff, as traditional RH projects make great use of volunteer educators and project staff themselves are often health technicians and not trained as facilitators and animators. Community agents were needed that could provide education as well as animate and facilitate discussions. In the end, both projects continued to have volunteer educators play their traditional roles and used project staff as facilitators. But the projects in both Ethiopia and Sudan are currently exploring the possibility of training volunteers as both educators and facilitators so that they can become more effective change agents.

Related to this is that there are no prescribed outcomes when supporting social change. We cannot know in advance how communities will react to information and engage in debates about traditional practices such as FGC. Thus, staff and volunteers need to be constantly on the alert for changes that are occurring in communities, analyzing why such changes are occurring, to ensure that CARE's actions are being supportive and relevant to on-going changes. This requires a level of critical thinking and analysis that is often not required of staff (and indeed, this quality of thinking is what makes excellent

community-based projects stand out from others!) and such skills may need to be developed on-the-job.

In the FGC project, field and management staff from all countries met together to identify changes that were being observed and analyze deeply why we thought such changes were occurring. For example, we were seeing a shift in communities' desire to change from the practice of infibulation to less severe forms of female 'circumcision.' CARE was never promoting such a shift, so why was this occurring and what could the project be doing to address this (undesirable) change?

F- Working with community institutions that play critical roles in defining social norms. One final issue that is still not resolved is how to effectively work with community institutions that set community norms, such as religious institutions and traditional authorities and leaders. Such institutions and institutional members can play strong advocacy roles for changing social norms. Yet as noted earlier in Section 4, these institutions can play both positive and negative roles in areas of gender inequities. How can a project engage traditional authorities in discussions on rights and their at-times unequal application?

Both projects chose to take up specific issues with community leaders and not directly address the issue of gender inequalities. For example, in Ethiopia project staff invited religious leaders to come together and develop a consensus on the position of religion and FGC. In Kenya, project staff approached elders and local religious leaders on the issue of protecting those who were publicly stating that they were against the practice of FGC. Such actions can help to make leaders more accountable to different, sometimes more vulnerable, members in their communities.

In both projects, too, work has begun on developing support groups of community people committed to ending the practice of FGC. These "Circles of Friends" (as they are being called in Kenya) may result in community members themselves organizing to make leaders more accountable to their specific issues.

6-Conclusions

This case study was developed to share methods of defining rights with communities and then deciding how to use this information to incorporate rights-based approaches into community-based RH /FGC projects. Many valuable lessons have been learned.

Using inductive (bottom-up) approaches to <u>define</u> rights and responsibilities is an effective way to work at the community level and conceptually easy for staff to understand. Linking rights to good health and good standards of living is probably as well understood in communities in other parts of the world where CARE operates as it was understood in Ethiopia and Kenya. Gathering and building upon a community's knowledge, values and beliefs on rights and responsibilities and adding into the mix similar information on FGC/RH creates a knowledge base upon which to begin defining viable community strategies that can address health and social well being issues from a rights perspective. To be effective in using inductive approaches, though, *project staff*

need to be skilled facilitators, trained to engage people in open-ended reflection processes as well as to mitigate conflict as it arises. They need practical knowledge of rights and responsibilities. Staff may also need to change their attitudes and the ways that they interact with communities – being aware of our own power relationships with communities and aware that our roles need to become more complex in relation to communities that we work with than they have in the past.

The application of community-defined rights to a project is more challenging. While rights are universal there are no set recipes for engaging in RBA. Oftentimes, indirect interventions on rights will be more appropriate than direct interventions. For example, different strategies were used in Ethiopia and Kenya because of the different contexts found in each country. In Kenya, staff addressed the issue of rights of women and girls directly in education and outreach activities as a way to end the practice. In Ethiopia, staff used a more indirect approach of working to improve women's status in a community as a way to end the practice of FGC. Both projects thought it critical to adopt a strategy of working with and encouraging community leaders to advocate for changes in the practice of FGC. And after analysis, project staff decided not to address rights in relation to FGC directly with community leaders; rather, advocacy positions related to other issues were promoted.

Changes that were seen at the community level indicated that as social change began there were few community mechanisms in place to protect those who were holding an alternative viewpoint. Staff responded by helping those individuals who approached them because they felt threatened. But staff also began engaging community leaders in discussions about their responsibilities to protect all community members as social change occurred. Thus, staff and volunteers in projects also *needed knowledge about social and power structures in the project communities and needed to be clear about what role CARE should take in terms of upholding rights of disenfranchised members of communities as people sought 'protection.'*

Finally, as this case study demonstrates, *we need to acknowledge our responsibilities to communities that we hope to 'accompany' in fulfilling their rights: If we begin social change interventions, we need to ensure that we can support communities over the long run.* Two to three year project cycles are insufficient and if we attempt social change in such a short time period we risk doing more harm that good to the communities that we are trying to serve. Interventions and aspirations need to be viewed in relation to the level of support that CARE can provide over the long run.

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Appendix A: Sexual and reproductive (S/RH) rights as defined in international conventions

RIGHTS-BASED APPROACHES TO SEXUAL AND REPRODUCTIVE HEALTH

(re-printed in part from *Sexual and Reproductive Health Briefing Cards,* Family Care International, 2000)

The **rights based approach*** to sexual and reproductive health adopted at the International Conference on Population and Development (ICDP) in 1994 reflects a new global policy consensus on the relationship between population policy and sexual and RH and rights: if women are empowered and people's needs for sexual and RH are met, population stabilization will be achieved by virtue of choice and opportunities, not coercion and control. The RBA is built on existing international human rights agreements and recognizes that sexual and RH are rights as important ends in themselves.

The RBA was reaffirmed and extended at the Fourth World Conference on Women (FWCW) in Beijing in 1995, and again at the ICPD+5 review in 1999. Among the **main components of the RBA are: gender equity and equality; sexual and reproductive rights and client-centered sexual and RH care**.

❖ **Gender equity and equality**

Gender refers to the socially defined roles and responsibilities of men and women, boys and girls. *Gender equality* means equal treatment of women and men in laws and pollicies and in access to resources and services within families, communities and society at large. *Gender equity* means fairness and justice in the distribution of benefits and responsibilities between women and mean, and often requires women-specific projects and program to end existing inequalities.

"advancing gender equality and equity are the empowerment of women…and ensuring women's ability to control their own fertility, are cornerstones of population and develop-related programs " ICDP Programmmes of Action Principle 4

❖ **Sexual and reproductive rights**

Reproductive rights include the rights of couples and individuals to:

? Decide freely and responsibly the number, spacing, and timing of their children, and to have the information, education, and means to do so;

? Attain the highest standard of sexual and RH; and make decisions about reproduction free of discrimination, coercion, and violence.

"The promotion of the responsible exercise of these [reproductive] rights should be the fundamental basis for empowerment – and community-supported polities and programmes in the area of RH, including FP." ICDP Programmes of Action, 7-3, Key action for the further implementation of the ICPD programme of action, 3

Sexual rights include the rights of all people to:

? Decide freely and responsibly on all aspects of their sexuality, including protecting and promoting their sexual and RH;

? Be free of discrimination, coercion or violence in their sexual lives and in all sexual decision, and

? Expect and demand equality, full consent, mutual respect, and shared responsibility in sexual relationships.

"the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and RH, free of coercion, discrimination and violence: FWCW Platform for Action, 96

❖ **Client-centered sexual and reproductive health care**

Sexual and RH care includes:

? FP information, counseling and services

? Prenatal, postnatal and delivery care

? Health care of infants

? Prevention of treatment of STD and RTIs

? Where legal, safe abortion services and management of abortion-related complications

? Prevention and treatment of infertility

? Information, education, and counseling on human sexuality, RH and parenthood.

? If additional services, such as diagnosis and treatment of reproductive system cancers and HIV/AIDS are not offered, a system should be in place to provide referrals to this care.

"Governments, in collaboration with civil society, including NGOs, donors and the UN system, should: increase investment designed to improve the quality and availability of sexual and RH services, including establishing and monitoring clear standards of care; ensuring the competence, particularly the technical and communication skills, of service providers; ensuring free, voluntary and informed choice, respect, privacy, confidentiality, and client-comfort…taking care that services are offered in conformity with human rights and ethical and professional standards." Key actions for the further implementation of the ICPD Programmes of Action, 52(E)

** NOTE: The characteristics of RBA as defined by CARE go beyond the RBA components listed above, and focus more on the role of civil society actors in assuring that rights and responsibilities are upheld. Please refer to Appendix B.*

Appendix B: Seven characteristics of programs using rights based approaches

The following statement is a product of the October 2001 RBA Reference Group workshop held in Nairobi. It is intended to explore more deeply what we understand to be the defining characteristics of a rights-based approach with a particular emphasis on operational implications. While it benefited from some initial staff feedback in October and November, it remains a working draft with refinements envisioned at some point in the future.

Defining Characteristics of a Rights-Based Approach[4]

Working Draft, November 2001

Believing firmly in the equal dignity and worth of all human beings;

Affirming that human rights and fundamental freedoms are the birthright of all human beings;

Appreciating that human rights are universal, inalienable, and interdependent;

Recognizing that violations of human rights render many people poor, marginalized and chronically vulnerable throughout the world;

Envisioning a world of hope, tolerance, and social justice, where poverty has been overcome and people live in dignity and security;

We have adopted a rights-based approach to programming.

To CARE, a rights-based approach means:

1. **We stand in solidarity with poor and marginalized people whose rights are denied, adding our voice to theirs and holding ourselves accountable to them.**

   This implies that:

   - ✓ We have the courage to take a stand in the face of opposition, confronting, in a spirit of principled engagement, those responsible for the denial of rights;
   - ✓ We do not accept funding where a significant portion of the poor and marginalized people we intend to support feel that such funding will impede realization of their rights;
   - ✓ To those we serve, we systematically provide:
     - o All important program information;
     - o Opportunities to orient, assess and reorient our programs.
   - ✓ We ensure that poor and marginalized people take the lead in determining an acceptable pace of change and level of risk.

[4] A rights-based approach is evolutionary of our good programming practices in that it helps us continue to build on and sharpen the more innovative, progressive and effective shifts we have already been making, and challenges us about how we should continue to move forward.

2. **We support poor and marginalized people's efforts to take control of their own lives and fulfil their rights, responsibilities and aspirations.**

This implies that:

- ✓ We cede power in our programming to the people we serve, ensuring they are increasingly represented and heard in program decisions;
- ✓ We support rights and responsibilities awareness raising;
- ✓ We facilitate the empowerment of poor and marginalized people and the development of their capacities to fulfil their rights and responsibilities;
- ✓ We enable poor and marginalized people and their organizations to participate in governance and decisions affecting their lives;
- ✓ We assist poor and marginalized people to recognize and manage the risks associated with social change.

3. **We hold others accountable for fulfilling their responsibilities toward poor and marginalized people.**

This implies that:

- ✓ We work with others to identify and categorize responsible actors at all levels;
- ✓ We create and/or facilitate opportunities for poor and marginalized people to safely confront and interact with responsible actors;
- ✓ In a spirit of principled engagement, we confront responsible actors and encourage and, where appropriate, assist them to meet their responsibilities;
- ✓ We help to transform power relations in favor of poor and marginalized people;
- ✓ We join forces with others to promote and pursue the adoption and implementation of pro-poor, pro-rights policies.

4. **We oppose any discrimination based on sex/gender, race, nationality, ethnicity, class, religion, age, physical ability, caste or sexual orientation.**

This implies that:

- ✓ We exemplify nondiscrimination across all our operations;
- ✓ We work with poor and marginalized people to overcome such discrimination;
- ✓ We promote open dialogue about any such form of discrimination;
- ✓ We do not partner with any organization that practices such discrimination without openly confronting and seeking to redress it;
- ✓ We differentiate and disaggregate social information so as to uncover and address hidden discrimination.
- ✓ Recognizing that sex discrimination is universal and has devastating effects, we do all we can to understand its roots and combat it in and through our work.

5. **We examine and address the root causes of poverty and rights denial.**

This implies that:

- ✓ We look closely and systematically at social, political and economic structures, especially power relations, at all levels;

- ✓ Our analyses include the active and meaningful participation of poor and marginalized people;
- ✓ We are committed to acting at local, regional, national, and international levels, as necessary, to address these root causes;
- ✓ We advocate in public spheres with, and/or on behalf of, poor and marginalized people.

6. We promote nonviolence in the democratic and just resolution of conflicts contributing to poverty and rights denial.

This implies that:

- ✓ We continually assess our programs to ensure that our actions neither create nor sustain violent conflicts;
- ✓ We include conflict management (recognition, prevention, resolution) plans in our programs;
- ✓ We oppose the promotion or practice of violence, whether against or by the people we serve.

7. We work in concert with others to promote the human rights of poor and marginalized people.

This implies that:

- ✓ We actively support and are willing to follow the leadership and initiative of others, seeking to add value to their work;
- ✓ We welcome and seek the engagement of other actors in our own initiatives;
- ✓ We explore whether and how alliances can give us and those we serve greater leverage for the realization of rights.

In adopting a rights-based approach, we hold ourselves accountable to these principles in all our programming throughout the world.

This implies that

- ➢ *We consider periodically whether our programs reflect these principles;*
- ➢ *We document where programs deviate from these principles and articulate the steps we commit to take to progressively realize them;*
- ➢ *We take the steps necessary to ensure we have the capacity and resources to implement these principles;*
- ➢ *We encourage, reward and protect those who apply these principles in their work.*

Appendix C: The Multi-Country Female Genital Cutting Prevention project - Brief summary of negative health and social consequences of FGC and CARE's response

The problem. FGC is a traditional practice that can have serious RH consequences. The most severe form of female 'circumcision' has been associated with maternal mortality (due to prolonged labour), sexual dysfunction (due to pain and/or lack of sensitivity during sexual relations), and chronic pain and disability (due to inability of menstrual blood to leave the vagina and urine retention caused by scars from cutting).

In addition, the practice has many serious social consequences. Girls who are cut transition to womanhood in the eyes of their family and community and become eligible for marriage. While in itself this is not bad, girls' educational and income opportunities can become limited, either because they become married or because they are more frequently absent from school due to the chronic pain experienced during menstruation. The pressure on families to circumcise their daughters is extreme and those who choose not to have their daughters cut face ostracism from their community and stand to lose their ability to access the social safety nets of family and community that protects individuals from harm in periods of crisis.

Due to the social complexities of the practice, people experienced in FGC programming know several things: Focusing on health consequences of FGC alone will not necessarily help communities work towards abandonment of this practice. Too many positive cultural and religious values are associated with female "circumcision" and these beliefs are so deeply ingrained that many women feel that they have a right to be circumcised. Programs must also address social issues. Top-down efforts have also proven ineffective and can drive the practice underground. In Sudan, for example, when FGC was outlawed in the late 1940s, thousands of people rushed to circumcise their daughters before the law went into effect. Today, FGC is still almost universally practiced by many ethnic groups in northern and western Sudan. Communities cannot be told to eliminate the practice; such decisions have to come from within the communities themselves.

CARE's response. CARE works in 15 African countries where FGC is practiced. In these countries, if we want to improve reproductive health outcomes we need to address issues of FGC. In 1999, with funding from CARE-USA's Africa Fund (and later, with additional funding from USAID and private donors), CARE began a multi-country FGC prevention project. FGC-abandonment interventions were integrated into on-going health projects in Ethiopia, Kenya, and the Sudan. While the ultimate goal of all projects is to improve the reproductive health of women by increasing access to quality services and information, the *goal* of the FGC project is to improve the health and social well-being of women and girls in regions where the project will operate by decreasing the practice of FGC. The *FGC project objective* is to increase the interest and ability of communities, NGOs, and Ministries of Health to address FGC issues appropriately and effectively. The project also has an operations research component built into it and the concurrent *study objective* is to increase understanding of the effectiveness of different interventions to reduce the practice of FGC that are implemented at the community and district level.

Over a three and one-half year period CARE, working with local partners and the Program for Appropriate Technology in Health (PATH), has planned and is currently implementing different interventions (educational activities using behavior communication change and community-level advocacy approaches) designed to improve awareness of, create debate, and support community-led actions to combat the harmful effects of FGC, eventually leading to abandonment of the practice. CARE, with technical support from its primary research partner, the Population Council, has designed an operations research component that uses an experimental design. This

study is being implemented concurrently with project intervention activities to test the effectiveness of different combinations of community-based strategies.

In the latter part of 2002, CARE will conduct end-of-research studies in order to measure changes seen in knowledge, attitudes, beliefs, and intended practices in all three study sites. This will allow the project to determine the effectiveness of its community-based approach in informing communities and advocating about FGC-related issues – the health, social, and religious issues – as well as providing 'spaces' for communities to debate the issue of FGC and make their own decisions regarding whether the practice should continue or eventually be abandoned.

Appendix D: Main findings and lessons learned from conducting focus group discussions on community-defined rights

1-Methodology

How does one begin to look at rights at the community level? The legal language of international treaties and conventions is not used in daily conversation anywhere. Such language is not meaningful to people in the rural, isolated settings were the projects were operating. These assessments allowed staff to develop a relevant language on rights that was used and understood by communities with which the project worked.

The assessment sought to answer the following questions:

- Did words exist in local languages that reflected the idea of rights and responsibilities to uphold rights?
- What rights (to a good life and good health) existed within communities served by the project?
- Did rights differ between different community groups – women, men, and children?
- Who was responsible to uphold rights and to protect the rights of community members?

Staff and partner agency staff met together to plan the question guides and which groups to bring together. In Ethiopia the project staff and volunteers facilitated discussions in three villages on rights with nine groups, representing the following categories of community members: men, married women of reproductive age, and youth. In Kenya, discussions were held in the Dagahaley refugee camp with three groups, representing married women, young men, and elderly men above 40 years. (Young girls were invited to attend the sessions but had to leave before the youth discussion began, so their views are not represented in the findings.)

Facilitators agreed upon the word to use for 'rights.' The questions focused on general human rights, rights of women and men, as well as rights of boys and girls. It was decided beforehand that if groups did not spontaneously mention the issue of FGC, then the facilitators would not broach this subject. It could be taken up in later discussion sessions.

At the end of the discussions, the focus group facilitators came together and shared and synthesized the information that had been gleaned from discussions. Main findings were analyzed, with particular attention being paid to identifying commonalties and differences between groups.

The reports of findings from the FGDs in Ethiopia and Kenya were then analyzed together in Atlanta and the combined findings presented here.

2-Findings and discussion

A-The tenor of discussions. We were pleasantly surprised at the tone of the discussions in both Kenya and Ethiopia. People liked to talk about their rights and discussions were lively. There was no noted discomfort in talking about any of the discussion areas except when talking about how and why certain rights, eg, of women, were not upheld by others in the community. At these moments, some women got angry and some men got defensive. Even at these moments, though, the tenor of discussions was not one of intense conflict. (How the tone of discussion would have been if this had been discussed in mixed groups of men and women is unknown.)

B-Did words exist in local languages that reflected the idea of rights and responsibilities to uphold rights? In both country settings, specific words were used to signify 'rights.' In the Somali community of Kenya, the word for rights is *xuqwq*. In the Afar

community of Ethiopia, the word for rights is *haki*. During discussions people spontaneously spoke about rights and responsibilities. The two were often linked in discussions, to the point that it was sometimes unclear whether people were distinguishing between the two ideas. But, when facilitators probed to see if people distinguished the two concepts, it seemed that people had a good idea of the difference in meaning between rights and responsibilities.

C-What rights existed within communities served by the project? In discussions, people were first asked to define what constituted a good life and good health (roughly equivalent to 'highest standards' in human rights language). Then they were asked to talk about what rights they had to good health, as men, as women, and as children. (See Table 1.)

Although there were basic rights common to both countries, both ideal life situations and rights of people seemed to be defined operationally in slightly different ways between the two countries, which was expected. In Ethiopia, people were defining rights more precisely than Kenya groups and many rights were associated with inheritance and marriage. The rights of boys and girls in both countries were very similar and did not vary much by gender (compared to rights of men and women, which were less similar between groups). Also interesting to note was how holistically people defined the *elements* of good health and conversely, how medically-defined were *rights* to good health by both Ethiopian and Kenyan groups. (It is unclear why this distinction exists. Perhaps this is a consequence of how projects or CARE is viewed by recipient communities in terms of our health work.)

D-Who was responsible to uphold rights and to protect the rights of community members? In both communities, the main 'definer' of rights was religion (both communities are strongly Moslem) and the Koran, Hadiths, and Sunnas were instruments that defined rights. In Kenya, some people also said that 'culture' defined rights (and we could interpret this to mean that societal norms, such as norms regarding how people select their partners, helped to define what were the rights of people in a given community).

People had well-defined concepts regarding who had the responsibility to uphold rights. Both men and women viewed men / their husbands as having a responsibility to *uphold the rights of women*. Regarding who had the responsibility to *ensure the rights of children*, the groups were a bit more divided in opinion: Some people said that men / husbands had this responsibility towards children while other people said that both fathers and mothers had responsibilities.

We also asked people if the *community* at large had a responsibility to *uphold the rights of its members*. In Kenya, the responses were mixed, with some saying that the community had no role and others saying that communities did respond to some things by supporting each other, eg, during times of epidemics or crises. One person described it this way: 'the community is made of brothers and sisters who support each other.' In Ethiopia, the Afar people said that in principle, elders and clan leaders had the responsibility to uphold rights of its community members. Note, though, that women stated (but not men) that these leaders did not tend to listen to the women of the community and so were not very good at upholding the rights of women.

Table 1: Summary of discussions on rights with the Afar community in Ethiopia and the Somali refugee community in Kenya, 2000 and 2001

Ethiopia	Kenya	Definition of 'highest standards'
? Food ? Good health ? Prosperity (animals, clothing) ? Respect from others, having good social reputation ? Having many children ? Having many wives	? Having peace and security ? Good health, strength ? Shelter ? Food, adequate food ? Prosperity (money, clothing) ? Education (for yourself and for your children)	Elements of a good life
? Ability to work well, have strength ? Physical fitness ? Mentally normal	? Balanced diet, good food ? Good morale ? Psychologically stable ? Clean surroundings ? Access to medical services ? Adequate income and shelter (to maintain good health)	Elements of good health
Ethiopia	**Kenya**	**Rights that were defined**
Right to: ? Have medical treatment and medicines available	Right to: ? Have medical treatment and medicines available ? Be treated for illness regardless of being able to pay	Right to good health
Right to: ? Choose who to marry ? Receiving cattle at her wedding and take her cattle at divorce ? Inherit her parent's wealth upon their death ? Have good economic situation (clothing, ornaments) ? Have a hut and basic household articles upon marriage and keep them after divorce ? Good health	Right to: ? Choose who to marry ? Have a good husband ? Have a good economic situation ? Have adequate food ? Good health	Rights of women (as defined by culture and religion in Ethiopia and as defined by religion in Kenya)
Right to: ? Have many children ? Hold a rifle and knife ? Inherit his parents' wealth ? Take over his brother's wife upon his death ? Prosperity (wealth)	Question not asked	Rights of men
Right to: ? Be educated in religion ? Receive a calf at birth and pass this to her children ? Marry who they choose ? Be circumcised ? Good health ? Good food ? Good clothing	Right to: ? Be educated ? Schooled in religion ? Be respected and loved by parents ? Good health ? Be treated equally with other siblings, ie, no preferential treatment of children (responsibility of father and mother)	Rights of children – girls
Right to: ? Be circumcised ? Have a rifle and knife once circumcised ? Cattle and small animals on wedding day ? Good health ? Good clothing ? Good food	? Boys have same rights as girls	Rights of children – boys

Sources: Trip Notes: Rights as defined by Somali refugees: Findings from exploratory focus group discussions, Igras, 2000. WoldeMariam and Igras, 2001, Findings from focus group discussions on how 'rights' are perceived among the Afar

E-Did rights differ between women, men, and children? In both countries, both men and women agreed that, while men, women, and children had specific rights, these rights were not always upheld equally. In reality, some groups' rights (women and girls) were not equally upheld.

These differences were particularly true when comparing how well the rights of women were upheld versus men. In Ethiopia, women very openly stated that men had control over all the rights, were authoritarian, and did not always help ensure that women's rights were upheld. The Afar men agreed to this in their discussions. Women and men in Kenya made similar statements.

Participants in the group discussions thought that children seemed to be the most assured of their rights, regardless of gender. In both Ethiopia and Kenya, both women and men agreed that boys and girls had equal rights and that they should be treated equally. With some probing in Kenya, though, men and women both admitted that girl children sometimes were not afforded the same rights as boys, eg, to be educated.

The role of religion in defining rights (and constraining equal rights) was also highlighted in both countries. One person in Kenya said that religion dictated different rights for men and women in the sense that the Koran gave different prescriptions based on gender. For example, the Koran prescribes compensation for a man who had been wronged as 100% whereas for a woman it was 50%. Religion also dictated the direction of certain rights, eg, while all agreed that men and women had the right to marry whom they chose, in reality, Moslems did not have the right to marry non-Moslems.

Although this is recognized everywhere, it is worth re-stating in the context of the FGC project: Community institutions such as religious institutions and traditional leadership and adjudication structures play key normative roles in both the Afar and Somali communities. Yet such institutions can and often do play a role in ensuring that rights were *un*-equally upheld – whether consciously or unconsciously - particularly regarding the rights of women. (Participants were not probed on this point during discussions and this might be an interesting thing to do in later discussions around rights with community members.)

F-Could practicing FGC be seen as a violation of certain rights? In both communities, FGC was not mentioned as a right that had been violated so facilitators did not probe participants to talk about whether the rights of children, women, and men were violated when FGC was practiced. (In fact, discussions with the Afar communities in Ethiopia pointed out quite the opposite: that boys and girls had a right to be circumcised.)

3-Some lessons learned in doing a community-based assessment on rights

Staff in both countries felt that this exercise was a fascinating one and yielded very interesting information. Some lessons learned are shared below, for other project staff to consider as they begin discussions with communities about rights:

- People liked talking about rights and were free in their comments. Although project staff were worried how community people would react to a discussion on rights (eg, would they view staff with distrust or suspicion) we found such concerns were unwarranted. Communities already had well-defined rights, which could facilitate the incorporation of right-based approaches into health programming approaches.

- In both countries, staff felt that they could have been better facilitators if they themselves had had more practical knowledge about rights and responsibilities. It is always easier to learn new concepts in training and more difficult to apply new concepts in the field. Staff –

all who were experienced facilitators of focus group discussions – felt like they could have gone further in questioning and probing communities on rights and responsibilities if they had had a better (more practical) understanding of rights and responsibilities themselves. They felt that they needed more experience in facilitating discussions on rights in order to do a better job at capturing nuances and being better able to probe participants in their reflections on rights.

- Facilitators need to be experienced enough to handle tensions in discussions and know when they can probe a group to reflect further on a theme. The group discussions showed that if one wanted to probe more into issues of unequal application of rights, this could be a sensitive issue (assumedly because such discussions could lead to the attribution of blame and/or self-defensive reactions to discussions on why rights of groups such as children were not being upheld equally). If people were somewhat uncomfortable talking about the rights of women that were not upheld, how uncomfortable would they be discussing about the unmet rights of even *more* marginalized groups found in communities, such as men and women wanting to abandon a culturally-condoned and universal practice like FGC?

- The order of introducing discussions on new topics such as rights may be critical. It may be critical to introduce discussion topics sequentially, in a way that allows a facilitator to 'accompany' a community in a discussion on a particularly sensitive issue. Different starting points with communities require different timing of discussions. Recall that as the project was beginning, FGC was a taboo topic and not discussed publicly. In Ethiopian communities where no known discussion of rights or of FGC had occurred, it was better to begin with general discussions on rights, and not move immediately into a discussion on rights as they related to FGC. Recall that in Kenya, the refugee population had sophisticated understanding of rights as defined in international refugee conventions and some prior work in FGC sensitization had occurred. Staff could move relatively quickly into discussions on FGC as a violation of women's rights. (Interestingly, too, the prior awareness-creation work on FGC had been done by a Christian organization. As the FGC project advanced in Kenya, certain Moslem leaders publicly brought up the issue of the Christians' role in talking about FGC. The knowledge and association of rights with FGC in the camps very probably provided ammunition for Moslem leaders to display their discomfort with having non-Moslems providing services and education in the camps.)

- What could be done differently in the future when learning from communities about rights and responsibilities?

  Allow communities to help decide which groups in the community to interview regarding community definitions of rights and responsibilities. The staff decided up front that it would be good to interview men, women, and adolescent boys and girls. Would the communities have identified other groups for special consideration of rights? In the future, it would be interesting to ask this question of groups after they have been interviewed as they might have ideas of other groups with interesting perspectives to learn from.

  Explore the nuances of the idea of 'upholding' rights. Facilitators often talked broadly of upholding rights and who had responsibility to ensure that rights were upheld. In future sessions, it might be useful to modify the fourth discussion question, 'Who was responsible to uphold rights and to protect the rights of community members?' Facilitators could ask or probe for who had responsibilities to 1-respect the rights of others, 2-protect the rights of others, and 3-to create an environment that would allow people to exercise their rights? (This would help to better understand the three commonly-cited responsibilities in relation to rights: respecting, protecting, and fulfilling the rights of all community members.)

Have more discussion on traditional structures and mechanisms that are used to ensure that rights are upheld. In retrospect, staff could have added another line of questioning in their discussions on rights to gain a better understanding of traditional mechanisms used by communities to adjudicate the infringement of rights. We are finding, for example, that such structures exist, yet judgement is on a limited set of issues that do not include rights of women, particularly in relation to a right to not undergo FGC if not desired. (And as noted in the main document, such structures are often biased towards men in terms of problem resolution!)

Again, timing is an issue and when 'accompanying' communities in their reflections one should probably start with a general discussion on adjudication structures and their scope of problem resolution. Later, the relation of these structures to possible violations of rights around FGC could be added. (And this latter discussion might never occur! In Ethiopia and Kenya, staff in discussions with leaders who play adjudication roles in their communities are focusing on the right of people in communities to hold opposing views on FGC and not on violations of rights specifically linked to FGC.)