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**Faculty of Natural Science
Department of Statistics
MPHIL (Population Studies)**



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WESTERN CAPE

**Thesis title:
Female Genital Mutilation in Africa: What will encourage
its discontinuation?**

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Abstract

Between one hundred and one hundred and forty million young girls around the world have reportedly been subjected to some form of genital excision during 2005. Approximately three million young girls are at risk every year of undergoing this harmful procedure (WHO, 2008). Female genital mutilation is reported to occur, and is expected to continue occurring in twenty-eight African countries (London Safeguarding Children Board, 2007). This paper aims to firstly observe the levels of excision in Africa, and then highlight the underlying factors that encourage certain women to continue this dangerous ritual by analysing national datasets, such as the child info database, obtained from the United Nations Children's Fund. By calculating and comparing common indicators, the prevailing ones that dominate FGM appreciation can be further analysed. The final objective will be to suggest strategies that can be put in place to encourage the discontinuation of female genital cutting universally.



Table of Contents

GENERAL PLAGIARISM DECLARATION	2
Acknowledgments.....	3
Abstract	4
Table of Contents	5
Table of Figures.....	9
Table of Tables	11
List of Acronyms and Abbreviations.....	12
Chapter One.....	13
Introducing Female Genital Mutilation	13
1.1 Brief Background	13
1.2 General problem.....	13
1.3 Problem statement.....	14
1.4 Objectives.....	14
1.5 Overview of methodology	15
1.6 Conceptual framework	16
Chapter Two	17
Characteristics surrounding Female Genital Mutilation	17
2.1. Types of Female Genital Mutilation	17
2.1.1 Type I: Female Circumcision (Sunna)	18
2.1.2 Type II: Excision (Clitoridectomy).....	18
2.1.3 Type III: Infibulation (Pharaonic circumcision).....	19
2.1.4 Type IV: Unclassified.....	19
2.2. Age at which FGM is performed	19
2.3. Ritual procedure.....	20
2.4. Consequences that follow female genital mutilation	21
2.4.1. Short term consequences	21
2.4.2. Long term consequences	22
2.5. Reasons for female genital mutilation	23
2.6. Prevalence of FGM in Africa	25
Chapter Three	27
Reviewing previous FGM studies	27
3.1. The case of Nigeria	27
3.2. The case of the Somali ethnic community in Kenya and Somalia	29
3.3. The case of Sudan.....	32
3.4. Studies linking FGM to adverse reproductive health of the woman.....	36
3.5. Where this research fits in.....	39
Chapter Four	40
Methodological Approach	40
4.1 Describing the data.....	40
4.2 Study Design	42
Chapter Five	47
Analysing the Data	47
5.1. Northern Sudan.....	47
5.1.1 Age of the excised women	47

5.1.2 Age at which excision was performed	49
5.1.3 Types of female circumcision practiced	50
5.1.4 Person who performed the operation	52
5.1.5 State	53
5.1.6 Urban/Rural settlement	54
5.1.7 Education level.....	57
5.1.8 Socioeconomic Status	59
5.1.9 Level of acceptance.....	60
5.1.10 Husbands' opinion	61
5.2. Sierra Leone.....	64
5.2.1 Age of the excised women	64
5.2.2 Person who performed the “initiation”	65
5.2.3 Region.....	66
5.2.4 Settlement Area	67
5.2.5 Religion.....	69
5.2.6 Education level.....	71
5.2.7 Socioeconomic status.....	72
5.3.1 Age of excised women	74
5.3.2 Person who performed the operation	75
5.3.3 Region.....	76
5.3.4 Area of settlement.....	77
5.3.5 Religion.....	79
5.3.6 Ethnic group	82
5.3.7 Level of Education.....	84
5.3.8 Socioeconomic status.....	88
5.3.9 Level of acceptance.....	89
5.4 Cote d’Ivoire	90
5.4.1 Age of the excised women	90
5.4.2 Types of excision practiced.....	91
5.4.3 Person who performed the excision on the respondent	92
5.4.4 Region.....	93
5.4.5 Area of settlement.....	94
5.4.6 Religion.....	96
5.4.7 Ethnic Group	97
5.4.8 Education level.....	99
5.4.9 Socioeconomic status.....	102
5.4.10 Level of acceptance.....	103
5.5 Ghana	104
5.5.1 Age of excised females.....	104
5.5.2 Person who performed the operation	105
5.5.3 Regions in Ghana	106
5.5.4 Area of Settlement.....	107
5.5.5 Religion.....	108
5.5.6 Education level.....	110
5.5.7 Socioeconomic status.....	111
5.5.8 Level of acceptance.....	112

Chapter Six	114
Overall Results From the data analysis.....	114
6.1 Age of the excised females	114
6.2 Region or State of residence	115
6.3 Area of settlement.....	115
6.4 Religion.....	116
6.5 Ethnicity	117
6.6 Education level.....	117
6.7 Socioeconomic status.....	117
Chapter Seven.....	119
Discussion.....	119
7.1 Current status of abandonment campaigns.....	119
7.1.1 Egypt.....	119
7.1.2 Kenya.....	120
7.1.3 Sudan	120
7.1.4 The Gambia	120
7.1.5 Other African countries.....	121
7.2 FGM is a violation of human rights.....	121
7.2.1 The right to life, liberty, and security.....	123
7.2.2 The right to reproductive self-determination	123
7.2.3 The right to consent to marriage	123
7.2.4 The right to health.....	124
7.2.5 The right to be free from discrimination	124
7.2.6 The right to not be subjected to torture or other cruel, inhuman, or degrading treatment or punishment.....	124
7.2.7 The right to be free from sexual violence	125
7.2.8 The right to education and information	125
Chapter Eight	126
Recommendations	126
8.1 Data recommendations	126
8.1.1 Age at which excision is performed	126
8.1.2 Type of excision	127
8.1.3 Did the female give her consent to be excised?	127
8.1.4 Excision status of the daughter	128
8.1.5 The husband's role in the decision making process.....	128
8.1.6 Health consequences	128
8.1.7 Reasons for and against FGM.....	129
8.2 Anti-FGM program recommendations	130
8.2.1 Education of the female	130
8.2.2 Male involvement	131
Chapter Nine.....	132
Conclusion.....	132
List of References	134
Appendices	137
A. Chi-square test results.....	137
A.1. Sudan	137

A.2. Sierra Leone	138
A.3. The Gambia	140
A.4. Cote d'Ivoire	142
A.5. Ghana	144



Table of Figures

Figure 1: Diagram of normal female genitalia	17
Figure 2: Diagram of Type I mutilation	18
Figure 3: Diagram of Type II mutilation.....	18
Figure 4: Diagram of Type III mutilation	19
Figure 5: Photograph of an instrument used for excision	21
Figure 6: Map of Africa showing the 28 FGM practicing countries divided into the four prevalence groups.....	26
Figure 7: The percentage of women who have undergone excision by age group	48
Figure 8: Age at which girls are circumcised.....	49
Figure 9: Distribution of the type of female circumcision received	51
Figure 10: Distribution of the person who performed the excision	52
Figure 11: Female excision within the Northern States	54
Figure 12: Proportion of excised females in each Northern state by settlement area	56
Figure 13: Proportion of excised females according to their level of education.....	59
Figure 14: Proportion of excised females according to their wealth index.....	60
Figure 15: Proportion of excised females according to their age group	64
Figure 16: Distribution of person who performed initiation on respondent	66
Figure 17: Proportion of excised females in each region.....	67
Figure 18: Proportion of excised females in each region by settlement area.....	68
Figure 19: Distribution of religion of the head of household in Sierra Leone	69
Figure 20: Proportion of excised female in each region according to their religion.....	70
Figure 21: Proportion of excised females in each region according to school attendance	71
Figure 22: Proportion of excised females in each region according to level of education	72
Figure 23: Proportion of excised females according to their wealth index.....	73
Figure 24: Proportion of excised women according to age group	74
Figure 25: Distribution of who performed the excision on the respondent	76
Figure 26: Proportion of excised females within each region.....	77
Figure 27: Proportion of excised females in each region by settlement area.....	79
Figure 28: Distribution of religion within each region	80
Figure 29: Proportion of excised females in each region according to their religion	81
Figure 30: Proportion of excised females for each ethnic group by religion	82
Figure 31: Distribution of ethnic groups within each region	83
Figure 32: Proportion of excised females according to their ethnic group	84
Figure 33: Proportion of excised females in each region according to school attendance	86
Figure 34: Proportion of excised women in each region according to their level of education	87
Figure 35: Distribution of socioeconomic status.....	88
Figure 36: Proportion of excised females according to their wealth index.....	89
Figure 37: Proportion of excised females according to their level of acceptance.....	89
Figure 38: Percentage of women in each age group who have been excised	90
Figure 39: Distribution of the types of excision performed on the respondent.....	92
Figure 40: Distribution of the person who performed the excision on the respondent.....	93
Figure 41: Proportion of excised females, per region	94
Figure 42: Proportion of excised females in each region, per area of settlement	96
Figure 43: Distribution of religion in Cote d'Ivoire.....	96
Figure 44: Proportion of excised females in each region according to their religion	97

Figure 45: Proportion of excised females by ethnic group	98
Figure 46: Proportion of excised females in each region according to school attendance	100
Figure 47: Proportion of excised females in each region according to their level of education	101
Figure 48: Distribution of socioeconomic status.....	102
Figure 49: Proportion of excised females according to their wealth index.....	103
Figure 50: Proportion of excised females according to the age group.....	105
Figure 51: Distribution of person performing excision on the respondent	106
Figure 52: Proportion of excised females according to region	106
Figure 53: Proportion of excised female in each region according to the area of settlement ..	108
Figure 54: Distribution of religions in Ghana	109
Figure 55: Proportion of excised females in each region according to religion	109
Figure 56: Proportion of excised females in each region according to school attendance	110
Figure 57: Proportion of excised females per region according to level of education.....	111
Figure 58: Proportion of excised females according to socioeconomic status	112
Figure 59: Proportion of excised females who wanted the FGM practice to continue or not	113



Table of Tables

Table 1: Distribution of FGM status by country	38
Table 2: Response rates of the five analysed countries.....	42
Table 3: Female Genital Mutilation prevalence in Africa by country	42
Table 4: The five countries selected for analysis	43
Table 5: Age at which girls are circumcised in Northern Sudan by State	50
Table 6: Proportions of urbanisation in Northern Sudan	55
Table 7: Female school attendance by state	57
Table 8: Proportion of schooled females who undergone excision	58
Table 9: Proportion of females who appreciated excision	61
Table 10: Proportion of husbands who agreed with excision when their wives discussed the topic with them.....	62
Table 11: Proportion of women who have undergone excision and discussed the topic with their husbands.....	63
Table 12: Proportion of husbands who agree with excision when their wives are excised	63
Table 13: Proportion of urbanisation within each region.....	67
Table 14: Proportion of urbanisation in each region.....	78
Table 15: Proportion of females who have ever attended school by region	85
Table 16: Proportion of urbanisation in Cote d'Ivoire, per region	95
Table 17: Proportion of excised females by ethnic group.....	98
Table 18: Distribution of female school attendance aged fifteen to forty-nine	99
Table 19: Level of approval according excised and non-excised females.....	103
Table 20: Proportion of urbanisation within each region in Ghana	107

List of Acronyms and Abbreviations

DI	Department of Institutions
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
IAC	Inter-African Committee
IOM	International Organisation for Migrations
IPPF	International Planned Parenthood Fund
IPU	Inter-Parliamentary Union
LSCB	London Safeguarding Children Board
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
OHCHR	Office of the High Commissioner for Human Rights
SPSS	Software Package for Social Statistics
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organisation

Chapter One

Introducing Female Genital Mutilation

1.1 Brief Background

Various terms have, over the years, been used to describe the needless reconstruction of the female genitalia. Among them were female circumcision, female genital mutilation and female genital cutting. Although the term female circumcision was used predominantly at first, many believed that this term should not be used since it implied that female circumcision was equivalent to male circumcision, which it was not (Cook, 2003). The understanding was that only the foreskin of the male genitalia was removed without harming the organ itself, whereas the female adaptation damaged the organ as well as the surrounding tissue (Toubia, 1995). When the male foreskin was removed the penis functioned just the same as if the foreskin was still there. When part of the female's genitals was excised, however, not only was its appearance different, but the genitals no longer functioned like it would have before the reconstruction, since the woman was unable to experience sexual pleasure (Bourdanne, 2005).

Subsequently, female genital mutilation became the preferred term ever since the late seventies in an effort to emphasize the gravity of its practice (WHO, 2008). At the community level, however, this loaded term carried a negative undertone and therefore 'mutilation' is often replaced with 'cutting' in local surveys and campaigns except in official UN and WHO documentation (WHO, 2008). Female Genital Mutilation (FGM) was consequently defined as the practice of cutting, removing and/or sewing together part of or all of the external female genitals for non-medical reasons (WHO, 1996).

1.2 General problem

Between one hundred and one hundred and forty million young girls around the world have reportedly been subjected to some form of female genital mutilation during 2005. Approximately three million young girls are still at risk every year of undergoing this harmful procedure (WHO, 2008). Female genital mutilation was reported to occur in twenty-eight

African countries of which only half of these countries had some laws in place banning this practice (London Safeguarding Children Board, 2007). In Egypt, for example, FGM was banned since the late fifties and their courts advocated this law again in 1997, but the FGM prevalence remained as high as ninety-seven percent (London Safeguarding Children Board, 2007). On the other hand, in countries like Mauritania and Yemen (which is not an African country) where FGM was legal but banned in hospitals, prevalences were below twenty-five percent for both these countries (London Safeguarding Children Board, 2007). This showed that persistently high levels of female genital cutting could not only be lowered through legislation. Other factors therefore need to be investigated as well that will complement local legislation.

1.3 Problem statement

What are the underlying factors that contribute to the acceptance and approval of female genital mutilation? Are these underlying factors universal across the twenty-eight practicing African countries or are they diversified? Are these underlying factors so influential that they overshadow the negative consequences that follow? Overall, which underlying factor(s) dominates FGM appreciation in Africa and what will encourage its discontinuation?

1.4 Objectives

This research paper aims to investigate the female genital mutilation situation in certain African countries thereby bringing the underlying rationale to light. The steps involved in this investigation included:

- Identifying and describing the female genital mutilation situation in a few countries;
- Grouping the twenty-eight practicing countries according to their FGM prevalence levels;
- Analysing at least one country per prevalence category to highlight the underlying factors of acceptance;
- Comparing those underlying commonalities across the countries;
- Identifying any FGM awareness campaigns in these countries;

- Developing questions related to female genital cutting that should be included in future surveys;
- Recommending possible strategies that will help lower the FGM incidences and eventually eradicate female genital mutilation.

1.5 Overview of methodology

This research study had a quantitative nature since secondary data (data not collected first hand but rather obtained from another source) was used for the analyses. The type of research design was descriptive in which females from certain African populations were examined in order to determine the underlying characteristics that lead to excision. These specific countries were chosen according their FGM prevalence rates. The two countries above ninety percent were Sudan (ninety percent) and Sierra Leone (ninety-four percent). The selected country with FGM prevalence between seventy and eighty-nine percent was The Gambia (seventy-nine percent), while Cote d'Ivoire (forty-five percent) fell into the twenty-five to sixty-nine percent category. The selected country with the lowest FGM prevalence between one and twenty-four percent was Ghana (five percent). These five African countries where female genital mutilation was practiced were then investigated. The United Nations Children's Fund (UNICEF) created a 'child info' database that housed restricted national datasets. Once access was granted, the women and child data files in SPSS format was downloaded for analysis.

Since this study entailed descriptive research, data from Multiple Indicator Cluster Surveys (MICS) from these African countries were obtained and analysed. The statistical software package (SPSS) was used to make these analyses. The variables under consideration were those underlying factors that were expected to encourage communities to continue practicing female genital cutting. These underlying characteristics were then compared across countries so as to highlight any distinguishing patterns or trends. Chi-square tests for association were conducted when cross tabulation was performed in SPSS. The result of the chi-square test made it possible to identify whether or not the dependent variable (excision status) was associated with the independent variables (age, region of residence, area or settlement, religion, ethnicity, education level and socioeconomic status). The results were then reported

in the form of distribution and proportion tables and appropriate figures such as bar charts and pie charts.

1.6 Conceptual framework

The first chapter in this research paper will introduce the topic of Female Genital Mutilation. It provides a brief background; describes the general problem associated with this practice and then highlights the main objectives of this study. The second chapter discusses characteristics which were found to surround the FGM ritual. The third chapter then provides a broader scope of this subject by reviewing previous literature. It summarises the main ideas of other researchers so as to create a basis to which this study will link. Chapter four then describes the research approach which will be taken to investigate Female Genital Mutilation in Africa. The methodology used will be explained in terms of the research design and procedural techniques. Thereafter, chapter five consists of the data analyses. Secondary data obtained from UNICEF will be analysed to establish which underlying factors encourage female genital cutting. Once the analysis is completed, chapter six will discuss the results of the data analysis. This involves accumulating all the vital pieces of information that show that the objectives are achieved. It also discusses anti-FGM campaign strategies and human rights violation. Second to last, chapter seven will include recommendations for future data retrieval and strategies that would assist in reducing FGM incidences in the future. Finally, the chapter eight concludes the research that was performed and the results that were obtained.

Chapter Two

Characteristics surrounding Female Genital Mutilation

The World Health Organisation (WHO) has identified that female genital mutilation included four types of procedures involving different levels of removing the external female genitalia or any injury to the female genitals for cultural, religious or any other non-therapeutic rationale (WHO, 1996). Some twenty-eight African countries have been practicing this rite of passage procedure for centuries (Unknown, 2007) and it is still practiced to this day. This chapter will describe the different facets around female genital mutilation. They include the different types of Female Genital Mutilation; the ages at which this ritual is done; the procedure involved; the consequences that follow; the reasons for doing this to young girls and women; and finally the prevalence's in Africa.

2.1. Types of Female Genital Mutilation

The World Health Organisation has, in the past, convened many meetings to discuss the different classifications of female genital mutilation for research and comparability reasons (WHO, 2008). Between the first classification conference in 1995 and a more recent one in 2007 (WHO, 2008), FGM typology has become more specific with a few sub-divisions within each major type. These four main classifications with their sub-divisions are explained as follows and are accompanied by a diagrammatic representation of these four types of FGM.

Figure 1: Diagram of normal female genitalia

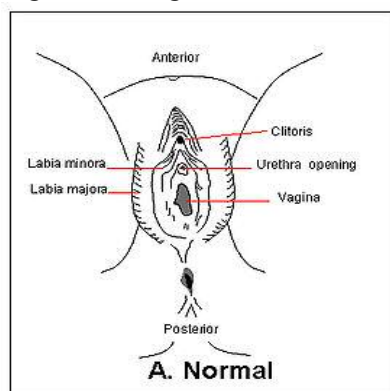
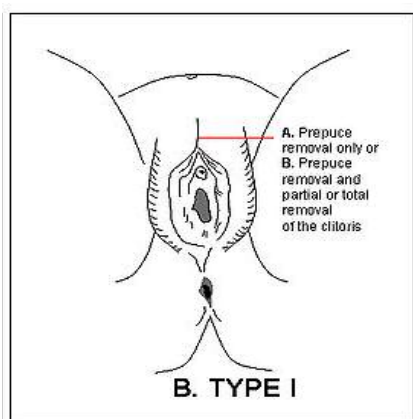


Figure 1 is a representation of a normal female genitalia with no excision. It could be seen that all her genital parts are still uncut and unchanged.

Source: Kaylima, 2007

2.1.1 Type I: Female Circumcision (Sunna)

Figure 2: Diagram of Type I mutilation



Source: Kaylima, 2007

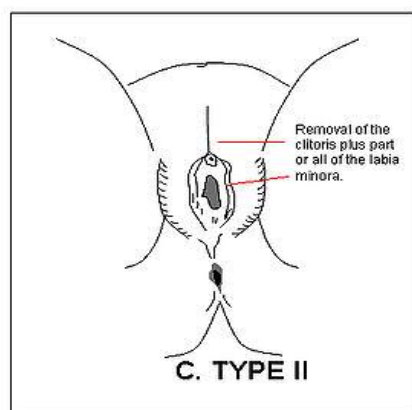
Figure 2 shows what the female genitalia looks like when the young girl or woman underwent type I mutilation. Type I is therefore classified as removing the prepuce (fold of skin covering and protecting the clitoris) with or without partial or total removal of the clitoris. WHO (2008) reports that, when required, the sub-divisions are:

Type Ia: Removing the prepuce only;

Type Ib: Removing the prepuce *and* clitoris.

2.1.2 Type II: Excision (Clitoridectomy)

Figure 3: Diagram of Type II mutilation



Source: Kaylima, 2007

Type II mutilation is represented in Figure 3. Type II involves cutting out the clitoris and part of or the entire labia minora (small lips that cover and protect the vagina and urinary opening). Once the genitalia have healed, scar tissue encompasses the vulva region. When necessary, WHO distinguishes the following sub-divisions:

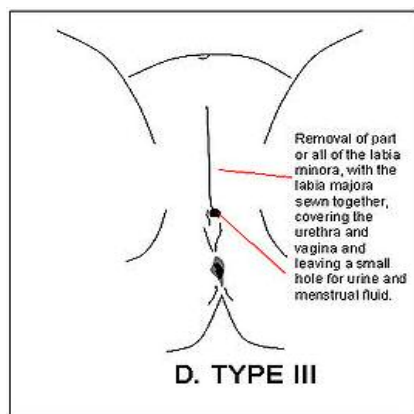
Type IIa: Removing the labia minora only;

Type IIb: Removing the labia minora *and* partial or total removal of the clitoris;

Type IIc: “Partial or total removal of the clitoris, the labia minora *and* the labia majora” (WHO, 2008).

2.1.3 Type III: Infibulation (Pharaonic circumcision)

Figure 4: Diagram of Type III mutilation



Source: Kaylima, 2007

Figure 4 shows type III mutilation which is the most extreme and most brutal form of FGM. Infibulation entails partial or total removal of the clitoris as well as the labia minora and/or the labia majora (outer genital lips) (WHO, 2008). Once all these parts are cut out, the sides are sewn together leaving a tiny opening for urine and menstrual flow to pass through. In order to preserve this opening, a foreign body is then inserted for the duration of the healing process (London safeguarding Children Board, 2007). Once this procedure is complete the vaginal opening is narrowed and partially covered. When distinctions need to be made, the following sub-divisions are specified by WHO (2008):

Type IIIa: "Removal and apposition of the labia minora";

Type IIIb: "Removal and apposition of the labia majora".

2.1.4 Type IV: Unclassified

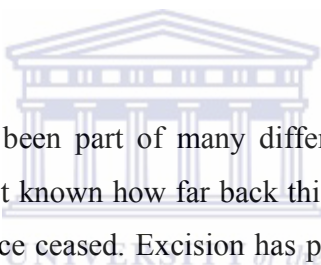
This category includes all other harmful practices done to the female genitalia which are not therapeutic such as pricking, piercing, cutting or stretching the clitoris and/or labia; cauterizing the clitoris and surrounding tissue; scraping the tissue surrounding the vaginal opening or inserting corrosive foreign materials into the vagina (London Safeguarding Children Board, 2007; WHO, 2008).

2.2. Age at which FGM is performed

Reports differ somewhat when describing the age at which this procedure is conducted on young girls. The age of genital mutilation varies from a disturbing seven days old to the time at which the girl births her first child (Bourdanne, 2005). Adult females are also known to

have this procedure done when they marry. When this ritual is carried out on girls below four years old, the ritual ceremony is minimal compared to when the girls are older than twelve (Yoder, Abderrahim, Zhuzhuni, 2004). The decision as to the age of genital mutilation lies within the cultural or religious beliefs of the different countries who conduct female genital cutting (Office of the High Commissioner for Human Rights, 2009). In Egypt, for example, approximately ninety percent of girls undergo FGM between five and fourteen years old. On the other hand, most countries in West Africa perform this procedure before the girl reaches her fifth birthday. On the extreme end is Eritrea and Ethiopia where majority of the girls are mutilated within their first year of life (Yoder, Abderrahim, Zhuzhuni, 2004). The average age at which this procedure is performed is consequently reported by the London Safeguarding Children Board between ten and twelve years old (2007).

2.3. Ritual procedure



Female genital mutilation has been part of many different communities for many decades (Abdi & Askew, 2009). It is not known how far back this tradition dates and unfortunately, it is one tradition that has not since ceased. Excision has passed on through the generations via the older females in the communities. These older women have not only gained prestige through conducting this practice but have also earned extra income there from (LSCB, 2007). In Egypt, however, “men are known to perform the operation” (Office of the High Commissioner for Human Rights (OHCHR), 2009).

The type of cutting to be administered is predefined by the child’s mother or grandmother and she will pay the excisor throughout the operation to guarantee the best service (OHCHR, 2009). A group of older women hold the young girl down during the ten to twenty minute operation while the excisor (usually the traditional birth attendant) cuts away her genital flesh. No anaesthetic is used (OHCHR, 2009). This procedure often takes place outside the village away from home with no medical equipment or expertise. The cutting tools used to permanently alter the young girls' genitals include sharpened stones, broken glass, house knives, or razor blades (LSCB, 2007).

Figure 5: Photograph of an instrument used for excision



Photo: UNICEF Egypt/Pirozzi 2005

An instrument used for excision.

Source:

<http://www.irinnews.org/report.aspx?reportid=70148>

When the girl undergoes infibulation, the older women performing the procedure will use silk, catgut sutures or thorns to allow the incised skin to grow together (LSCB, 2007). Others will apply “herbs, earth, cow-dung, ash or butter” to the wound, then strap the legs tightly together so that the girl cannot walk for approximately forty days (OHCHR, 2009). This allows the wound to heal and scar tissue to grow properly.

Since no concern for cleanliness or safety is maintained during this procedure, many problems arise with the young girl who has had her genitals cut and/or infibulated. These issues include medical, mental and sexual problem that have both short and long term effects.

2.4. Consequences that follow female genital mutilation

Many complications follow the genital cutting procedure. They include short term complications as well as long term issues. Unfortunately, the suffering women do not link their excision and/or infibulation with the medical, sexual or mental issues which are inevitable. The short and long term consequences are thus further explained.

2.4.1. Short term consequences

The least traumatic short term consequence is excruciating pain since no anaesthetic is used during the procedure and is accompanied by an intense amount of bleeding. A number of infections may follow including urinary tract or wound infections (OHCHR, 2009). If the cutter is not careful, surrounding organs like the urethra or rectum or both may be injured which leads to many long term problems. If the cutting or sewing instruments are not properly sanitized and disinfected, the young girl may develop a Tetanus infection or viruses such as

HIV, Hepatitis B and C (LSCB, 2007). In some instances this procedure causes so much blood loss that death is certain (WHO, 2008). In such instances the excisor is not at fault but rather it is assumed that the girl had evil spirits which caused her death (OHCHR, 2009). The mental issues associated with female genital mutilation in the short term are most often emotional and psychological shock (LSCB, 2007). The young girls may understand the process, in some communities, but that makes it no less traumatizing.

2.4.2. Long term consequences

Understandably, if the short term complications are left untreated, they will evolve and develop into more severe long term complications which are much harder to eradicate. Persistent vaginal, urinary and pelvic infections may be experienced by the excised women. WHO reports that “urinary tract infections can ascend to the kidneys, potentially resulting in renal failure, septicaemia and death” (2008). Severe complications regarding the menstruation process, sexual intimacy, the reproductive system, pregnancy and childbirth are also among the long-term health risks. Studies show that women who have undergone genital mutilation have a higher risk of contracting genital herpes. Unfortunately, “genital herpes is a risk factor in the transmission of HIV” and therefore, the female is even more susceptible to HIV (WHO, 2008). Some unfortunate women may become infertile as a result of chronic infections or severe tissue damage related to excision (LSCB, 2007).

Childbirth complications increase with each type of genital mutilation. A common problem associated with childbirth is the tearing of keloid scar tissue resulting in excessive bleeding (OHCHR, 2009). Incidences of delivery by caesarean section are increased as well as elevated frequencies of postpartum haemorrhage, which is a lifetime problem (WHO, 2008). Those women who are infibulated have to be opened up or deinfibulated before delivery and then reinfibulated again, once the child is born. This will continue for each child she carries (OHCHR, 2009).

A WHO study group on female genital mutilation in 2006 reported that death rates among babies during delivery and immediately after birth are elevated when the mother has

undergone genital mutilation of type I, II and III (WHO, 2008). The following statistics were found from that study:

- Type I: infant death rates are fifteen percent higher compared to non-mutilated mothers;
- Type II: infant deaths are thirty two percent higher than non-mutilated mothers;
- Type III: infant deaths are approximately fifty five percent higher than non-mutilated mothers.

The mental health issues that develop as the young girl grows older include trauma, feelings of incompleteness, emotional irregularities, and anxiety as well as stress disorders. According to the London Safeguarding Children's Board research done in certain African communities' states that women who have undergone excision and/or infibulation, experiences the same amount of Post Traumatic Stress Disorder as adults who have been sexually abused as children. "Also that the majority of the women (80%) suffer from affective (mood) or anxiety disorders" (LSCB, 2007). More recently, young woman have begun opposing this sort of social acceptance (Bourdanne, 2005) as they recognize that the negative consequences of excision outweigh the social benefits.

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Since female genital mutilation has negative implications for the mother and her child, a strategy towards reducing and eliminating all type of excision may lie within the Millennium Development Goals. MDG 4 is mainly directed at reducing child mortality, while MDG 5 plans to improve maternal health. These two goals do not explicitly aim to eliminate female genital cutting, but by tackling the FGM problem, mainly in Africa, child mortality may decrease as well as improving maternal health. The negative consequences of FGM adversely affect both MDG 4 and 5, therefore, by using these Millennium Development Goals as a platform, the task of eliminating excision may be less difficult.

2.5. Reasons for female genital mutilation

The exact origins of female circumcision are still unknown but "evidence from Egyptian mummies suggests that a form of FGM was routinely practiced some 5000 years ago"

(International Planned Parenthood Foundation (IPPF), 2008). In ancient Rome, the female slaves were forced to have “metal rings passed through their labia minora” in order for them not to bear children (OHCHR, 2009; IPPF, 2008). In America and nineteenth century England, type I mutilation was performed on women to control psychological ailments (OHCHR, 2009) as well as to control epilepsy, cause sterilization and prevent masturbation (IPPF, 2008).

An array of reasons exists for the cutting of young girls’ genitals. All of them in some way relate to cultural or religious beliefs but non are for medical benefits even though FGM predates Islam and Christianity (OHCHR, 2009) and is not advocated in the holy scriptures of Christianity, Judaism or Islam (IPPF, 2008). The main idea behind this sort of cutting lies in the fact that women are to be subservient to the man. By removing the clitoris the woman is unable to feel pleasure during sexual intercourse and is therefore completely submissive (Bourdanne, 2005).

According to the London Safeguarding Children Board (2007), the following are rationales for female genital mutilation in many African communities. For the young girls, part of being a woman involves genital cutting which serves as a “rite of passage” thereby ensuring her virginity until marriage. This consequently provides the girl and her family with the appropriate respect and status in the community which makes her worthy of marriage. In countries like Liberia and Sierra Leone, for instance, groups of girls aged twelve and thirteen are taken away from their home to undergo an “initiation rite” (OHCHR, 2009). An older women of the village, the “Sowie”, teaches the group of young girls how to be a good wife to their future husbands; shows them how to use plants and herbs for medicine; and then a form of FGM (usually type I) is performed on each young girl (OHCHR, 2009). These young girls are now ready for marriage.

In terms of personal hygiene, it is believed that cutting and removing the female genitals makes her clean, “cosmetically desirable” (LSCB, 2007) and more pleasurable for her husband (OHCHR, 2009). Even though childbirth is painful, in Mali it is thought that if the infant touches the mother’s clitoris during birth, the baby may have severe health problems

(Bourdanne, 2005) or even die (OHCHR, 2009). For this reason, many women still succumb to this detrimental procedure so as to protect their offspring.

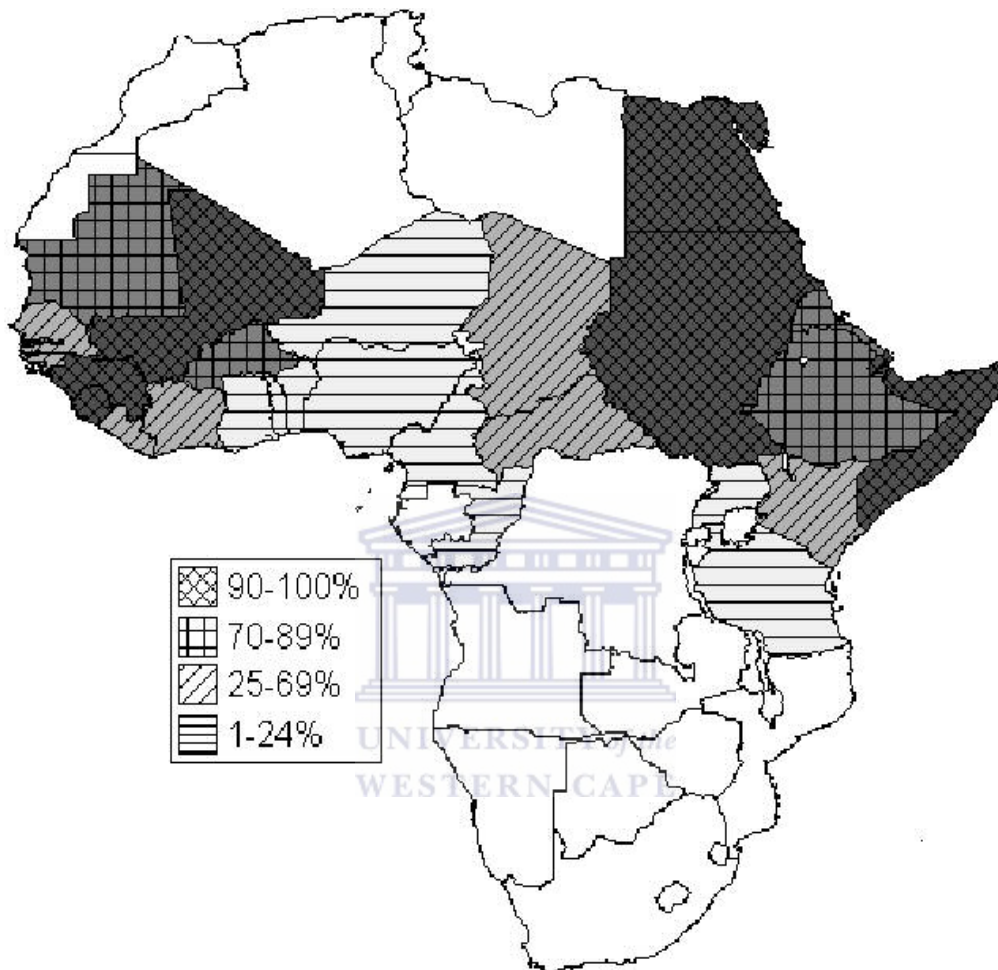
A final reason why the men in these communities also opt for infibulation is to ensure that their wives remain faithful to them while they are away from home, mainly for work, for extended periods of time (LSCB, 2007). Alarming, in certain communities, the man would sew his wife's genitals closed when he embarks on a journey and then reopens it again once he returns. This is done each time the husband leaves the home for a long time (LSCB, 2007) or each time the female delivers her baby (WHO, 2008).

2.6. Prevalence of FGM in Africa

Female genital mutilation is reported to occur in twenty-eight African countries (LSCB, 2007). This does not imply that excision only occurs in Africa. The LSCB (2007) has reported that approximately eighty thousand women and girls are living with the consequences of FGM in the United Kingdom and an additional seven thousand girls below seventeen years of age are at risk of being excised. These affected women are either "refugees, asylum seekers, overseas students or the wives of overseas students" (LSCB, 2007) of African origin living in British communities. A few countries in Asia and the Middle East are also accustomed to FGM (WHO, 2008). Between one hundred and one hundred and forty million young girls around the world have reportedly been subjected to some form of excision and approximately three million young girls are at risk every year of undergoing this harmful procedure (WHO, 2008).

Figure 6 displays the estimated FGM prevalences in the twenty-eight practising countries across Africa. Four categories of prevalence rates were identified. Countries that fell into group one had prevalences above or including ninety percent; group two countries had FGM prevalences between seventy and eight-nine percent; group three countries had FGM prevalences between twenty-five and sixty-nine percent; and the last group included those countries with very low prevalences below twenty-five percent.

Figure 6: Map of Africa showing the 28 FGM practicing countries divided into the four prevalence groups



Source: UNICEF databases, 2006; WHO, 2005

Chapter Three

Reviewing previous FGM studies

This chapter provides an understanding of previous studies that were conducted regarding Female Genital Mutilation. Researching such articles lead towards the realisation that not much articles have been published regarding this subject. The few that were found were mainly focused on one particular country and provided accounts of mostly qualitative data. Focus groups and interviews were mainly used as a tool to gather information regarding excision prevalences. The editor of the African Journal for Reproductive Health reported that only one study, conducted by a WHO study group, across six African countries provided statistical evidence that excision increased the risk of adverse reproductive health (Okonofua, 2006). This chapter first reviews three countries; then examines the WHO study that linked adverse reproductive health with complications from excision, and finally discusses where this research fits in.

3.1. The case of Nigeria

A group of researchers conducted a cohort analysis regarding the trends in Female Genital Mutilation in the Osun and Ogun States of Southwest Nigeria over a period of seventy years from 1933 to 2003 (Adeokun et al, 2006). Within these two states, four hundred and thirteen married women were interviewed and reported to have borne one thousand four hundred and twenty one live baby girls between them. However, only one thousand one hundred and seventy four females were included in this cohort analysis as two hundred and forty seven women were unable to provide accurate information regarding dates of live births and subsequent traditional practices including female genital cutting.

Among the approximate nineteen percent of excised females in Nigeria (WHO, 2005), seventy-nine percent had undergone genital cutting during infancy. In Southwest Nigeria, however, the Female Genital Mutilation prevalence was much higher at roughly forty five percent. The proportion of girl children who were excised at infancy in the Southwest was therefore also increased. The dominant type of Female Genital Mutilation was Type I

(Clitoridectomy) mutilation while there was “little evidence that type four Female Genital Mutilation existed in Nigeria” (Adeokun et al, 2006) and particularly in the Southwest.

Four distinct observations were identified through this cohort analysis. The first verified the validity of the data sets that were used in this study. The calculated Female Genital Mutilation prevalence in the Ogun and Osun states closely mirrored the previous reported figure. Therefore, the expected value and the observed value coincided with one another. Statistically, this result was significant. The fact that the observed figure were within the specified scope, it meant that the data set obtained was of a high quality.

Secondly, there was “clear evidence of a downward trend in the circumcision of female children reflected for all birth orders” (Adeokun et al, 2006) particularly since the beginning of the 1980’s. This meant that the expected decrease in female genital mutilation was confirmed by the decrease in excision by approximately twenty-six percentage points from the eighties to the nineties.

The third observation involved the timing of the decline in Female Genital Mutilation prevalences. More specifically, the cohort of first born females had a different prevalence shape compared to the other birth orders. The decline in Female Genital Mutilation prevalence within the first born females was noticed a decade prior to the onset of the other birth order declines. This subsequently meant that ten years prior to the onset of the international anti-FGM campaign, the excision prevalences began declining.

Lastly, an age and education effect was dominant. The older females were “less well educated” and relied more on traditional practices for social acceptance than the younger, more educated females (Adeokun et al, 2006). This phenomenon could be expected since education has positive repercussions. The older traditional females thus had higher excision prevalences than the younger, more educated females in the same community.

This set of researchers maintained that due to the emotional attachment, women provided accurate accounts of their childbearing history, however long ago it may have been. Moreover,

they believed that the childbearing history of the mother was more dependable than the circumcised women accounting for her childhood events (Adeokun et al, 2006). Adeokun and partners also stated that the declining trend in the FGM prevalence in Nigeria could not only be attributed to the international campaign against female genital cutting but also to local movements discouraging its practice, the education of women as well as the modernisation of Nigerian society.

3.2. The case of the Somali ethnic community in Kenya and Somalia

Kenya was home to a community of Somalis in which the majority of the Somali tribe resided in the North Eastern Province of Kenya (Abdi & Askew, 2009). WHO reported that in 2005 the Female Genital Mutilation prevalence in Kenya was approximately thirty-two percent, while the 2003 Kenya Demographic and Health Survey found an almost ninety-seven percent prevalence rate in the Somali ethnic group as well as a ninety-nine percent prevalence rate in the North Eastern Province (Abdi & Askew, 2009). In Somalia itself, the reported FGM prevalence rate was virtually universal at an estimated ninety-eight percent (Mohamud and colleagues, 2004). This displayed the intensity of Female Genital Mutilation within the Somali community in Kenya and in Somalia itself.

Reported at ages as young as four in the Somali community in Kenya (Abdi & Askew, 2009), the qualification age in Somalia ranges between five and eight years old (Mohamud and colleagues, 2004). This reinforced the idea that this practise was no longer a rite of passage. “Hawa Aden of Galckayo Education Centre for Peace and Development (GECPD) noted that one hundred percent of six to eight year olds who enrolled in the school system had been infibulated” within the Somali community in Kenya (Mohamud and colleagues, 2004). Infibulation or type III mutilation was the dominant type of excision practised in the North Eastern Province of Kenya (Abdi & Askew, 2009) and reached ninety percent in Somalia in a 1993 study (Mohamud and colleagues, 2004). The belief lies in the fact that types I and II mutilation could not control a woman’s sexual desires as effectively as type III or infibulation would. Therefore, infibulation was viewed to promote a female’s trustworthiness and consequently protect her virginity and fidelity (Abdi & Askew, 2009).

Many studies conducted in the past by different groups of researchers have shown that underlying indicators such as area of settlement, levels of education and household income, do not display differing FGM prevalences within the Somali community (Mohamud and colleagues, 2004). This meant that these socio-economic indicators were not core factors that encourage Female Genital Mutilation in Somalia and Somali villages elsewhere. However, it was found that the two core influencing factors behind Female Genital Mutilation are the “fact that it is a Somali tradition and the belief that it is an Islamic requirement” (Abdi & Askew, 2009). These two researchers then developed a programme which used religious teachings as a basis to eradicate Female Genital Mutilation within the Somali community (using the North Eastern Province in Kenya as the basis of the study). Using in-depth interviews and discussion groups with religious leaders and village leaders within the community and newly married and unmarried women and men, qualitative data was obtained and analysed (Abdi & Askew, 2009).

Abdi and Askew (2009) found that there are seven key reasons why the Somali community in the North Eastern Province encourages cutting the female genitals. The first and most important rationale was that Female Genital Cutting was a Somali tradition that has passed on from generation to generation. Therefore, the cultural tradition of the Somali females was shown to be deeply imbedded in these communities. Cultural traditions are one of the most difficult independent variables to analyse, measure and consequently change. It may even be impossible to change a tradition that has transcended so many generations.

The second reason was that it was believed to be an Islamic requirement and therefore shunned non excised women. Somali females were reported to be religious followers. This therefore meant that if perceived beliefs were taught to them by religious leaders and scholars, the religious act of excision would be expected to continue from generation to generation. The third most important reason for having females excised it that the woman is thought to be less likely to be unfaithful when she has been excised. Subsequently, her sexual desire could be controlled and she would remain faithful only to her husband. Since the clitoris is removed when the female is infibulated, her sensation during sexual intercourse is diminished and thus her sexual desire is also lessened (Bourdanne, 2005).

The fourth main reason for excising females reported in this interviewing process stated that both men and women found infibulated genitalia more beautiful than non excised genitalia. Alarmingly, this rationale was reported by both the males and the females. This therefore meant that both genders found infibulation “cosmetically desirable” (LSCB, 2007). The fifth reason for female genital cutting closely related to the fourth reason. It was believed that the woman would always be seen as unclean if she was not excised. Therefore, an unexcised female was considered to be unclean which made her genitalia less beautiful as well.

The sixth reported reason for excising females was that the virginity of the female was preserved only when she was infibulated and not any other form of FGM. Since infibulation requires the removal of the clitoris, the labia minora and majora, the sexual desire experienced by the female was expected to be non-existent. The result of no sexual desire meant that the female would not be promiscuous, which in turn increased the probability of marrying a virgin bride. The final reason was that infibulation enhances the marriageability of the female. This meant that Somali men were drawn to and would only marry a woman who was excised by infibulation. All six reasons mentioned before, culminates into this final and probably the most important rationale. In order to marry and have a family, Somali females are expected to undergo infibulation since the alternative would be expulsion from the Somali community by way of abandonment and non-marriageability.

Based upon the perpetuating rationale, and the religious loyalty of the Somalis in Kenya, four sets of elements were found to justify the suggested religious orientated abandonment campaign. The research by Abdi and Askew determined that girls as young as four years old had been infibulated in this community and therefore, excision could not be attributed to a “rite of passage” from childhood to adulthood (2009). Consequently, a campaign such as Alternative Rites of Passage would not be successful within North Eastern Province of Kenya.

The act of excising a young girl was considered a ‘right’ in itself. For that reason, employing strategies along the lines of human rights violation could only be effective if incorporated into the context of violating another person’s rights. In the Islamic faith, violating others’ rights was regarded as committing a sin. Again, the strong religious affiliation of this community

surpasses all other beliefs and practises. The movements against FGM on the local and international front were seen by the Somalis “to be man-made” (Abdi & Askew, 2009) making it easier to follow the Islamic discipline, which they felt encouraged infibulation.

Their strong religious beliefs appeared to negatively sway their judgment in terms of the consequences resulting from the excision operation. Any and all medical conditions that followed infibulation were not attributed to the FGM practice but rather to the will of God and those conditions would have materialised whether or not the woman has been excised. Thus, an abandonment campaign, solely based on scaring people with the frightening medical consequences (menstrual complications being the most common consequence, followed by infections including urinary tract infections, then excessive bleeding, difficult and prolonged childbirth and finally, painful sexual intercourse) (Mohamud and colleagues, 2004) would not be as successful as one which complements the Shariah laws (Abdi & Askew, 2009).

As a result, the most suitable plan of action against Female Genital Mutilation in the Somali ethnic group in Kenya should incorporate religion at its base. This would prove to be more successful than a universal strategic plan developed for all practicing countries. Also, by assessing the development and success of this strategic plan in a smaller Somali community like the one in Kenya, researchers and anti-FGM advocates are able to determine whether this campaign will be successful in the greater Somalia.

3.3. The case of Sudan

Although Female Genital Mutilation prevalences were reported for Sudan, very little information was known for South Sudan as Female Genital Mutilation was seldom practised in this region (Berggren et al, 2006; Department of Immigration and Citizenship of Australia, 2007). Consequently, FGM prevalences reported at approximately ninety percent (WHO, 2005) pertains to the northern territory of Sudan. Berggren and colleagues also confirmed a ninety-three percent FGM prevalence rate in the urban areas and eighty-nine percent within the rural areas of North Sudan (2006). Relying on the Central Bureau of Statistics of Sudan for these figures, Berggren and colleagues could also determine that an estimated sixty-five

percent of those excised females were infibulated (2006). This meant that approximately sixty percent of Sudanese females had undergone the most severe form of Female Genital Mutilation. This proved to be quite alarming since almost half (forty-five percent) the Sudanese population was reported to be below the age of fifteen (Berggren et al, 2006) with a median age of approximately 18.3 years (Department of Immigration and Citizenship of Australia, 2007).

Since infibulation or type III mutilation was the most common form of Female Genital Mutilation in Sudan, Berggren and colleagues decided to investigate the perceptions and experiences of both Sudanese men and women with the emphasis on reinfibulation (2006). Reinfibulation often occurs after childbirth. The scar tissue that developed from the primary infibulation operation tears during childbirth and therefore, the women were compelled in certain instances to succumb to reinfibulation (Berggren et al, 2001). The procedure involves the mid-wife re-stitching the torn scar tissue, and/or “additional tightening mimicking the narrow introitus of a virgin” two hours or forty days after delivery (Berggren et al, 2006). Berggren and colleagues were most interested in the perceptions of reinfibulation since previous studies showed that more than half of the infibulated Sudanese women underwent reinfibulation at least once after childbirth (2006). They also discovered “another study from 1983 showed that almost eighty percent of infibulated married women submitted themselves to RI [reinfibulation] and, of these, over forty-five percent had undergone RI five times or more” (Berggren et al, 2006).

A qualitative study was subsequently conducted in two parts; an initial feasibility phase and thereafter a main study. Both phases involved a number of in-depth interviews with men and women separately. Once the feasibility phase was successfully modified, the main study entailed interviewing twelve women and ten men using purposive sampling (Berggren et al, 2006). Different ages, education levels, ethnicities, and geographic orientation formed the basis of the participation. Three commonalities, however, were that the interviewees were married (except for one divorced male), Muslim and resided in the state of Khartoum (Berggren, 2006).

Of the twelve interviewed women aged nineteen to sixty-eight years old, eleven reported that they had undergone infibulation (type III mutilation) while the other one was submitted to a clitoridectomy (type I mutilation). Of the eleven infibulated women, eight underwent reinfibulation after childbirth, and a few even between births. Seven of the twelve women had their daughters excised; two had all their daughters infibulated while the other five had their daughters' clitoris cut and/or removed (type I). Of the five women who still had unexcised daughters, four reported that they had every intention of sending them to be excised while the remaining one refused to subject her young daughter to any form of Female Genital Mutilation (Berggren et al, 2006). In other words, almost all of the interviewed females had their daughters excised in one way or another.

Although the aim of this study was to investigate the perception of the males and females regarding reinfibulation, it would have been quite interesting to identify which women would subject their daughters to which type of excision. For example, was the woman who underwent a clitoridectomy only (and not infibulation), one of those who intended sending her daughter to be excised or was she the one who refused to continue the FGM cycle? Unfortunately, this study did not investigate and report such cross tabulations but it was clear that the practice continued to perpetuate during 2006.

Similarly, in terms of the ten men who were interviewed, only one man's wife had undergone type I mutilation while the other nine were submitted to type III. Five of the nine infibulated wives were reinfibulated after childbirth. Three men reported that their daughters had undergone some form of excision, five men's daughters were unexcised, one gentleman had no daughters while another had no idea which form of mutilation his daughters had endured (Berggren, 2006). At least two of the men never clearly understood the FGM process and one male "only considered infibulation to be FGC, not the "sunna" type, or "clitoridectomy" (Berggren, 2006), while all the women interviewed were knowledgeable about the types of Female Genital Mutilation.

The results from this qualitative study in Khartoum highlighted six main perspectives regarding reinfibulation. The three female perceptions include:

Viewing oneself as normal

Since excision is considered to be a huge part of being a woman in North Sudan, the perpetuating practice has left these women believing that if an individual was not excised, she was not a 'normal' woman. Therefore, those infibulated women who are torn open during childbirth, feel that they are no longer normal and so do the other women in the community. Some of the woman interviewed felt that undergoing reinfibulation would reinstate their normality again.

Being caught between different perspectives

The women were caught between a feeling of upholding a valued tradition and a feeling of changing these traditions based on personal negative health complications. Although marital discussion regarding reinfibulation seemed to be lacking, other community females perceive reinfibulation to be an expected wifely duty to "keep" her husband. On the other side, some of the women want initiate a change by not sending their daughters for infibulation but rather a less sever form of FGM. However, social pressure was highlighted as a hindering factor.

Having limited influence on the decisions to perform FGC and RI [reinfibulation].

The intense social pressure around this valued tradition removes the decision making power from the woman. The influential parties involved in the decision were "female relatives, older women and especially their own mothers, but also the midwife and the husband" (Berggren et al, 2006). The strong female influence is due to the customary patriarchal nature of the female role in the Sudanese society. The mid-wives influence stems from financial gains and the perceived husbands' persuasion lies in the gifts of gratitude he affords his wife after reinfibulation.

The three male perceptions brought to light were:

Suffering from the consequences of FGC

This study brought forward some complications males endured as a result of their wives being excised. They include sexual frustration, challenges to their masculinity (resulting from sexual

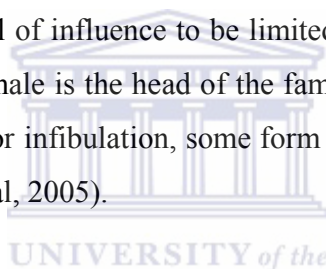
dissatisfaction) and sympathy for their wives' suffering. Physical complications include penetration problems, pain, wounds and inflammation (Berggren et al, 2006).

Trying to counterbalance the negative sexual effects of FGC

Majority of the males interviewed had sexual experiences with both excised and unexcised women. Sexual incidences with unexcised women were reported to be highly satisfying. Dissatisfying sexual intercourse with excised women was perceived to stem from a culture of female subordination regarding their sexuality as well as the negative side effect of their clitoris being removed. Some men discussed alternative methods to sexually arouse their wives since they enjoy intercourse more when the woman is in touch with her sexuality.

Striving in vain to change female traditions.

The males perceived their level of influence to be limited since the female patriarchal culture is dominant, even though the male is the head of the family. Even if they forbade their wives from sending their daughters for infibulation, some form of excision would still take place for religious reasons (Berggren et al, 2005).



Notably, each gender group felt the other gender group was partially responsible for the continuation of Female Genital Mutilation (Berggren et al, 2005). The women believed that infibulation and reinfibulation was expected of them to satisfy their husbands and the males perceived their influence to be nonexistent due to the strong female roles in their society.

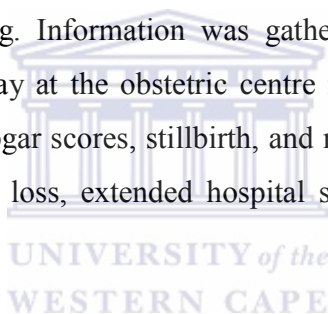
Communication seemed to be lacking between the husband and wife regarding reinfibulation, since the husband was not present for primary infibulation. Reinfibulation was deemed a sensitive topic that was a female issue and was therefore left unspoken (Berggren et al, 2005).

3.4. Studies linking FGM to adverse reproductive health of the woman

Between November 2001 and March 2003, a WHO study group assessed twenty eight thousand three hundred and ninety three pregnant women attending twenty eight obstetric centres in six African countries. Before delivery they were examined by trained midwives who

would classify each participant in terms of the official WHO Female Genital Mutilation definitions and then after delivery the women and their infants were continually assessed until discharged from the obstetric centre. The purpose of this empirical study was to “investigate the effects of different types of FGM on a range of maternal and neonatal outcomes during and immediately after delivery” (WHO study group, 2006). According to the editor of the *African Journal of Reproductive Health*, not many studies linking FGM with adverse reproductive health consequences has been documented in the past and “this [WHO] study has now provided the best evidence to date” (Okonofua, 2006).

The five centres in Burkina Faso, three centres in Ghana, three centres in Kenya, six centres in Nigeria, eight centres in Senegal, and three centres in Sudan, produced response rates quite close to 100 percent. Only 0.4 percent was excluded from the study since some of their demographic data was missing. Information was gathered from both the mother and her newborn during their entire stay at the obstetric centre regarding the “delivery, episiotomy, perineal tears, birth weight, Apgar scores, stillbirth, and neonatal and maternal death” as well as levels of postpartum blood loss, extended hospital stay, and infant resuscitation (WHO study group, 2006).



The type of excision which the mother was submitted to shows considerable variation and even though the authors recognises that this study was somewhat less than representative, the “prevalences are broadly in keeping with the few data for FGM from these countries” (WHO group study, 2006). Table 1 depicts this distribution across countries.

Table 1: Distribution of FGM status by country

Country	No FGM (%)	FGM I (%)	FGM II (%)	FGM III (%)	Total	Sample size
Burkina Faso	19.0	23.0	45.0	13.0	100.0	4816
Ghana	60.0	11.0	28.0	1.0	100.0	3094
Kenya	40.0	21.0	29.0	10.0	100.0	4167
Nigeria	12.0	63.0	24.0	1.0	100.0	5366
Senegal	21.0	24.0	54.0	1.0	100.0	3449
Sudan	17.0	5.0	5.0	73.0	100.0	7501
Total	25.0	24.0	27.0	23.0	100.0	28393

Source: WHO study group on female genital mutilation and obstetric outcome, 2006

The statistical analyses involved estimating the risk of acquiring a specific adverse maternal or newborn health issue as opposed to not acquiring this specific health issue, for both excised and unexcised women. Separate models were used for each type of Female Genital Mutilation and were then compared to the group of unexcised women who formed the baseline (WHO study group, 2006).

The results from the comparisons between excised women and unexcised women were found:

- Women who had undergone type II and type III mutilation were significantly more likely to deliver via caesarean section as compared to those women who not excised.
- Type II and III sufferers were also considerably more at risk of postpartum blood loss of 500mL or greater compared to unexcised women.
- Excised women were found to be more likely to have an extended stay at hospital after delivery than non-excised women.
- No significant relationship was found between excision and risk of infant birth weight less than 2500g.
- Women with type II and III mutilation have a significantly higher risk of delivering an infant that requires resuscitation than those women who are not excised.
- The risk ratio of inpatient “perinatal death was significantly greater in the infants born to women with FGM II and FGM III than for those of women without FGM” (WHO study group, 2006).

In terms of infant perinatal death rates, Female Genital Mutilation results in one to two additional deaths per hundred live births.

3.5. Where this research fits in

Previous studies in Female Genital Mutilation have documented reliable prevalences within the twenty eight African countries as well as those countries in which migrants from FGM practicing have settled (Okonofua, 2006). A few studies regarding the different males and female FGM perceptions showed that the lack of communication between man and wife attributes to the perpetuating practice of excision (Briggs, 2002). Unfortunately, for the majority, the husband is not present for primary excision as FGM is administered at young ages when the girl is still unmarried. If the women and men speak more openly about their perspectives regarding Female Genital Mutilation, future generations may benefit through decreasing prevalences.

Three important aspects came to the fore during this literature review. They are a lack of strong scientific evidence relating FGM practices to the adverse outcomes regarding female reproductive health; insufficient research and development concerning the appropriate abandonment techniques that will be sustainable in the long run; and finally the fact that FGM studies are mainly conducted within specific regions of a country or in a particular country. The higher the FGM prevalence in a country, the more studies conducted within that country. Subsequently, this research was directed towards identifying underlying factors that are common across countries and develop strategies that could be utilised across borders to put an end to this customary tradition and be sustainable in the long term.

Chapter Four

Methodological Approach

This research paper followed a quantitative perspective in that measurements and magnitudes were calculated regarding the levels of Female Genital Mutilation within specific African countries. This quantitative standpoint was more appropriate based on the fact that the analysis used secondary survey data obtained from UNICEF (United Nations Children's Fund). Consequently, a descriptive type of study proved to be most efficient and beneficial. This chapter first describes the data which was obtained from the United Nations Children's Fund and then provides more detail concerning the design of this quantitative study.

4.1 Describing the data

Data regarding Female Genital Mutilation was obtained from the UNICEF database. The United Nations Children's Fund, together with their local Statistics ministries, administered Multiple Indicator Cluster Surveys (MICS) in various countries. They gathered information by means of four questionnaires including the household questionnaire; the household listing questionnaire; the female questionnaire; and finally the children questionnaire. These questionnaires were standard for each country where they were administered including specific modules per questionnaire. There was, however, a separate booklet containing additional questions pertaining to malaria; children orphaned and made vulnerable by HIV/AIDS; marriage/union with polygamy; female genital cutting; and sexual behaviour for fifteen to twenty-four year old women. This set of additional questionnaires was only administered to those countries affected by one or more of these five subjects. In order to access, download and utilise the datasets pertaining to female genital cutting, formal consent was required. Access was obtained once an electronic request to UNICEF's 'child info' data centre was sent.

It was noticed that the data regarding female genital cutting was included in the female questionnaire and thus this was the main source of information. The general form of the additional questionnaire, designed by UNICEF, comprised of sixteen questions pertaining to

female genital mutilation. Each country, however, had the option of asking those questions they deemed fit. The Gambia, for example, included only ten of the sixteen questions and excluded those which were deemed as “offensive or sensitive and those that were considered of little importance or interest to the country” (Gambia Bureau of Statistics, 2007). Sierra Leone, on the other hand, never used the term ‘female genital cutting/mutilation’ at all in their questionnaire. It was said that “respondents would not give accurate responses if they were directly asked whether they had undergone FGC” (Statistics Sierra Leone and UNICEF-Sierra Leone, 2007). Sierra Leone thus only included half of the sixteen female genital cutting questions. It was determined that women who had undergone any form of female genital cutting belonged to a society based solely on secrecy. This was known as the Female Secret Society or the Bondo Society. Consequently, Statistics Sierra Leone and UNICEF used this term (Bondo Society) as a proxy for all questions pertaining to female genital mutilation. Cote d’Ivoire included sixteen questions and an additional two pertaining to the continuation and discontinuation of this practice totalling eighteen questions. Since each country could alter the questionnaire to suit their citizens and communities, all variables under consideration were not available for interpretation as they were excluded from the questionnaire.

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Each of the selected countries utilised more or less the same sample design. A two-stage stratified sample frame which would be representative of the population at the national level. One of the main tools that each survey used within the sampling was the probability proportional to size. This therefore indicated that the results drawn from these surveys could be generalised onto the national population. It was thus a national representation as opposed to a general tendency.

The five African countries that were analysed in this study had the following response rates when the MICS2 and MICS3 was administered. These female response rates seemed favourable since the non-responses are miniature. Non responses were subsequently excluded from the data sets when analysed.

Table 2: Response rates of the five analysed countries

Country	Eligible females	Females interviewed	Female response rate
Sudan	25 200	22 946	91.1%
Sierra Leone	9 257	7 654	82.7%
The Gambia	10 252	9 982	97.4%
Cote d'Ivoire	13 020	12 888	98.6%
Ghana	6 240	5 891	94.4%

Source: UNICEF databases, 2001; 2006

4.2 Study Design

The first task at hand was selecting a sample. This, however, never meant selecting a sample for administering a self designed questionnaire, but rather purposively selecting a few African countries that were to be analysed. The first criterion was obviously the fact that the country should be practicing Female Genital Mutilation.

Table 3: Female Genital Mutilation prevalence in Africa by country

Group 1: FGM: above 90%		Group 2: FGM: 70% - 89%		Group 3: FGM: 25% - 69%		Group 4: FGM: below 25%	
Guinea	99%	Eritrea	89%	Liberia	50%	Cameroon	20%
Djibouti	98%	Ethiopia	80%	Cote d'Ivoire	45%	Nigeria	19%
Somalia	98%	Gambia	79%	Chad	45%	Tanzania	18%
Egypt	97%	Burkina Faso	77%	Guinea-Bissau	45%	Benin	17%
Sierra Leone	94%	Mauritania	71%	Central African Rep.	36%	Togo	12%
Mali	92%			Kenya	32%	Ghana	5%
Sudan	90%			Senegal	28%	Niger	5%
						Uganda	1%
						Congo	1%

Source: UNICEF databases, 2006; WHO, 2005

Therefore, a list of all twenty eight African countries was drawn up. Once the list was drawn, the second criterion included a sub-division of these countries into four main groups. The first group included countries with FGM prevalences above ninety percent; the second group had FGM prevalences between seventy and eighty-nine percent; the third group included those with FGM prevalences between twenty-five and sixty-nine percent; and the final group was made up of countries with FGM prevalences below (not including) twenty-five percent (see Figure 6. page 22).

This simple sub-division allowed for the selection of two countries from group one, since these countries have almost universal excision levels and thereafter, one country for group two, one for group three and one for group four' which made up the final five countries that were analysed. Those countries that were selected were chosen because their datasets were readily available from the United Nation's Children Fund database. They were:

Table 4: The five countries selected for analysis

Group 1: FGM: 90% - 100%		Group 2: FGM: 70% - 89%		Group 3: FGM: 25% - 69%		Group 4: FGM: 1% - 24%	
Sudan	90%	Gambia	79%	Cote d'Ivoire	45%	Ghana	5%
Sierra Leone	94%						

Source: UNICEF databases, 2006; WHO, 2005

The purpose of investigating these African countries aims to highlight those underlying factors which encourage the practice of female genital cutting. Therefore, the variables under consideration follow a pattern of examination. The list of variables studied in this analysis is provided next, while the dependent variable was excision.

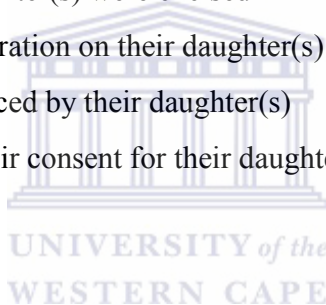
Demographic variables (Independent variables):

- Age of the respondents who have been excised
- Age at which they underwent excision
- Region / state of residence
- Settlement area (urban or rural)

- Ethnic group of the respondent
- Religious affiliation of the respondent
- Education level attained by the respondent
- Wealth index of the respondent

Variables relating to the female genital cutting module of the additional questionnaire:

- Prevalence of Female Genital Mutilation
- Type of mutilation experienced by the respondent
- Person who administered the operation
- Consequences of the operation
- Number of living daughters that were excised
- Age at which their daughter(s) were excised
- Who performed the operation on their daughter(s)
- Consequences experienced by their daughter(s)
- Did the woman give their consent for their daughter(s) to be excised
- Level of acceptance



The first component of the analysis involved examining the data which responded to the FGM module in the additional questionnaire. This meant providing a picture of the FGM situation in the five African countries under consideration in terms of the prevalence rate, the age at which this operation is performed, the type of FGM practiced more widely in the country, who performed the operation, whether or not their daughters were excised as well as the level of acceptance in the country. Since each country included those questions in the FGC module which they saw fit, it was not possible to analyse all the FGM variables for all five countries. Sudan, for example, was the only country which had data pertaining to the type of excision undergone by the respondent and thus this information was only given for Sudan.

The two types of variables listed above were not considered as separate entities. Each of the demographic variables was cross tabulated with those females who had undergone excision and compared them to those who had not undergone excision. This indicated whether

differences existed within the variables which would highlight if that variable was an underlying factor which encouraged female genital cutting. It was expected that the underlying factors would differ slightly from country to country but also that a few main commonalities would be found. These common encouraging factors were to be further analysed in order to ascertain how this practice could be abandoned.

Simple descriptive statistics was used during the analysis using SPSS version 16 for Windows. Frequencies were calculated for the variables regarding the female genital cutting module. The demographic variables were measured and cross tabulated with the FGM variables in order to identify common indicators which encourage this practice. The results of such cross tabulation was analysed and displayed in the form of tables, bar and pie charts.

Tests for association were also possible using SPSS. When the cross tabulation was carried out with the dependent variable (excision) and the independent variable (age, region, area of settlement, religion, ethnicity, education level and socioeconomic status), a chi-square test was performed as well. The null hypothesis was that there was no association between the dependent and the independent variable, while the alternate hypothesis was that there was an association between the two variables. The chi-square test provided a p-value which made it possible to either reject the null hypothesis or to not reject the null hypothesis. A p-value below 0.005 implies significance. This means that there is a significant association between the dependent and the independent variable and thus the null hypothesis could be rejected. A p-value above 0.005 would yield the opposite result of not rejecting the null hypothesis.

This test for association was the statistical measure which validated whether or not an independent variable influenced the excision of a woman. Once the chi-square test proved association or not, the cross tabulation with row percentages (in relation to the independent variable) made it possible to better understand the main source of the association. This means that the larger percentages indicate a greater association of the independent variable with excision. The results of the chi-square test could be viewed in Appendix A.

Unfortunately, a few limitations were highlighted during the data analysis. The questionnaires which were administered to the females were inconsistent. Each country reserved the right to ask those questions which they thought were pertinent regarding female genital mutilation. This limits comparison of variables across countries. When questions are not asked in the same way or the same questions are not asked, homogeneity is absent. In some cases questions were left out completely which meant that certain variables were missing from the database, again, limiting the analysis of these datasets. These limitations resulted in an inconsistency in the country analysis but never decreased the quality of the data.



Chapter Five

Analysing the Data

Available data sets obtained from UNICEF were conducted in 1996 (MICS 1), 2000 (MICS 2), and in 2005 (MICS 3). Each of the countries examined herein stipulated the year in which the survey was administered. Northern Sudan was the only country for which data from 2000 (MICS 2) was utilised and analysed. The other countries (Sierra Leone, The Gambia, Cote d'Ivoire, and Ghana) were based on the 2005 MICS 3 data sets. Sudan as a whole was not analysed for the simple reason that the Southern parts were reported to little or no data pertaining to female genital mutilation (Berggren et al, 2006; Department of Immigration and Citizenship of Australia, 2007). Consequently, the northern part of Sudan was included in this study as a separate entity but still reflecting Sudan as a country.

5.1. Northern Sudan

The 2000 documentation of the household survey conducted in Sudan reports vital information regarding female genital mutilation. Sixteen main questions and further sub-questions regarding female circumcision were posed to the females and ranged from knowledge thereof to its level of acceptance to the subsequent consequences. Some of these questions included in the Northern Sudan questionnaire were more specific and were not included in the other countries surveys. According to the MICS data set, of the 22,946 women interviewed, 88.6% had undergone some form of genital mutilation.

5.1.1 Age of the excised women

The following diagram shows the prevalences of female genital cutting among women in North Sudan according to their age group at the time of the survey. The age in completed years were divided into age groups from fifteen to nineteen to forty-five to forty-nine. The chi-square test for association indicated a p-value below 0.005 which means that a significant association exists between age group and excision.

From the dataset it can be found that the age group with the highest female circumcision prevalence is at age forty-seven years with 94.8%, closely followed by women aged forty-nine years old with 93.8% and then the forty-four year olds with 93.3%.

Figure 7: The percentage of women who have undergone excision by age group

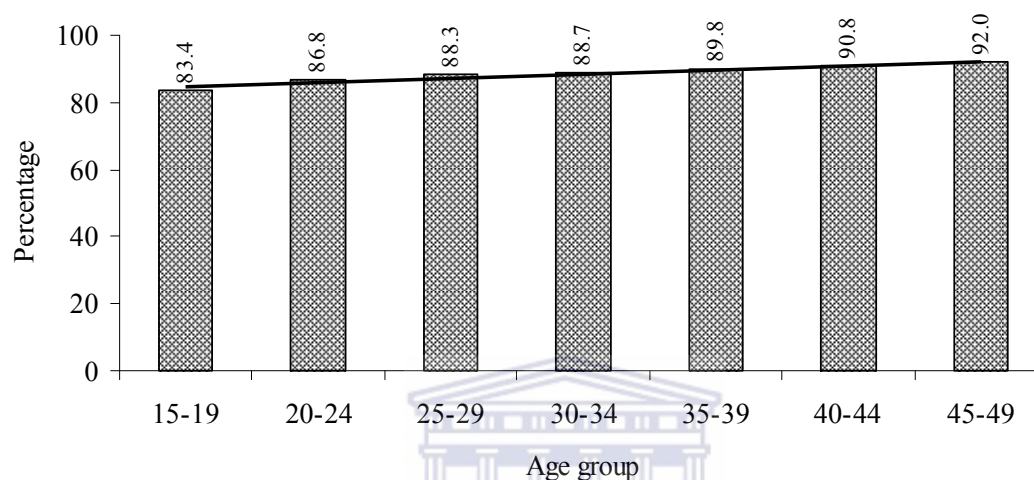


Figure 7, above, depicts the FGM prevalence of woman in North Sudan when they are sorted into age groups. It is noticeable that for each age group the FGM prevalence is above eighty percent and increases slightly as the age groups increase in five year periods. Evidently, the age group with the highest FGM prevalence is age group forty-five to forty-nine. This makes sense since the highest FGM prevalence in age (completed years) falls into the highest FGM prevalence age group as well. However, almost forty percent of the missing data is found in the age group forty to forty-nine. Also, each age group over twenty years old have extremely high female excision prevalences reaching rates well of over eighty-five percent.

When a trend line is inserted in the figure, one can see that the level of female genital mutilation in North Sudan is increasing slightly from left to right. This means that as the ages increase, so too does the FGM prevalence, but only slightly. This also indicates that no generational effect can be noticed since the women who were excised in their twenties, are excised in the same way as those women in their forties. The lower levels of FGM prevalence below the age of twenty may be attributed to the fact that some of those women had not borne any children yet.

5.1.2 Age at which excision was performed

Almost sixty percent of young girls in Northern Sudan were excised between the ages of three and seven years old. This means that approximately sixty percent of unsuspecting young girls were traumatised through genital mutilation before they even began their schooling careers. Approximately eight percent of young girls are reported to have been excised before they turned three years old, while 22.4% of them were circumcised after their seventh birthday. Practicing this irreversible procedure at these young ages, are displays of human rights being taken away from these girls since they were not given the option to refuse or elect this procedure. Since the majority of woman underwent type III mutilation (discussed later), it can be surmised that most young girls are forced to have their genitalia cut and sewn closed before they even entered primary school.

Figure 8: Age at which girls are circumcised

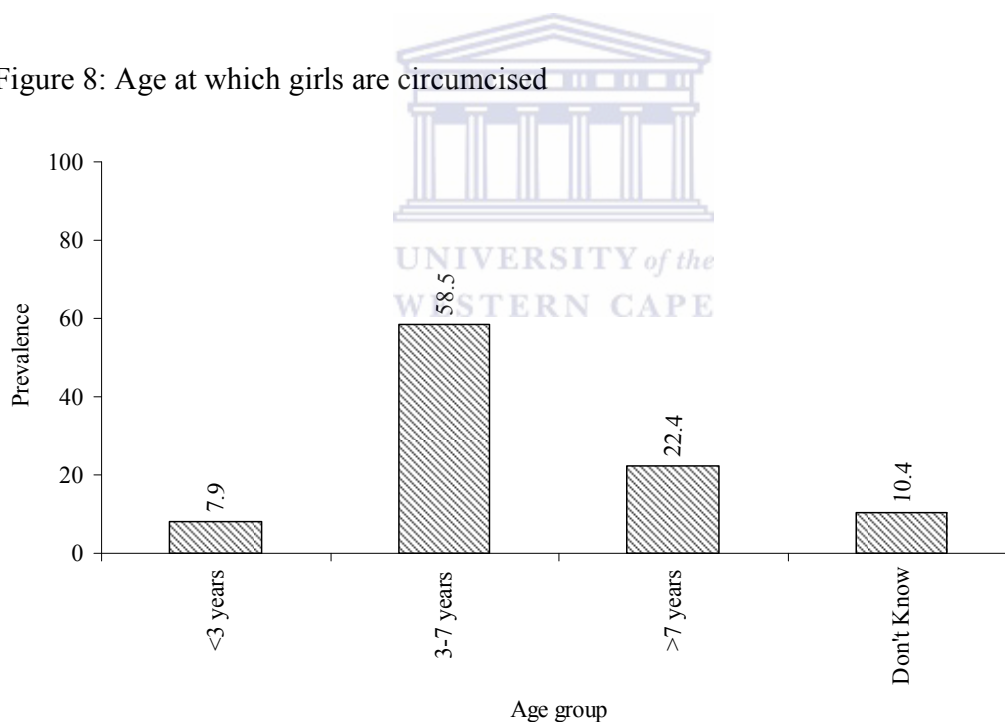


Table gives a clear depiction of the age at which young Northern Sudanese girls are excised within each state. As Figure 8 shows, the greater majority of these girls are excised between three and seven years old. This is the case in most of the Northern states except for Red Sea where 44.7% of girls are excised before age three; Western Kordufan, Northern Darfur, and Southern Darfur where 38.6%, 44% and 64% are excised after seven years old, respectively.

Western Darfur, on the other hand, shows the greatest proportion of girls (46.8%) who did not know at what age they were excised. This means that almost half of the females in Western Darfur could not remember when they had their genital cut. The war zone nature of Western Darfur penetrates all aspects of life. This is visible by the lack of information provided by this group as well as by the inability to gain such, or any, reliable information. The Red Sea state has the highest proportion of excision occurring before age three at 44.7 %, followed by Kassala with 18.1%.

Table 5: Age at which girls are circumcised in Northern Sudan by State

State	<3 Years	3-7 Years	>7 Years	Missing	DK	Total	Population size
Northern	4.6	88.4	5.3	0.1	1.6	100.0	1193
River Nile	10.1	81.9	6.4	0.2	1.4	100.0	1148
Red Sea	44.7	45.9	4.0	0.5	4.9	100.0	1215
Kassala	18.1	64.3	6.8	1.0	9.8	100.0	1255
Al-Gadarif	5.9	63.5	17.2	0.5	12.9	100.0	1292
Al-Gazira	0.4	71.2	25.1	0.2	3.1	100.0	1460
Sinnar	1.6	59.1	25.2	0.6	13.5	100.0	1208
White Nile	4.8	75.0	13.1	0.5	6.6	100.0	1577
Blue Nile	15.0	55.2	11.0	0.4	18.4	100.0	1326
Khartoum	5.8	61.6	22.0	2.0	8.6	100.0	1350
Northern Kordufan	3.9	77.5	16.7	0.8	1.1	100.0	1312
Southern Kordufan	10.3	59.4	20.9	0.4	9.0	100.0	1443
Western Kordufan	1.9	48.0	38.6	1.9	9.6	100.0	1375
Northern Dafur	0.1	49.0	44.0	0.4	6.5	100.0	1297
Southern Dafur	0.1	21.5	64.4	1.5	12.5	100.0	1269
Western Dafur	0.3	16.6	35.7	0.6	46.8	100.0	612
Total	7.9	58.5	22.4	0.8	10.4	100.0	20332

5.1.3 Types of female circumcision practiced

Three main types of female excision surfaced from this survey including Pharonic (type III), Sounna (type I), and Intermediate (type II). The distribution of the type of female genital cutting received can be seen in the following pie chart.

Figure 9: Distribution of the type of female circumcision received

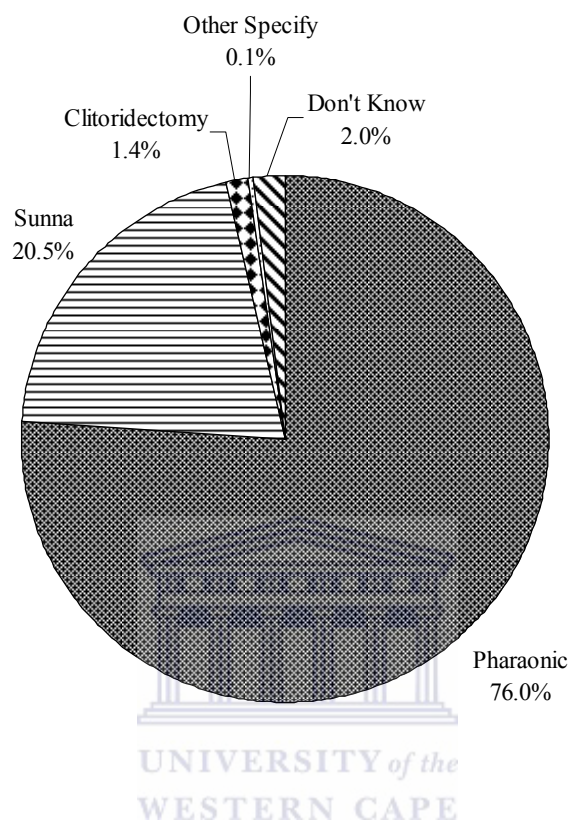
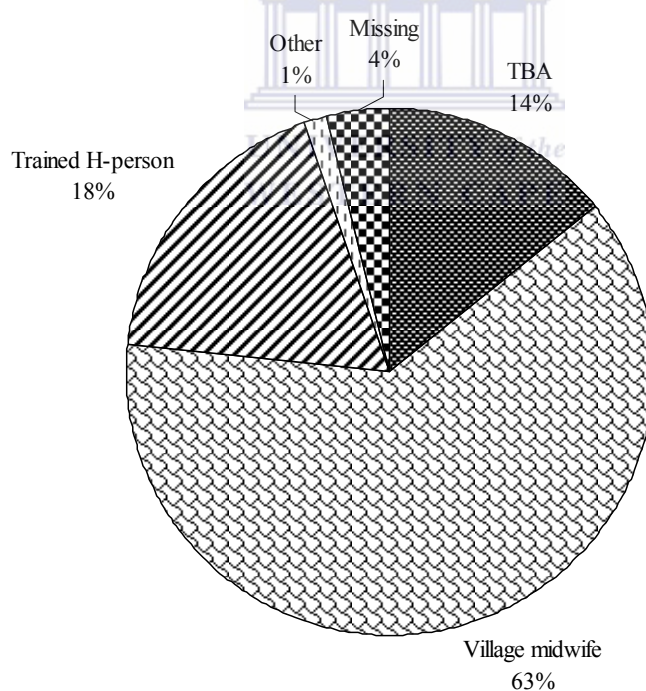


Figure 9, above, shows that more than three quarters (seventy-six percent) of all the women who have been excised in Northern Sudan have undergone the Pharaonic procedure, while 20.5% experienced the Sunna and a minor 1.4% had the intermediate, or clitoridectomy, procedure done. Two percent of these women did not know which type of procedure was done to them, only that they were excised in some way. It is clear that the majority of the Sudanese women were subjected to the most severe form of female genital mutilation. The context of the MICS 2 questionnaire unfortunately does not shed light on the reasons why the Sudanese prefer type III mutilation over the other forms; neither does it allow the females to explain the reason for this tradition in the first place. One may thus conclude that the two more severe forms of excision (type II and type III) are the predominant methods of protecting the woman's perceived chastity and loyalty, as well as maintaining the generational traditions and/or customs.

5.1.4 Person who performed the operation

The most commonly used practitioner who performs this operation on young girls was found to be the village midwife. Almost two thirds of the women who have been excised in Sudan have been excised by their village midwife. A possible reason for the frequent use of the village midwife may be as simple as location. It may be easier to obtain the services of the village midwife if she resides in the same district as the family seeking this type of operation. It may also be that the village midwife knows the family on a personal level and thus the outcome of the operation may be more satisfactory to all parties concerned. Another possibility may be that in the past it was mainly the duty on the village midwife to perform this operation and thus they are more sought after in more recent times.

Figure 10: Distribution of the person who performed the excision



Thereafter, a trained H-person and a traditional birth attendant (TBA) are commissioned at eighteen percent and fourteen percent respectively to perform the FGM operation. Unfortunately, the grounds for asking a TBA and/or a trained H-person are also not stated

since the choice of practitioner was not included in the questionnaire. Personal preference may be the dominant force when choosing a person to perform such a severe but delicate operation.

5.1.5 State

Upon investigating the prevalence of female genital mutilation within the sixteen northern states of Sudan, it is clear that Western Darfur has the lowest prevalence and is the only state in which the number of women who have been excised (47.6%) is lower than those who have not been excised (52.2%). All the other northern states have exceedingly higher excision prevalences among the women, which can be seen in Figure 11. The genocide taking place in Darfur (reportedly to have commenced during 2003), particularly in the west, has created many problems for the residents and consequently, data attainment has taken a back seat (International Crisis Group, 2008). IDP camps were set up during this continuous war which made data collection less attainable and less reliable. However, the situations in Western Darfur may have weakened the possibility of practicing female genital mutilation within such IDP camps. Consequently, the excision data for Western Darfur shows massive differences from the rest of North Sudan.

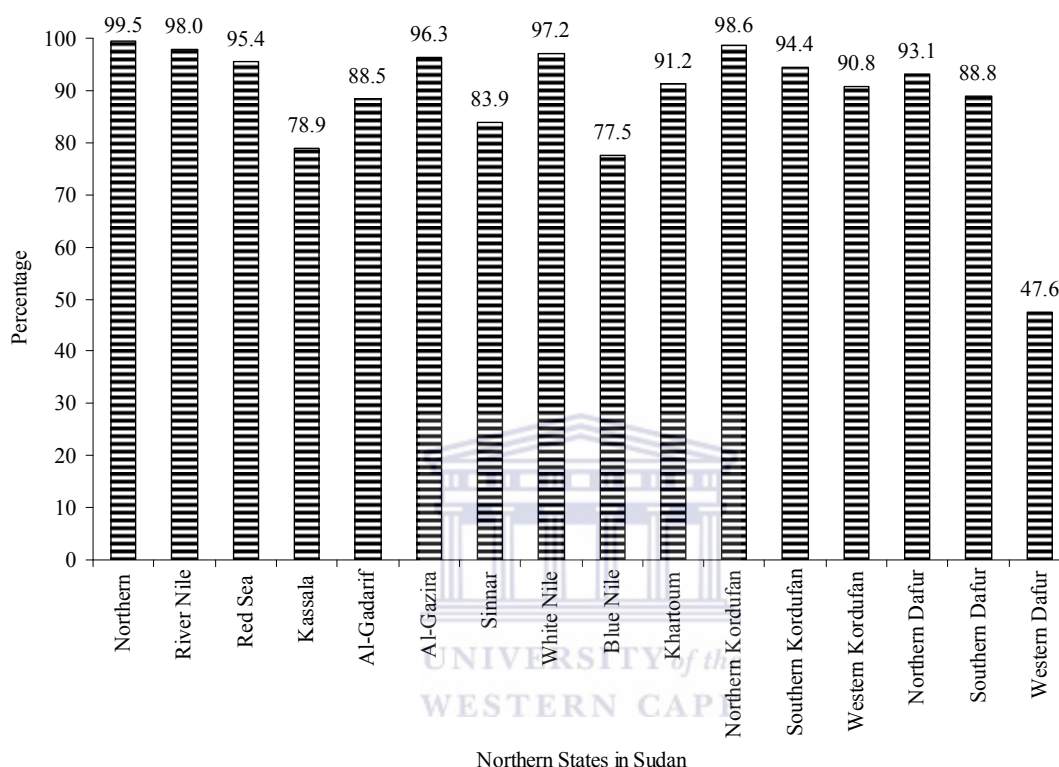
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The Northern state (99.5%) had the highest female excision prevalence in Northern Sudan, followed by Northern Kordofan with 98.6 percent and then River Nile with ninety-eight percent of women been excised within the state. This shows that these three states have almost universal FGM prevalences, which highlights the magnitude of this problem in North Sudan. More than sixty-six percent of each of these three states is rural settlements. Khartoum (66.7%) and Red Sea (61.5%), on the other hand, are the only two states in Northern Sudan in which the urban settlements outweigh the rural settlements. Even though this is true, Khartoum and Red Sea have female excision prevalences above ninety-one percent and ninety-five percent, respectively.

The association test performed in SPSS reported a p-value below 0.005 which indicated that the association between state and excision was significant. The null hypothesis was thus

rejected and one could deduce that region did in fact have some influence on the excision levels.

Figure 11: Female excision within the Northern States



5.1.6 Urban/Rural settlement

The majority of Northern Sudan is made up of rural settlements. In most states approximately one third is made up of urban settlements while the other approximate two thirds are rural settlements. Only Red Sea and Khartoum have higher proportions of urbanisation of 61.5 percent and 66.7 percent, respectively.

The Northern state has almost universal excision prevalence in both the rural and the urban settlements. In Red Sea and Khartoum, where the urban population is greater than the rural population, the excision prevalence is approximately six percent and eleven percent higher in the rural parts, respectively. In Western Darfur, just less than thirty percent of rural settlers have undergone excision, whereas more than eighty-five percent of its urban counterparts have

been excised. The phenomenon in which the greater part of Western Darfur is rural but excision is much more prevalent in the urban community may be attributed to the fact that Sudan has been at war for more than five decades to which Western Darfur has received the worst of it (International Crisis Group, 2008). The continuous war has left the states of Darfur in rural settlements over the past few years, which does not correspond with the MICS 2 data set. Might this disparity be due to the need to portray a more favourable situation in Darfur than what actually exists?

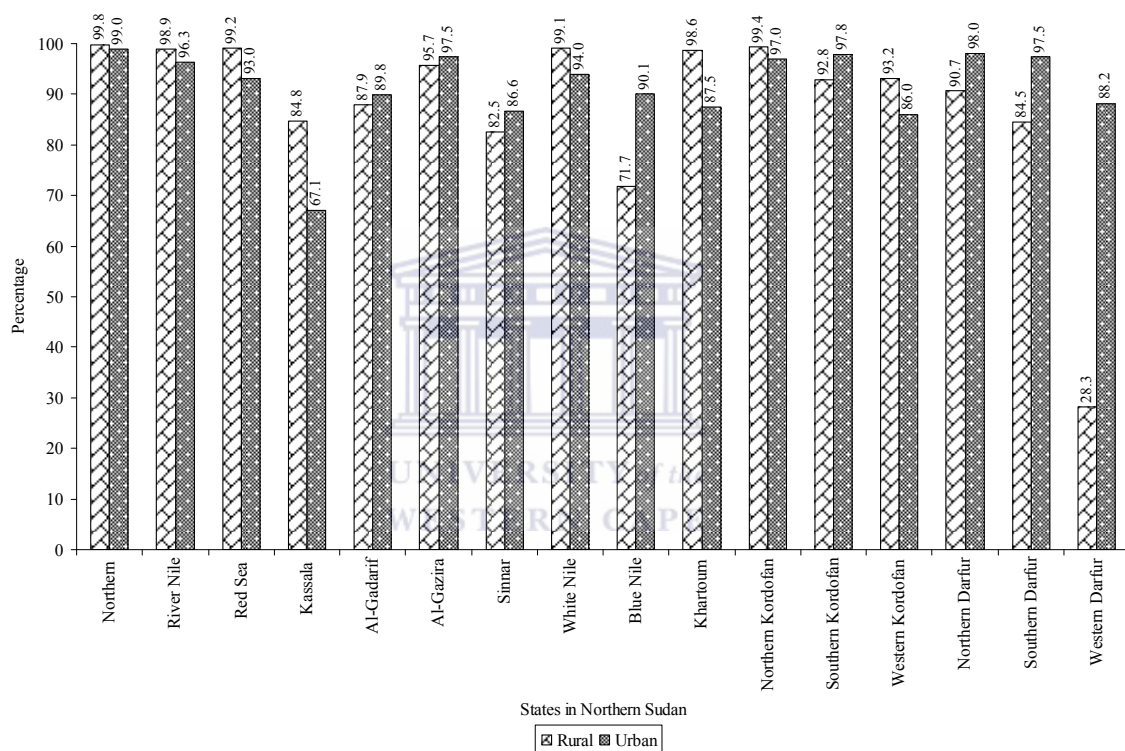
Table 6: Proportions of urbanisation in Northern Sudan

State	Urban (%)	Rural (%)	Total	Population size
Northern	33.1	66.9	100.0	1199
River Nile	32.3	67.7	100.0	1172
Red Sea	61.5	38.5	100.0	1274
Kassala	33.3	66.7	100.0	1590
Al-Gadarif	32.2	67.8	100.0	1460
Al-Gazira	32.1	67.9	100.0	1516
Sinnar	33.7	66.3	100.0	1440
White Nile	37.8	62.2	100.0	1623
Blue Nile	31.3	68.7	100.0	1711
Khartoum	66.7	33.3	100.0	1480
Northern Kordofan	30.4	69.6	100.0	1330
Southern Kordofan	32.8	67.2	100.0	1528
Western Kordofan	33	67	100.0	1514
Northern Darfur	33.1	66.9	100.0	1393
Southern Darfur	33.3	66.7	100.0	1429
Western Darfur	32.2	67.8	100.0	1287

Upon examining the FGM prevalence among the females in the urban areas during 2000, a pattern of consistency is noticed. This means that there are no real differences in the level of excision in the urban areas of North Sudan. Therefore, the women in these urban areas underwent excision approximately evenly, except for Kassala which showed a vast difference

in FGM prevalence in the urban settlements as compared to the other states. Kassala has an urban FGM prevalence level of at least ten percentage points lower than all the other Northern states. The chi-square test validated the association between the areas of settlement of the excision with a p-value of 0.000 but when one examines Figure 12, only three states have disparities between urban and rural excision.

Figure 12: Proportion of excised females in each Northern state by settlement area



The rural areas, however, show a slightly different trend in FGM prevalences. This differing trend can be seen most in Western Darfur which has the lowest rural FGM levels. For each state, however, only three shows major differences between the FGM prevalences for urban and rural settlements. They include Kassala, Blue Nile and Western Darfur. On average, the level of FGM in urban areas is slightly higher than that of the rural areas which indicates that the area of settlement does not play a major role in the levels of FGM in North Sudan since the levels across urban and rural settlements appear consistent.

5.1.7 Education level

The education level of the women in Northern Sudan was fairly low. In terms of the literacy levels, only thirty percent of females aged fifteen to forty-nine could read a newspaper easily, while more than fifty-seven percent could not read it at all. The dataset depicted that women aged twenty to twenty-four years had the highest levels of school attendance. Alarming, girls aged fifteen to nineteen years had lower levels of schooling than those aged twenty to twenty-four. All age groups have school attendance below fifty percent.

Table 7: Female school attendance by state

State	Ever attended school (%)	Never attended school (%)	Missing	Total	Population size
Northern	65.1	34.7	0.2	100	1199
River Nile	64.2	34.9	0.9	100	1172
Red Sea	37.5	61.6	0.9	100	1274
Kassala	25.9	73.7	0.4	100	1589
Al-Gadarif	26.8	72.5	0.6	100	1460
Al-Gazira	44.1	55.6	0.3	100	1515
Sinnar	35.0	64.5	0.5	100	1438
White Nile	48.3	51.5	0.2	100	1620
Blue Nile	26.9	72.2	0.9	100	1707
Khartoum	58.1	41.3	0.5	100	1479
Northern Kordofan	23.0	76.8	0.2	100	1329
Southern Kordofan	37.5	61.6	0.9	100	1526
Western Kordofan	26.8	72.3	0.9	100	1510
Northern Darfur	37.7	61.9	0.4	100	1393
Southern Darfur	31.2	68.3	0.5	100	1428
Western Darfur	21.9	77.8	0.4	100	1286

The Northern state had the highest level of female school attendance of 65.1 percent, followed by River Nile at 64.2 percent. This was surprising since these two states were more rurally populated than urbanised (see Table 6, pg 49). The lowest level of school attendance was in Western Darfur with 21.9%, which also represented the state that had the lowest level of reported female excision. In fact, Western Darfur was the only Northern state in Sudan that had a higher level of female non-excision as opposed to all other fifteen states. Northern

Kordofan had the second lowest female school attendance level of twenty-three percent as well as the lowest level of urbanisation in Northern Sudan at 30.4 percent. On average, less than forty percent of females aged fifteen to forty-nine had ever attended school in their lives. When a cross tabulation was conducted with those females who ever attended school and the number of females that were excised, the following was found (Table 8):

Table 8: Proportion of schooled females who undergone excision

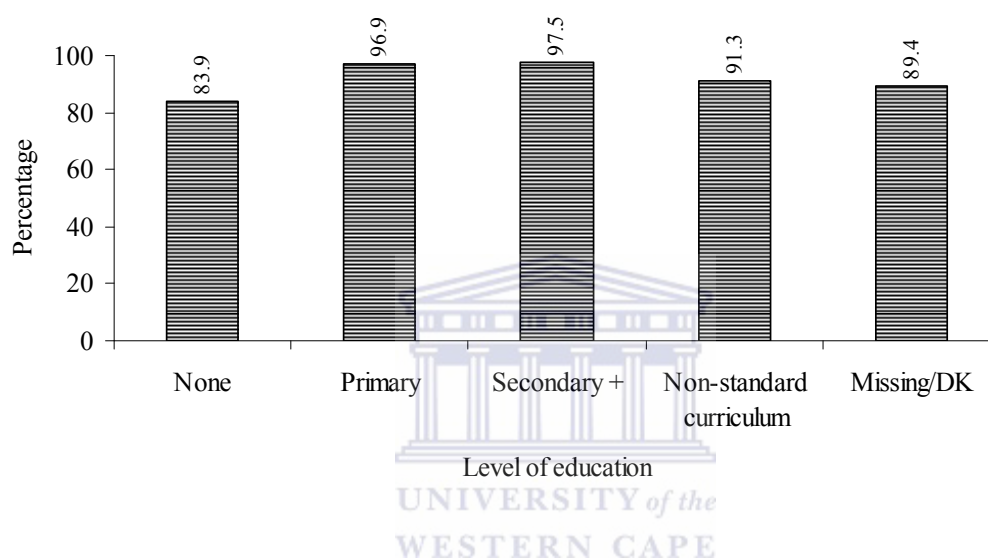
	Excised (%)	Not excised (%)	Missing (%)	Total	<i>Population size</i>
Attended school	96.0	3.5	0.5	100.0	7645
Did not attend school	84.2	15.0	0.8	100.0	12565
Total	88.6	10.7	0.7	100.0	20332

One could see that of those females who have attended school, ninety-six percent had undergone female genital mutilation. Of those who have not attended school, a high prevalence rate was also seen at 84.2%, but was approximately twelve percentage points lower than those who have attended school. When the female level of education was controlled for, the level of excision could be seen in Figure 13. One could see that the FGM prevalence among those women according to their level of education was fairly consistent but increased slightly with primary and secondary level. It could also be seen that for each age group the level of FGM prevalence was higher for those women who have attended school than for those women who have never attended school. This phenomenon may have resulted from the fact that there were almost five thousand more females who have never attended school than females who have attended school (see Table 8). It seemed as though those women who have never attended school have been excised less than those women who have attended school. One would have expected the results to be in the reverse since education is expected to lower the levels of FGM and not increase them.

The SPSS chi-square test reported a significant level of association between education level and excision, since the p-value was 0.000. The cross tabulation of females who have been mutilated with the highest school level attained and the highest grade completed, respectively, showed the following effect. For those females who have only attained preschool level, the

FGM prevalence (seventy-six percent) was approximately twenty percentage points below the FGM prevalences for those who have attained a higher than preschool level of education. Similarly, those women who had less than grade one had FGM prevalences (seventy-nine percent) approximately ten percentage points lower than the rest.

Figure 13: Proportion of excised females according to their level of education

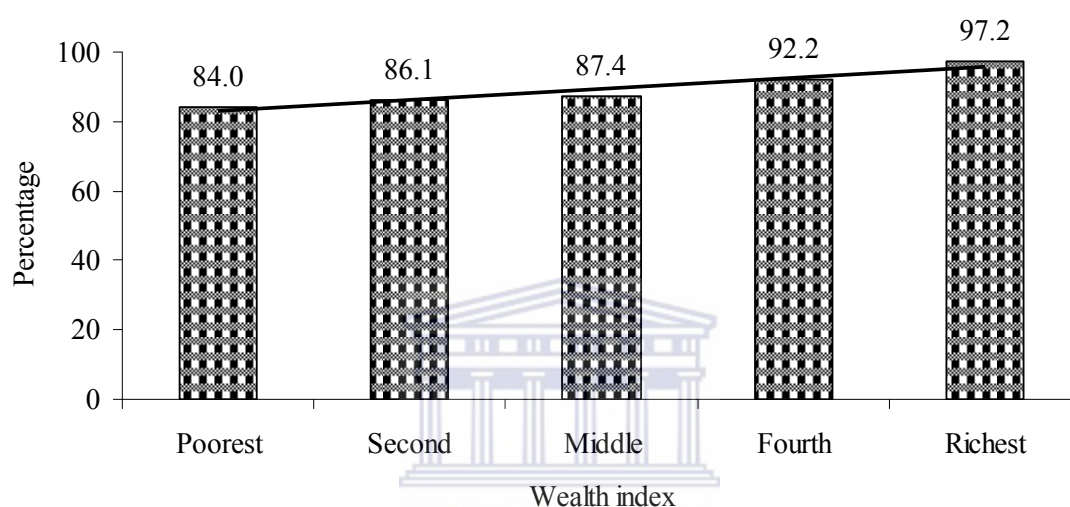


5.1.8 Socioeconomic Status

The socioeconomic status of females aged fifteen to forty-nine was divided into five categories from poorest to richest. Figure 14 is a representation of the proportion of females who have undergone excision according to their wealth index. It could be seen that the FGM prevalence increased with the female's level of wealth. The poorer women were excised the least of all the categories and the richest were excised the most. For each increase in the wealth index, so did the increase in FGM prevalence. This therefore meant that the richer the female, the more likely she was to have undergone excision and the poorer the females, the less likely they were to have undergone excision. Even though there was a positive relationship between wealth and FGM prevalence, the levels of female genital cutting were all higher than eighty-four percent.

The cross tabulation of wealth status and the person who performed the excision operation highlighted the fact that the wealthier females preferred using the services of a trained H-person as opposed to a traditional birth attendant. The poorer females were in the reverse but all woman used village midwives the most. The association between wealth index and excision was validated with the chi-square test that reported a p-value below 0.005.

Figure 14: Proportion of excised females according to their wealth index



5.1.9 Level of acceptance

The vast majority (78.4%) of women who have undergone the excision procedure were in fact in favour thereof, while 21.3 percent do not appreciate the genital mutilation tradition. On the other hand, of those women who have not been excised, 10.2 percent of them were in favour thereof while almost ninety percent were not. This implied that the probability of women being in favour of female excision was high when the excision prevalence was high and vice versa. A positive relationship thus emerged between excision prevalence and the appreciation thereof.

Table 9: Proportion of females who appreciated excision

	Appreciate excision (%)	Did not appreciate excision (%)	Missing	Total	<i>Population size</i>
Excised	78.4	21.3	0.3	100.0	20332
Not excised	10.2	88.8	1.0	100.0	2454
Missing	42.1	16.4	41.5	100.0	159
Total	70.8	28.5	0.7	100.0	22945

It was quite clear that there was a huge difference in the population size of those excised women and those non-excised women. The impact thereof was that although almost ninety percent of non-excised woman did not appreciate this procedure, they made up only ten percent of the female Sudanese population aged fifteen to forty-nine. Since 88.6 percent of women have been excised, 69.5 percent of all women appreciated FGM. This, in tern, implied that approximately seventy percent of North Sudanese women would continue practising FGM since they approved thereof. Unfortunately, this outcome implied that the FGM tradition was deeply rooted within these women's culture. The fact that so many women who have been excised believed in this practice meant that the tradition would trickle down through the generations to their daughters and their daughter's daughters.

5.1.10 Husbands' opinion

When comparing the amount of women who conversed with their husbands about female excision, those women who have heard about FGM and those who have undergone FGM, had roughly the same results. Less than forty percent of women spoke to their husbands about the excision procedure. The female's reasons for talking or not talking to their husbands about FGM were uncertain. This lead one to assume that female genital cutting was more a female issue than a family one. This also meant that when the women never spoke to their husbands about female genital cutting, more than sixty-five percent of males did not have an opinion thereof. But when the women spoke to their husbands about female genital cutting, almost seventy percent agreed with the tradition (see Table 10). On the other hand, twenty-two percent of males agreed with FGM even if their wives had not spoken with them about this topic.

One could also note, from Table 10, that majority of all the husbands have said that they did not know what their opinion about female genital mutilation was. This could either have meant that they did not want to disclose their true feelings, which was less likely, or they did not have an opinion simply because their wives have not discussed this procedure with them. On the other hand, the proportion of husbands that agreed with the FGM practice was not vastly different to those males who did not have an opinion. This meant that 38.4 percent of husbands agreed with the FGM tradition, just four percentage points less than those males who did not know.

Table 10: Proportion of husbands who agreed with excision when their wives discussed the topic with them

	Women spoke to their husbands (%)	Women never spoke to their husbands (%)	Missing	Total	Population size
Husband agrees	68.3	22.1	2.7	38.4	8811
Husband disagrees	29.0	10.7	11.0	17.3	3960
Missing	0.3	2.0	69.4	2.0	466
Don't Know	2.4	65.2	16.9	42.3	9708
Total	100.0	100.0	100.0	100.0	22945

Table 11 shows that majority of women who have been excised never spoken to their husbands about female genital cutting. This meant that approximately four out of five excised women did not discuss FGM with their husbands. It was thus conceivable that when women did not speak to her husband about FGM, he had no opinion thereof. And even less women spoke about this topic with their husbands when they had not been excised.

Table 11: Proportion of women who have undergone excision and discussed the topic with their husbands

	Excised (%)	Not excised (%)	Missing	Total	<i>Population size</i>
Talked to husband	38.6	12.1	19.5	35.6	8170
Did not talk to husband	61.0	84.8	41.5	63.4	14556
Missing	0.4	3.2	39.0	1.0	219
Total	100.0	100.0	100.0	100.0	22945

Table 12 provides a picture of the husband's opinion according to his wife's excision status. One could see that the majority of husbands agreed with female genital cutting when their wives were excised, while the majority of husbands did not have an opinion when their wives were not excised.

Table 12: Proportion of husbands who agree with excision when their wives are excised

	Excised (%)	Not excised (%)	Missing	Total	<i>Population size</i>
Husband agrees	42.4	5.8	23.9	38.4	8811
Husband disagrees	15.3	33.9	10.1	17.3	3960
Missing	1.7	2.6	40.8	2.0	466
Don't Know	40.6	57.7	25.2	42.3	9708
Total	100.0	100.0	100.0	100.0	22945

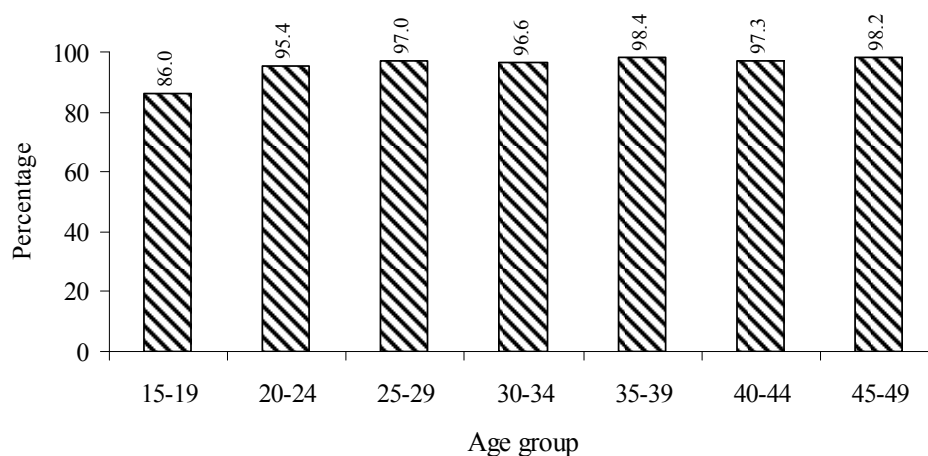
5.2. Sierra Leone

The vast majority of women in Sierra Leone belong to a secret society. Their initiation into this society takes place between the ages of eight and eighteen. This secret society is known as the Bondo Society. Due to this intense secrecy, the questions regarding female genital cutting were altered to ensure high response rates. Therefore, the Bondo Society served as a proxy for questions pertaining to female genital mutilation. For example, the first question in the female genital cutting module was rephrased from: *Have you heard of female circumcision?* to: *Have you heard of the Bondo Society?* Questions such as: *Have you been circumcised* and *Who performed the operation* changed to: *Are you a member of the Bondo Society* and *Who initiated you*, respectively. The MICS 3 (2005) questionnaire only included eight of the sixteen questions relating to female genital cutting mainly due to the extreme level of secrecy among the women. Of the 9 257 eligible women aged fifteen to forty-nine in the households, 7 655 women were successfully interviewed, and ninety-four percent of those interviewed had undergone some form of excision.

5.2.1 Age of the excised women

The eligible women between ages fifteen and forty-nine were grouped together to form the age groups from fifteen to nineteen, twenty to twenty-four, twenty-five to twenty-nine as so on. Figure 15 shows the prevalence of female genital mutilation in Sierra Leone during 2005 for each age group.

Figure 15: Proportion of excised females according to their age group



Since the overall FGM prevalence rate was estimated at ninety-four percent, the prevalences among the age groups showed no major differences, except for the age group fifteen to nineteen. This group of women had more than twenty percentage points lower than the other age groups. It thus indicated that once the girl became an adult (reached her eighteenth birthday) the probability of her belonging to the Bondo Society (being excised) increased. Although the chi-square test proved that the association between age group and excision was significant, the high levels of female genital cutting showed that age may not have been a leading influencing factor for excision.

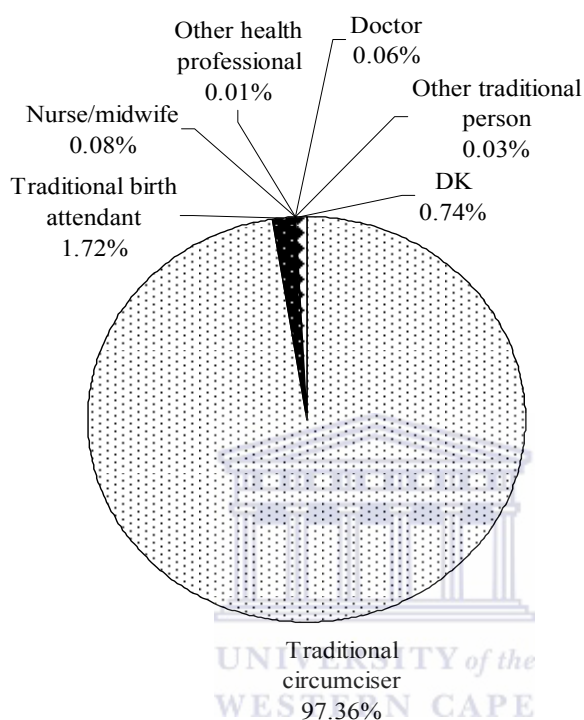
Since a mere eight questions were asked in the female genital cutting module, little information could be gathered and thus only a few variables were analysed. The type of mutilation was not included in the questions and therefore could not be analysed, nor was it possible to identify complications resulting from the excision. The final report produced by UNICEF and Statistics Sierra Leone stated, however, that the responses regarding the continuation of the Bondo Society should NOT be considered as equivalent to the continuation of female genital cutting (2007). The reason for this relates to the fact that the topic of excision was not explicitly addressed. Consequently, the interviewers were unable to distinguish whether the respondent wanted to end the Bondo Society as a whole or merely that part of the Society which calls for excision as the main initiation event into the Secret Society. The use of the Bondo Society as a proxy in this aspect proved to be less efficient.

5.2.2 Person who performed the “initiation”

In Sierra Leone, more than ninety-seven percent of females reported that they were initiated into the Bondo society by a traditional circumciser, while less than two percent used the services of a traditional birth attendant. Unfortunately, the reasons for preferring the traditional circumciser were not asked in the survey but it seemed most likely that when a girl was excised, the appropriate person for the job would have been the traditional circumciser (since this ‘occupation’ existed). One could also expect that when mothers brought their daughters to be initiated into the Bondo society, they too would use the traditional

circumciser. This was found to be true when the dataset was analysed. Figure 16 represents the distribution of practitioners who were asked to perform the initiation on the respondents.

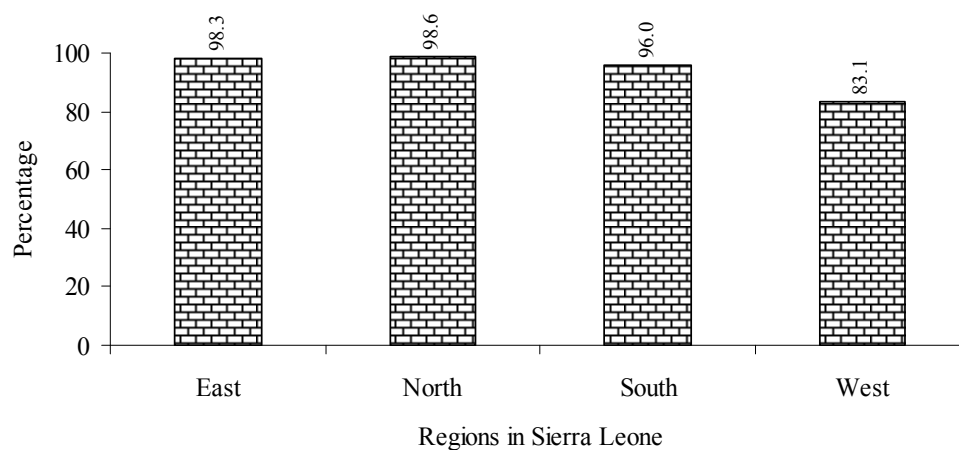
Figure 16: Distribution of person who performed initiation on respondent



5.2.3 Region

The four regions in Sierra Leone included the North, South, East and West. From Figure 17 one could see that the North, East and South regions had FGM prevalences well over ninety percent. The Western region of Sierra Leone, however, had the lowest level of FGM prevalence at about eighty-three percent. This was more than thirteen percentage points lower than the other three regions in Sierra Leone. During the cross tabulation process, the chi-square test was performed, and a p-value below 0.005 was obtained. One could therefore deduce that the association between region and excision is significant. However, the row percentages were somewhat consistent, making it difficult to see the source of the association.

Figure 17: Proportion of excised females in each region



5.2.4 Settlement Area

Approximately seventy-two percent of Sierra Leone was made up of rural settlements, while the other twenty-eight percent was urban. The distribution of urbanisation could be seen in Table 13, below. One could easily notice that the most rural region was the North region at 87.4 percent, followed by the South region at 80.7 percent and then the East region at about seventy-five percent. The Western region was almost completely urban reaching 97.7 percent. Perhaps this may have been the reason that the Western region had the lowest level of female genital cutting.

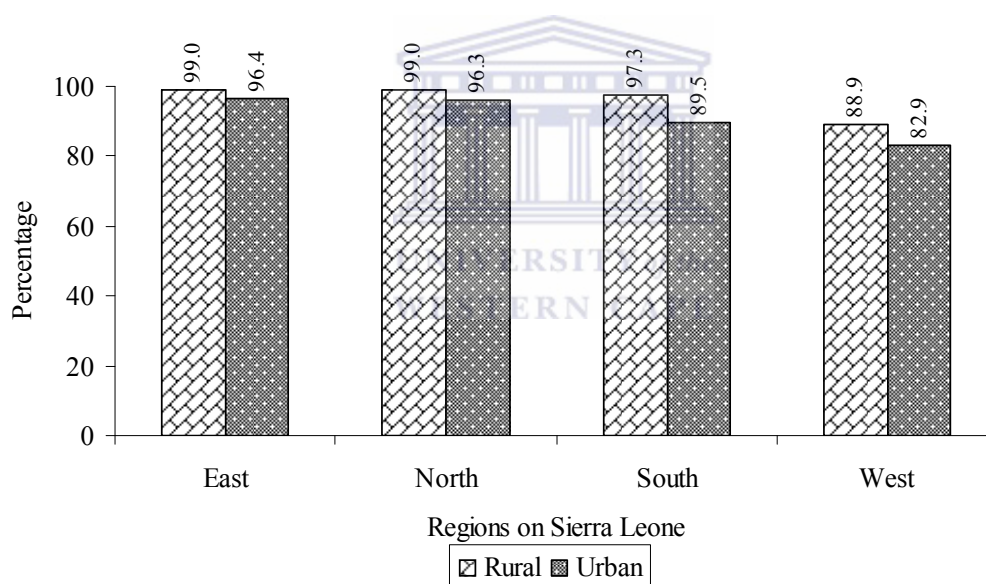
Table 13: Proportion of urbanisation within each region

Region	Rural	Urban	Total	<i>Population size</i>
East	75.2	24.8	100.0	2281
North	87.4	12.6	100.0	3548
South	80.7	19.3	100.0	2202
West	2.3	97.7	100.0	1226
Total	71.6	28.4	100.0	9257

Almost the entire rural community of females belonged to the Bondo society, which meant that more than ninety-eight percent of rural females have been excised in some way. Urban females also showed a high FGM prevalence reaching eighty-eight percent.

Figure 18 is a representation of the proportion of excised females in Sierra Leone according to their area of settlement for each of the four regions. Seventy-five percent of the Eastern region was made up of rural females and among them ninety-nine percent have undergone excision. Of the twenty-five percent urban females in the Eastern region, approximately ninety-six percent have been excised. This meant that even though the rural women made up much more of the Eastern region, females were excised almost the same in this region of Sierra Leone.

Figure 18: Proportion of excised females in each region by settlement area



The Northern region had the highest concentration of rural females of the four regions. The proportion of rural females that have been excised was almost universal and reached ninety-nine percent. The proportion of urban females in the North were approximately twelve percent and of them, more than ninety-six percent have undergone excision. Again, area of settlement seems not to influence the way in which they excised their females. The South and West regions have similar patterns but 97.7 percent of the Western region was urban. This did not,

however, change the way females were excised. There was a slight difference in rural and urban FGM prevalences in that rural females are excised slightly more than urban woman but this may purely have been a result of the absolute size of the rural population

5.2.5 Religion

It was appropriately considered that the family assumed the same religious affiliation of the head of the household. This meant that the women took on the religious beliefs of her husband and Figure 19 depicts the religious distribution in Sierra Leone. Approximately seventy-eight percent of the women were considered as Muslims because the head of their household was Muslim. Twenty-two percent was Christians and the minute remainder was made up of traditionalists, other religions or no religious affiliation. Approximately eighty-nine percent of all Christian women aged fifteen to forty-nine underwent the initiation process of excision, whereas more than ninety-five percent of the Muslim women, in the same age group, were reported to be excised during 2005.

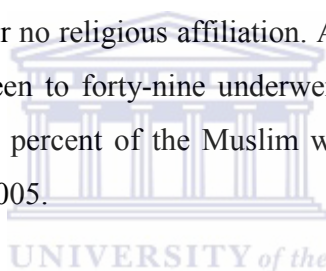
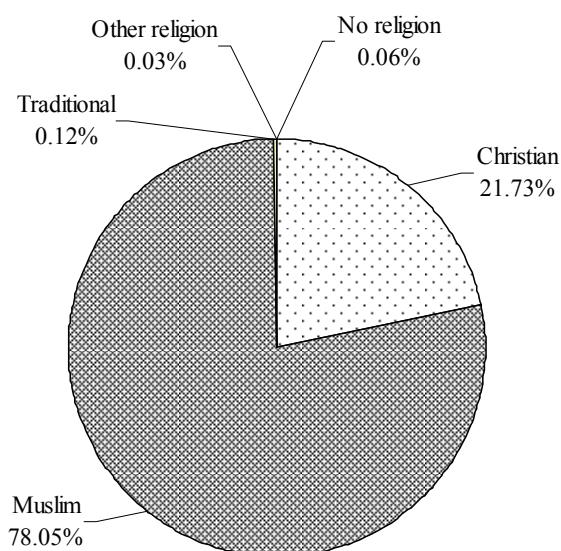
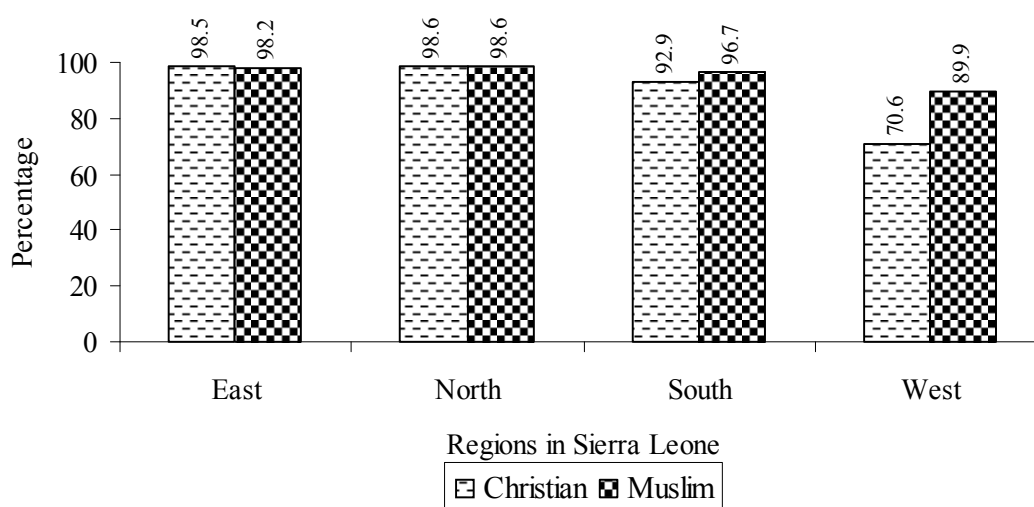


Figure 19: Distribution of religion of the head of household in Sierra Leone



Since the two dominant religious groups in Sierra Leone were Muslims and Christians, only these two were included in the analysis. Figure 20 represents the proportion of excised females in each region according to their religious affiliation. One could easily see that the three dominantly rural regions had similar FGM prevalences for Muslims and Christians. Seventy-three percent of the Eastern region was made up of Muslims, while the other twenty-seven percent were Christian. Even though the Eastern region was predominantly Muslim, the Muslim and Christian females were excised almost exactly the same. The same could be said about the Northern and Southern regions. All three of these regions were predominantly Muslim but all three regions had similar FGM prevalences according to their religion. The Western region, however, showed more variation. Approximately sixty-four percent of the Western region was Muslim; at least ten percentage points less than the other three regions. Much less Christian females (70.6%) were excised in the Western region as compared to the Muslims (almost 90%). In Western Sierra Leone, one could deduce that the religion of the head of the household had some influence on the proportion of women that were excised. More Muslim women were excised than Christian women in the Western region. The chi-square test for association yielded a p-value below 0.005. This meant that religion and excision was associated.

Figure 20: Proportion of excised female in each region according to their religion

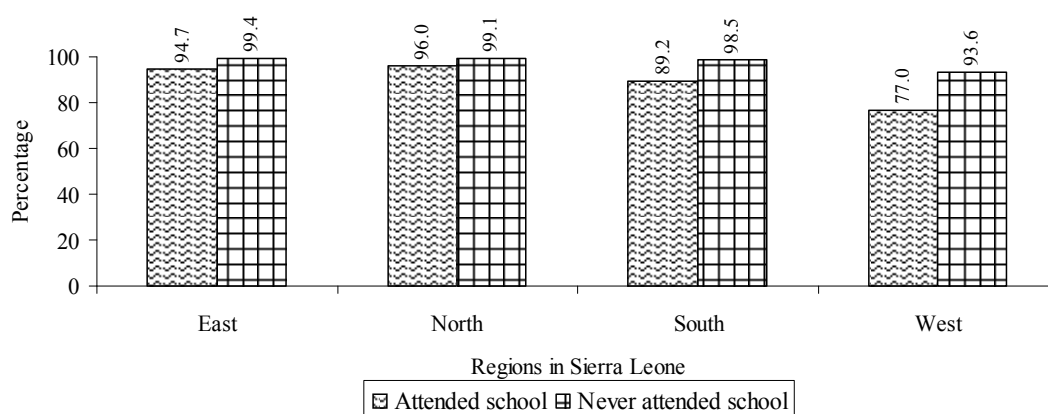


5.2.6 Education level

Females in Sierra Leone aged fifteen to forty-nine were reported to be poorly educated. The literacy level of the females was examined by asking whether or not the females could read part of a sentence. Approximately ninety-five percent of women could not read at all and more than seventy-two percent of females had not attended school. Since majority of the country resided in rural settlements, the lack of schooling may have been a resulting factor.

In each of the four regions, the proportions of females who have never attended school have higher prevalences of female genital cutting than those who have attended school. The biggest difference was noticed in the Western region where a sixteen percent difference existed. In order to be certain that education influenced the level of excision, the actual education levels were further analysed. Seventy-three percent of all females had no formal education, while only eleven percent attained primary level education and sixteen percent attained secondary level and higher. This confirmed that the female level of education in Sierra Leone was very low.

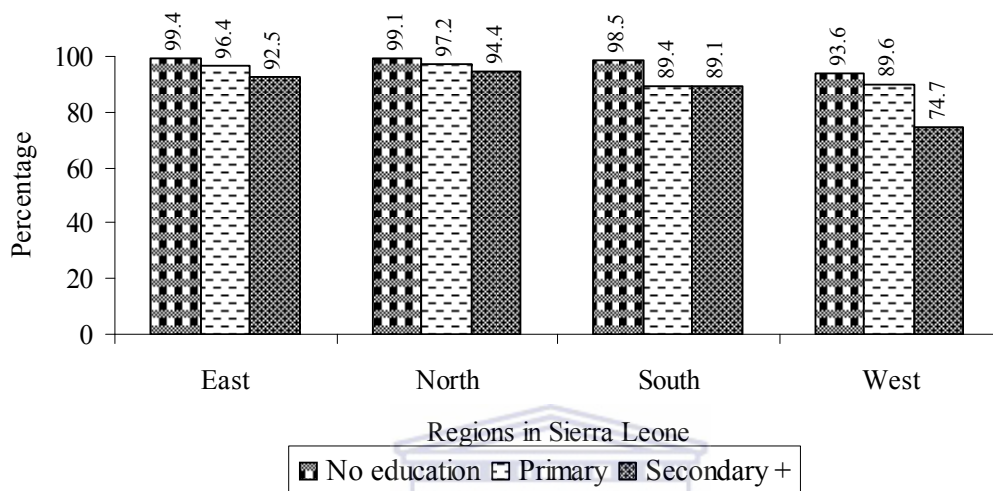
Figure 21: Proportion of excised females in each region according to school attendance



When each education level was further analysed, it was noticed that the highest level of excision occurred within the uneducated female community. A trend line showed a negative relationship between education level and FGM prevalence. This meant that the more educated women of Sierra Leone had lower levels of excision, even though the overall FGM prevalence was high. The region which showed the biggest difference in excision levels, due to increased

education levels, occurred in the Western region. With a p-value of 0.000, the association between education and excision was validated.

Figure 22: Proportion of excised females in each region according to level of education



5.2.7 Socioeconomic status

The distribution of females in Sierra Leone according to socioeconomic status depicted a fairly even spread among the four indexes. The poorest females made up the smallest portion of the five wealth indexes but were characterised with the highest level of excision in the country. Although the FGM prevalences were extremely high for all wealth indexes, the richest women had the lowest level of excision. A pattern was seen depicting a negative relationship between wealth index and FGM prevalence. This meant that the poorer communities had higher levels of excision and the richer females had lower levels thereof.

Figure 23: Proportion of excised females according to their wealth index

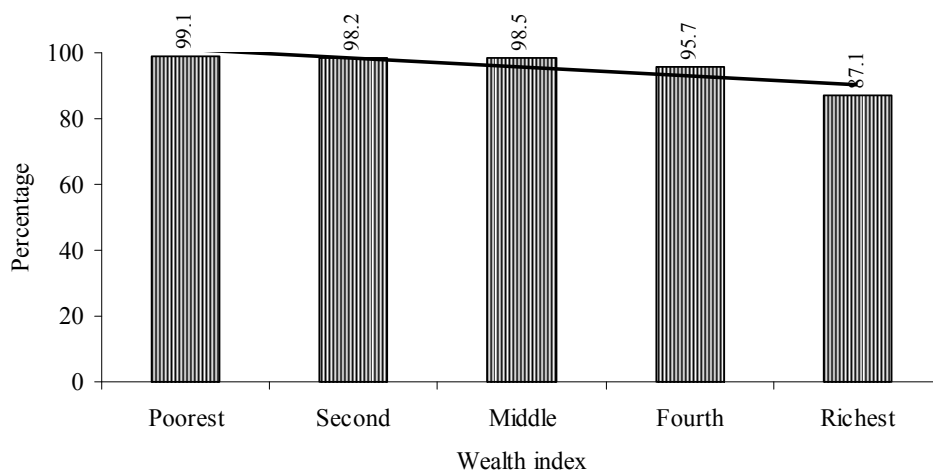


Figure 23 gives a clear indication that almost all females who fell into the poorest socioeconomic category had undergone some form of female genital cutting. As the wealth of the individual increased, the proportion of females who were subjected to female genital cutting decreased. The trend line therefore represented this negative relationship. Since the Western region was predominantly urbanised, it was understandable that one found most of the rich families residing in the Western region. Approximately fifty-six percent of the rich individuals were found in Western Sierra Leone. The North and South regions were fairly evenly made up of all five wealth indexes, while the poorest region was Eastern Sierra Leone.

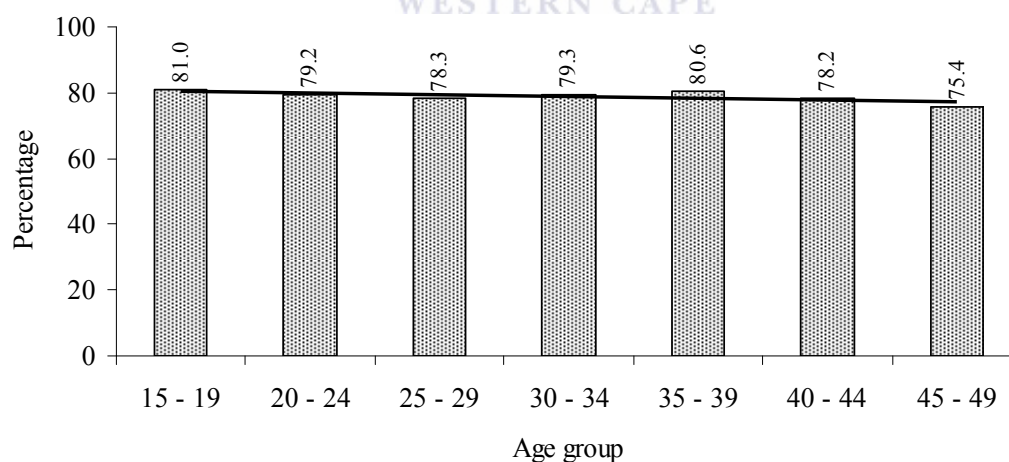
5.3. The Gambia

This tiny country situated on the West coast of Africa was also home to victims of Female Genital Mutilation. The United Nations Children’s Fund attempted to interview 10 252 women between the ages of fifteen and forty-nine during 2005-6 using Multiple Indicator Cluster Surveys (MICS). Of these 10 252 women, two hundred and seventy were missing and thus only 9 982 were actually interviewed. The consequent FGM prevalence rate among these Gambian women aged fifteen to forty-nine reached approximately 79.3% during this period.

5.3.1 Age of excised women

The FGM prevalence for the different age groups was provided in Figure 24, below. The level of female genital cutting among Gambian women ranged between 71.43 percent and 86.6 percent in ages forty-seven and forty-three respectively. The FGM distribution among the age groups seemed to be somewhat consistent.

Figure 24: Proportion of excised women according to age group



The trend line in Figure 24 showed that women in Gambia were excised more or less the same across all age groups. Girls aged fifteen to nineteen years seemed to have similar excision prevalences to that of the women aged twenty to twenty-four years and so on. The last age group from forty-five to forty-nine years old appeared to have a slightly lower prevalence

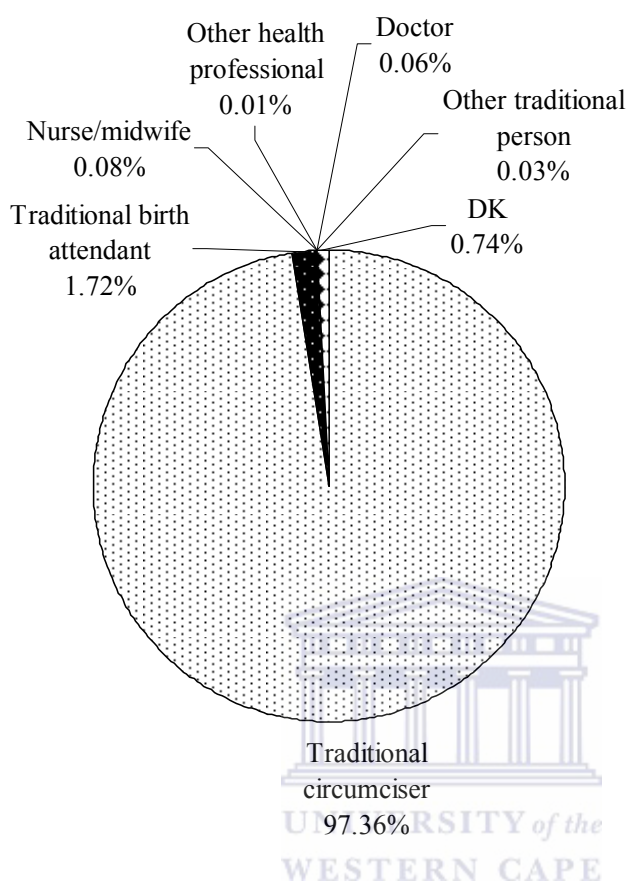
compared to the other groups. There was an approximate five percentage point difference in the first and last age groups, which indicated that the younger females were excised slightly more than the older females in Gambia. The difference was too small to imply that a generational effect existed since the percentage of females who underwent excision at the younger ages was approximately the same as the prevalences among the older females. This therefore meant that there has been no improvement over time regarding the FGM prevalences according to age. This was validated with a p-value of 0.201, which indicated that there was no significant association between age group and excision in Gambia.

Unfortunately, the SPSS data set obtained from UNICEF excluded data pertaining to the age at which the excision was performed on the women, and no information on the types of FGM that is practiced in Gambia was provided. The final report, however, published that the mean age at which FGM was performed ranged between four and fourteen years old, but incidences of infant mutilation has also been recognised (UNICEF, 2007). Since only ten of the sixteen original questions regarding female genital mutilation were included in the additional module for Gambia, it was reasonable that all the variables could not be captured.

5.3.2 Person who performed the operation

Of the 7 854 Gambian women who were excised, more than ninety-seven percent were excised by a 'traditional circumciser'. This may have implied that being a traditional circumciser was deemed as a serious profession in Gambia. This has been depicted in Figure 25 (page 70). Approximately one percent of excised women did not know who performed the excision operation on themselves. This may have been due to the fact that these females were so young when the operation occurred that they could not remember or because these women were older and could not remember the practitioner either. When one examined the excised daughters of the respondent, it was noticed that the excised women also preferred using the services of the traditional circumciser to perform the excision operation on their daughters. This was expected since almost all excised respondents were excised by a traditional circumciser and it seemed only natural to continue using the same practitioner which the respondent was accustomed to.

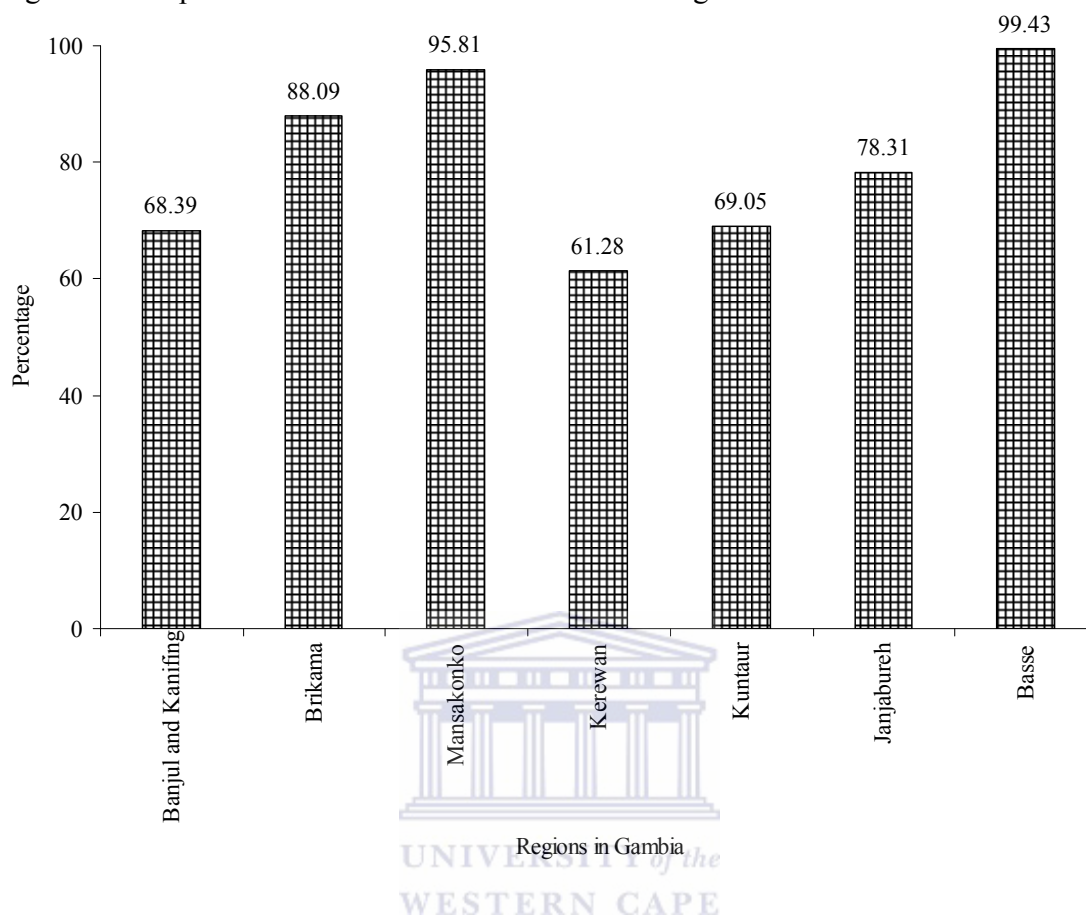
Figure 25: Distribution of who performed the excision on the respondent



5.3.3 Region

There were seven major regions in Gambia. Figure 26 provides a representation of the level of excision in each of the seven regions. One could easily see that vast differences in the FGM prevalence existed. The Basse region had the highest FGM prevalence at almost one hundred percent. This meant that almost all women in Basse had undergone some form of female genital cutting. Thereafter, Mansakonko had the second highest FGM prevalence at almost ninety-six percent and Brikama had the third highest at approximately eighty-eight percent. The region with the lowest level of female genital mutilation was Kerewen at just over sixty-one percent. Although there were big differences in FGM prevalences among the Gambian regions, all prevalences were above sixty percent. The region and excision cross tabulation reported a significant association with a p-value below 0.005.

Figure 26: Proportion of excised females within each region



The following sub-section pertaining to the level of urbanisation may provide some explanation as to the differences among the regions seen in Figure 26, above. The FGM prevalence seems to be different according to the region of residence. It was clear from Figure 26 that Basse, Mansakonko and Brikama had the three highest levels of female genital cutting in Gambia.

5.3.4 Area of settlement

Fifty-eight percent of Gambia was made up of rural settlements, while the other forty-two percent was urban areas. Within these settlements, 73.22% of urban females and 83.69% of rural females have undergone some form of excision. Table 14 gives a clear illustration of the level of urbanisation within each Gambian region. The entire population of Banjul and

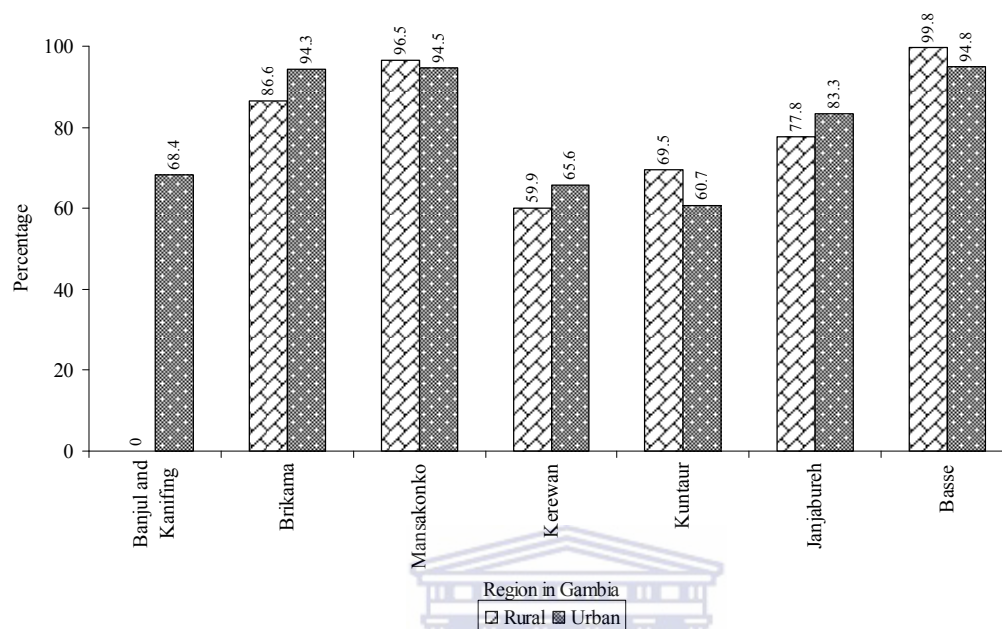
Kanifing was urbanised while the other six regions were more rurally developed. The most rural region in Gambia was Kuntaur at 94.6 percent, followed by Basse and Janjabureh reaching 93.4 percent and 90.6 percent, respectively.

Table 14: Proportion of urbanisation in each region

Regions	Urban (%)	Rural (%)	Total	<i>Population size</i>
Banjul and Kanifing	100.0	0.0	100.0	3153
Brikama	19.2	80.8	100.0	2445
Mansakonko	35.5	64.5	100.0	594
Kerewan	23.5	76.5	100.0	1097
Kuntaur	5.4	94.6	100.0	534
Janjabureh	9.4	90.6	100.0	964
Basse	6.6	93.4	100.0	1465

The Banjul and Kanifing region was entirely urbanised and had a fairly low FGM prevalence (68.4 percent) compared the other regions (see Figure 27). Kuntaur, on the other hand, was almost entirely rural and more than ninety-four percent of the females aged fifteen to forty-nine years were excised. Brikama was approximately eighty percent rural and twenty percent urban, but the smaller urban population had the higher FGM prevalence. More than ninety-four percent of Brikama's urban females had undergone female genital cutting while a smaller proportion (86.6%) of the rural females had been excised. In Mansakonko, rural females had undergone excision slightly more than urban females at 96.5 % and 94.5 %, respectively. This high level of FGM prevalence among both rural and urban females was seen in Basse as well. The lower FGM prevalences were noticed in Kerewen and Kuntaur. More than seventy-six percent of females in Kerewen resided in rural settlements but a greater proportion of the urban females had undergone excision. Kuntaur had the opposite effect, however. Almost ninety-five percent of Kuntaur was rural and almost seventy percent of them had been excised, while sixty percent of the urban females (5.4%) had undergone excision.

Figure 27: Proportion of excised females in each region by settlement area



It was thus deduced that the level of urbanisation did not impact the level of female genital mutilation in Gambia since urban females and rural females underwent excision in a similar way. The association test, however, reported a 0.000 p-value, which indicated a level of significance.

5.3.5 Religion

Expectedly, the entire family assumed the religious affiliation of the head of the household in Gambia. This meant that if the husband was Christian, the wife and their children were also considered as Christian. The greater majority (ninety six percent) of Gambians were found to be Muslim and female excision was almost universally heard of across all religions. The concept of genital cutting, on the other hand, was recognised by approximately twenty percent of Muslims and Christians. Most of the Christian community was found in the Banjul and Kanifing region (see Figure 28).

Figure 28: Distribution of religion within each region

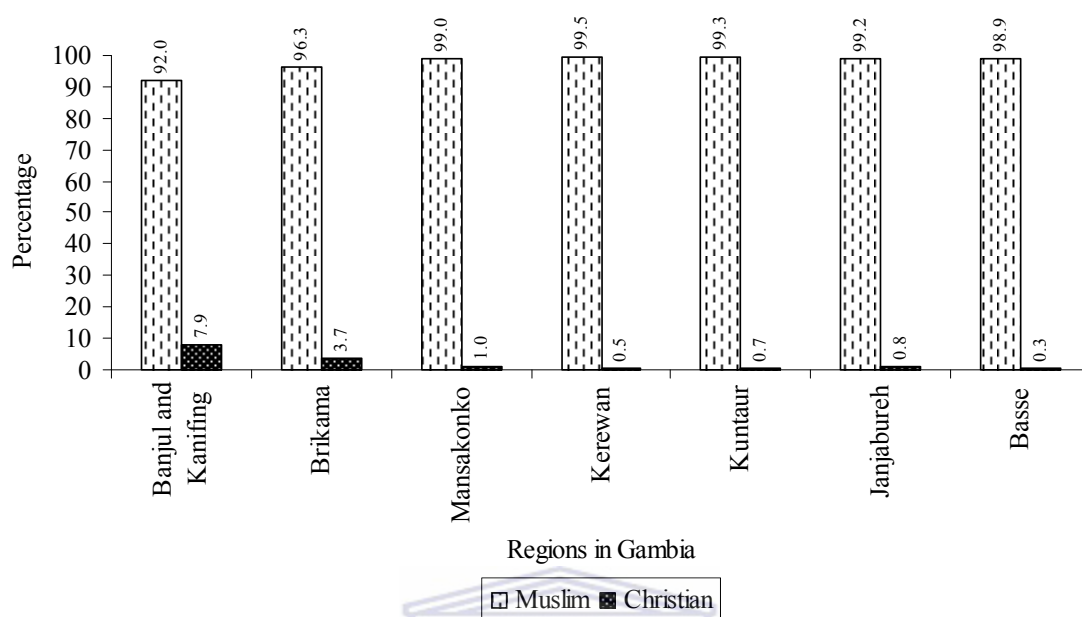
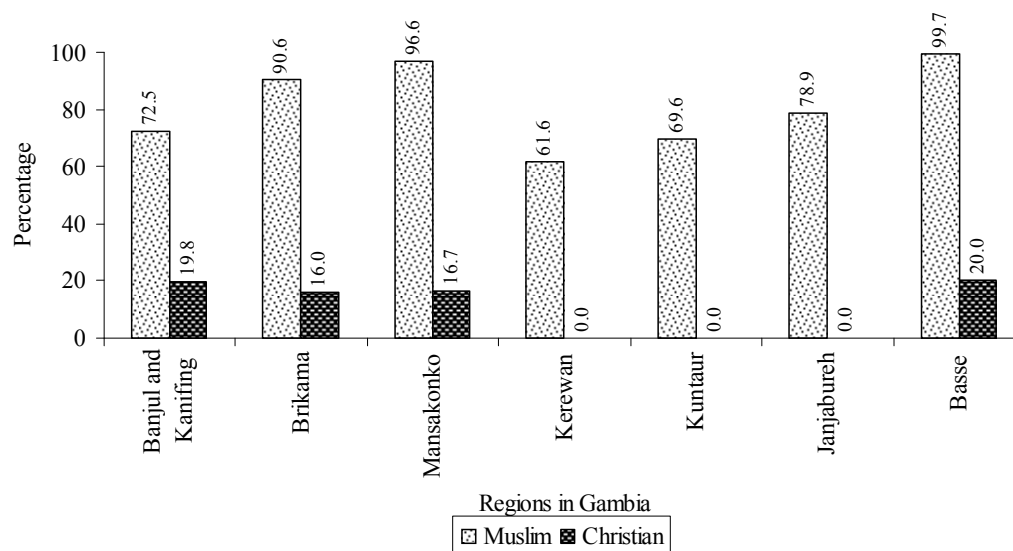


Figure 29 represents the proportion of females who have undergone some form genital mutilation in each region according to their religion. Kerewen, Kuntaur, and Janjabureh were the only regions in which zero Christian excision was reported. The reason therefore was that the Christian community made up less than one percent of each of these regions.

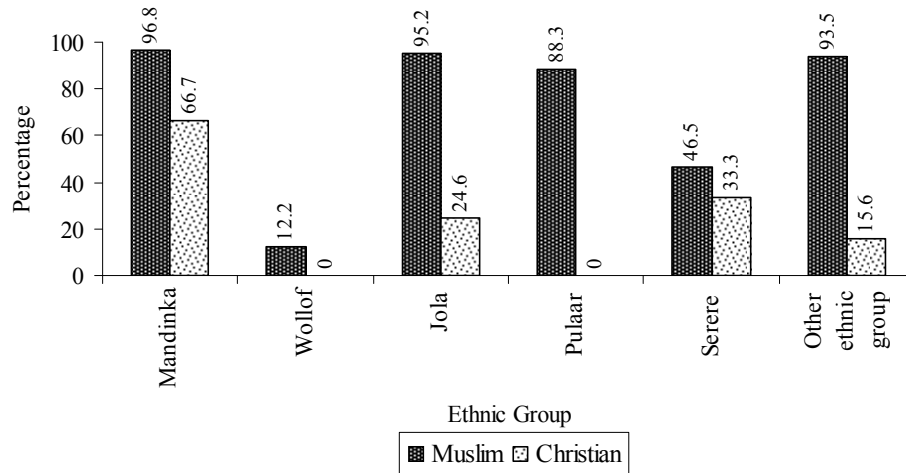
The cross tabulation of religion and excision reported a p-value of 0.000 which implied a significant association between these two variables. Basse had the highest FGM prevalence within the Muslim community and reached almost one hundred percent; followed by Mansakonko with 96.6% of their Muslims excised; and Brikama with 90.6% of Muslims excised. All seven regions in Gambia were made up of Muslims, constituting more than ninety percent each. It was thus deduced that more Muslims were subjected to female genital mutilation than Christians since less than twenty percent of Christians in Basse, Banjul and Kanifing, Brikama and Mansakonko had undergone excision.

Figure 29: Proportion of excised females in each region according to their religion



The fact that all seven regions were mostly Muslim but the levels of excision within each region varied greatly, lead one to think that another underlying factor was causing the variation in Muslim excision within the regions. A cross tabulation of religion and ethnic group resulted in Figure 29. Since more than ninety-six percent of the Muslim Mandinka females and two of the three Christian Mandinka females had been excised, it was deduced that the ethnicity of the female played a more influential role in the level of excision. Ninety-nine percent of Wollof females were Muslim and all Muslim Wollof females were excised. Of the ninety-four percent of Muslim Jola females, approximately ninety-five percent and almost twenty-five percent of the Christian Jola's were excised.

Figure 30: Proportion of excised females for each ethnic group by religion



5.3.6 Ethnic group

The state of Gambia was found to be home to five main ethnic groups namely; Mandinka, Wollof, Jola, Pulaar, and Serere. All other smaller ethnicities were grouped together to form 'other ethnic group'. The questionnaire requested the ethnicity of the head of the household and it was then assumed that the rest of the household members also belonged to the same ethnic group.

Thirty-five percent of Gambia constituted of females that belonged to the Mandinka group and therefore the largest ethnic group. Thereafter, the Pulaar group made up almost twenty percent and the Wollof community made up about thirteen percent of the Gambian population. Subsequently, these were the three main ethnic groups that were found in Gambia.

Figure 31: Distribution of ethnic groups within each region

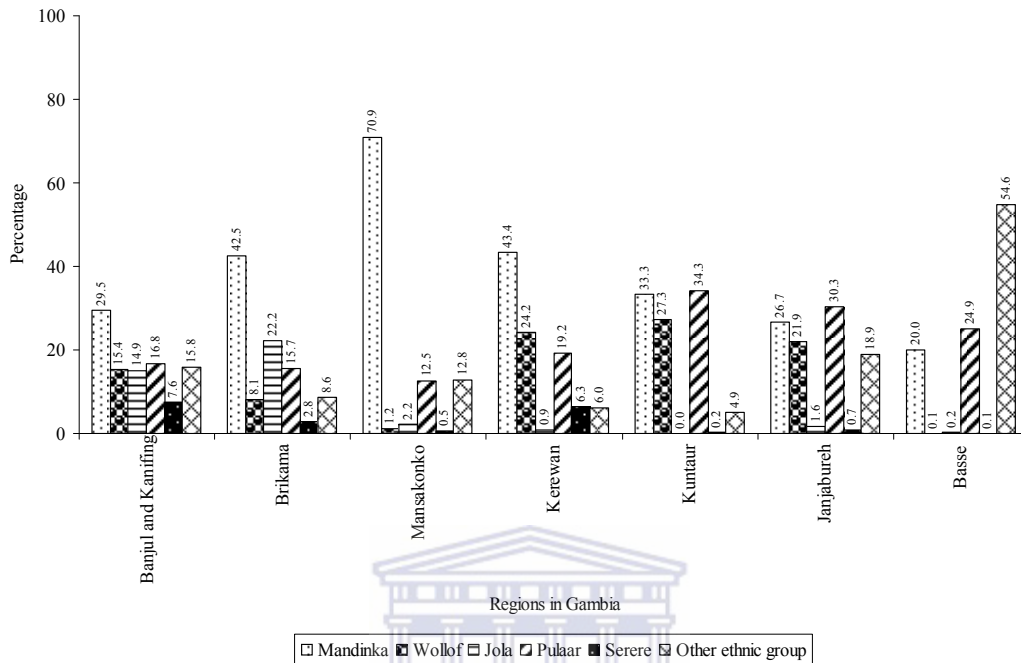
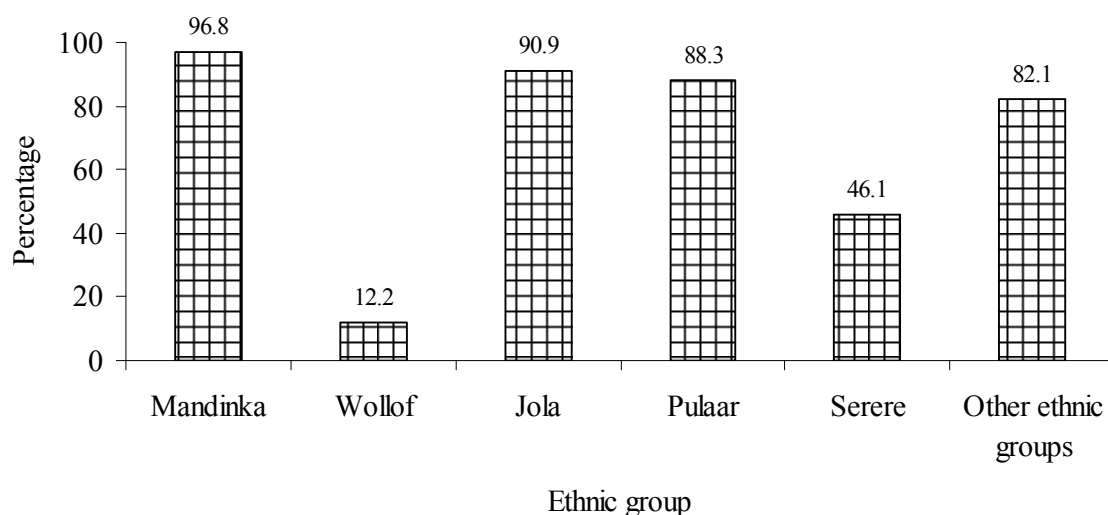


Figure 31 represented the ethnic distribution within each region. Mandinka people made up the majority ethnic group in four regions constituting approximately seventy percent of Mansakonko, 43.4 percent of Kerewan, 42.5 percent of Brikama and thirty percent of Banjul and Kanifing. Pulaar people were the majority ethnic group in Kuntaur at thirty-four percent, and Janjabureh at thirty percent. The Wolof people did not make the majority ethnic group in any region but were found mostly in Kuntaur (27.3%), Kerewan (24.2%), Janjabureh (21.9%) and Banjul and Kanifing (15.4%). More than 56.4 percent of Basse was made up of other smaller ethnic groups which implied that much diversity was found within this region.

Figure 32: Proportion of excised females according to their ethnic group



From Figure 32 it was seen that the largest ethnic group (Mandinka) had the highest level of FGM prevalence reaching 96.81 percent. The Jola people, who made up ten percent of Gambia, had the second highest excision levels within their ethnic group at an estimated ninety-one percent. The Pulaar community, who constituted twenty percent of Gambia, excised eighty-eight percent of their women. The Wollof people, which were the third largest ethnic group, had the lowest FGM prevalence at 12.15 percent. They were followed by the Serere people at 46.11 percent. This vast difference in the FGM prevalence according to the ethnic groups showed that the ethnicity in Gambia influenced the decision whether or not to have the young girls in the community excised. According to the 0.000 p-value, the association between ethnicity and excision was significant.

5.3.7 Level of Education

This West African country reported a low education level. The literacy level of Gambian women was investigated by asking the respondents whether they could read part of a sentence. Almost ninety percent of the interviewed women could not read at all, while only four percent could read parts of a sentence. This signified the poor level of literacy within the female community in Gambia. When asked whether they have ever attended school, less than half of

the women aged fifteen to forty-nine responded positively. This therefore meant that majority of Gambian women had no formal schooling.

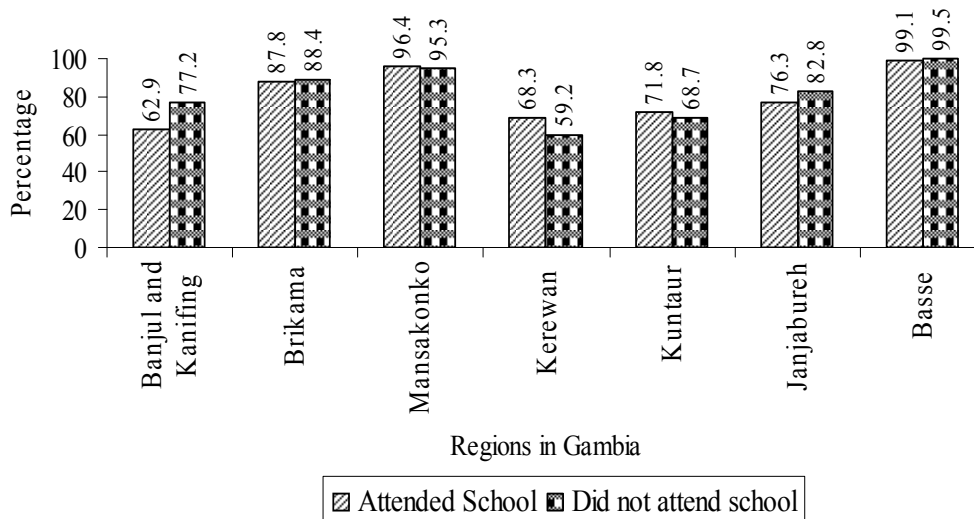
Table 15 depicted the proportion of females that have ever attended school according to their region of residence. It was noticed that the Janjabureh region had the highest level of school attendance by females at sixty-nine percent, followed by Banjul and Kanifing at 61.7 percent. The Kuntaur region had the lowest level of female school attendance which only reached fifteen percent.

Table 15: Proportion of females who have ever attended school by region

Regions	Attended school (%)	Never attended school (%)	Missing	Total	Population size
Banjul and Kanifing	61.7	38.2	0.1	100.0	3057
Brikama	48.6	51.3	0.0	100.0	2387
Mansakonko	48.5	51.5	0.0	100.0	573
Kerewan	22.4	77.6	0.0	100.0	1090
Kuntaur	15.4	84.4	0.2	100.0	506
Janjabureh	69.1	30.9	0.0	100.0	958
Basse	23.5	76.5	0.0	100.0	1411
Total	46.5	53.5	0.1	100.0	9982

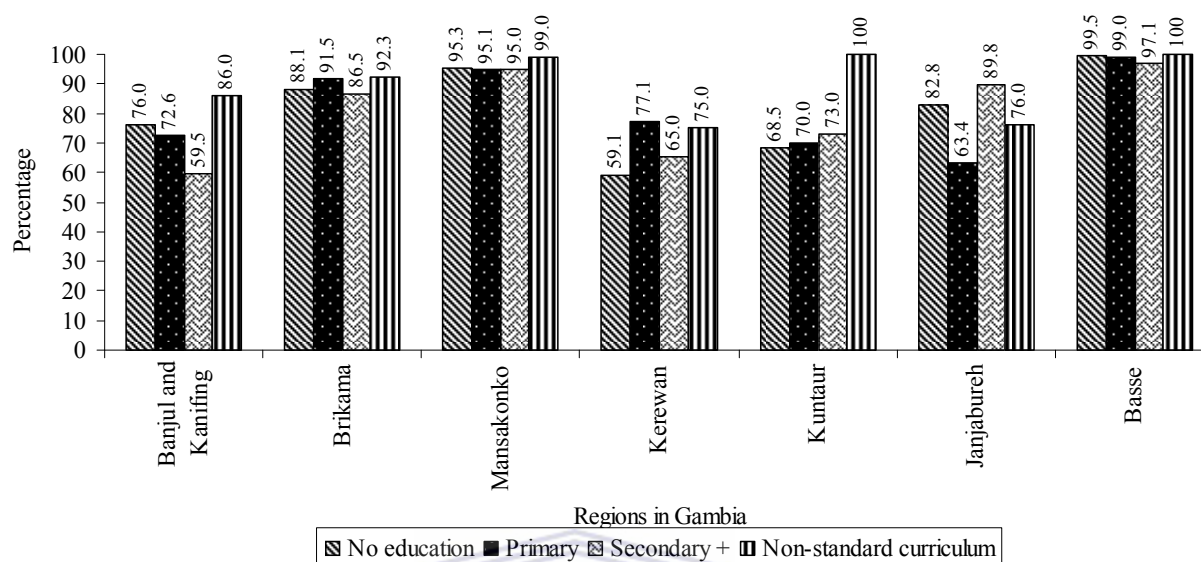
A comparison of the FGM prevalences among those women who had attended school and those who had not, was depicted in Figure 33. In the Banjul and Kanifing and Janjabureh regions, the FGM prevalence among those females who had never attended school was higher than for those who had attended school. In Kerewen and Kuntaur, however, those females who had attended school had higher FGM prevalences than those who had never attended school. Three regions, namely Brikama, Mansakonko and Basse, excised their women in the same way whether or not the females had attended school.

Figure 33: Proportion of excised females in each region according to school attendance



Approximately fifty-five percent of females in Gambia had no formal education, while almost twelve percent had primary level and twenty-six percent had a secondary+ level of education. In Basse and Mansakonko, almost all the females at each level of education had undergone some form of excision. Therefore in these two regions, education level did not greatly affect whether or not a female was excised. In Banjul and Kanifing, the majority of females who were excised were those who had a non-standard curriculum form of education. In this region, however, the FGM prevalence seemed to decrease as the education level increased. This meant that there was a negative relationship between education level and FGM prevalence in Banjul and Kanifing. A possible explanation for this phenomenon may be due to the region being completely urbanised, which increased the possibility of attaining an education. Another possibility may have been that approximately sixty-five percent of females in Banjul and Kanifing were below the age of thirty.

Figure 34: Proportion of excised women in each region according to their level of education

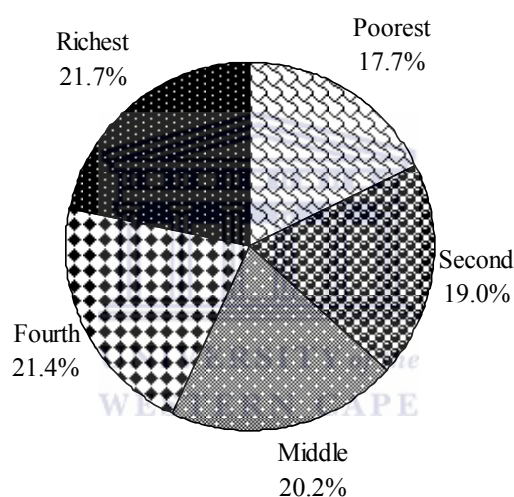


Education level did not seem to affect the level of excision in Brikama since more than eighty percent of females at each education level were excised in the same way. Therefore females with no education were excised the same as those females with primary and secondary education levels. Education, thus, had little impact on FGM levels in Brikama. In Kerewan, majority of females with primary and non-standard levels of education were excised more than those with no education and secondary level education. The Kuntaur females with a non-standard curriculum had all undergone excision, while females with standard curriculum education had been excised in more or less the same way. Janjasureh region had the most variation among excised females according to their level of education. The chi-square test for association reported a p-value below 0.005. This meant that the association between education level and excision was confirmed.

5.3.8 Socioeconomic status

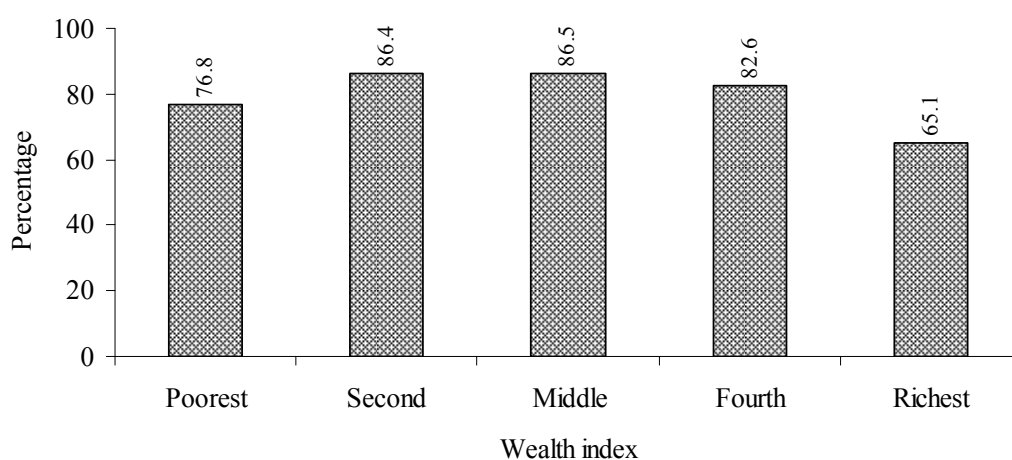
The distribution of wealth in Gambia was fairly evenly spread. There were miniature differences in the five levels of socioeconomic status; however, a small increase in wealth was noticed. This meant that there were slightly more wealthy people in Gambia than poor people. The poorest community made up the smallest proportion of the country and the richest ones made up the largest proportion.

Figure 35: Distribution of socioeconomic status



In order to examine whether the family's level of wealth influenced the female genital mutilation prevalence, the results from a cross tabulation of wealth index and excision was represented in Figure 36. Noticeably, the richest females were excised the least in Gambia at approximately sixty-five percent, followed by the poorest group at almost seventy-seven percent. There were not many differences in the three middle statuses as they ranged between eighty-two and eighty-seven percent. One could thus not deduce that the socioeconomic status increased or decreased the level of female genital cutting. The 0.000 p-value from the chi-square test confirmed association between these two variables.

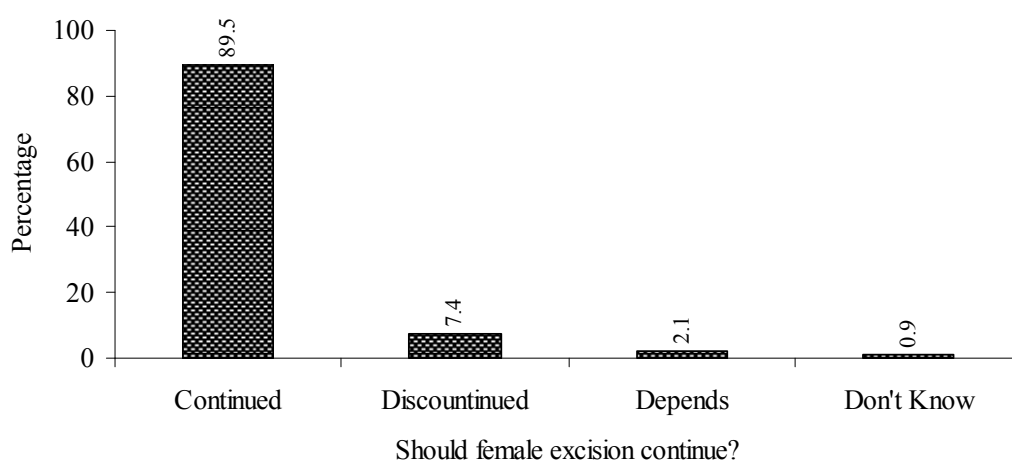
Figure 36: Proportion of excised females according to their wealth index



5.3.9 Level of acceptance

Approximately ninety percent of the excised females in Gambia supported the continuation of female genital cutting, while only seven percent did not. The result from the cross tabulation between excision and whether or not their daughter(s) should be excised, was thus not surprising. It showed that ninety-two percent of the excised females would send their daughter(s) to be excised and ninety-seven percent of non-excised females would not send their daughter(s).

Figure 37: Proportion of excised females according to their level of acceptance



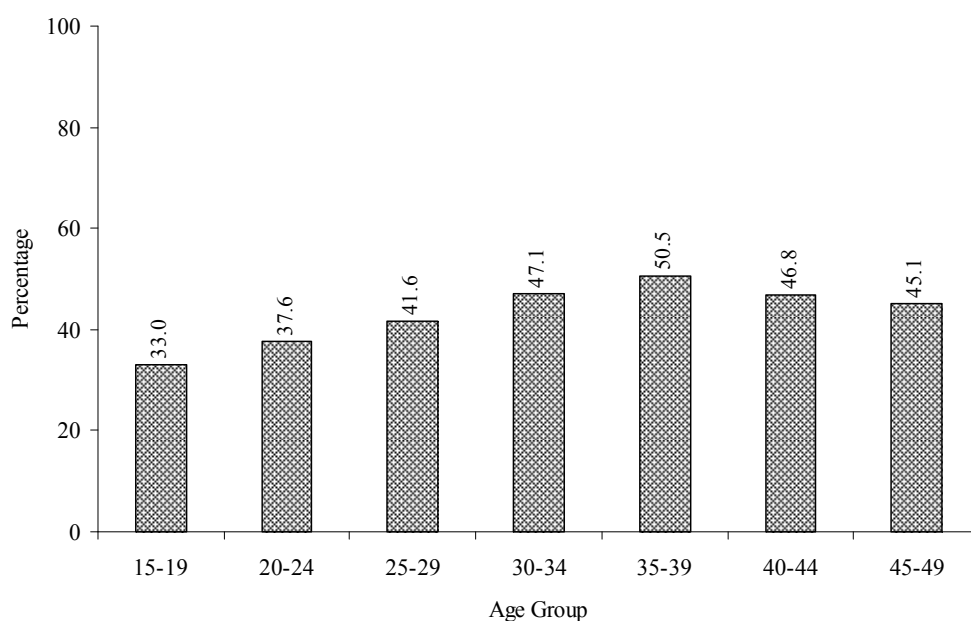
5.4 Cote d'Ivoire

The 2005 Multiple Cluster Indicator Survey that was run in Cote d'Ivoire interviewed 12 888 women aged fifteen to forty-nine years old. This drew a response rate of approximately ninety-nine percent. Compared to the other countries, only thirteen of the original sixteen questions were included in the 2005 MICS questionnaire for Cote d'Ivoire. The three excluded questions related to their husbands. Thus far, Sudan was the only country in which FGM questions were related to the male. This did not mean that the males were questioned about excision, but rather that the females were asked about their husbands position regarding FGM. This 2005 survey found that of the 12 888 interviewed women, 41.3 percent had undergone some sort of excision.

5.4.1 Age of the excised women

The first variable under consideration related to the age of the woman. Figure 38, below, provided a diagrammatic representation of the percentage of women in each of the seven age groups who had undergone female genital cutting. Upon inspection, some differences between the age groups were seen.

Figure 38: Percentage of women in each age group who have been excised



The age group which had the highest Female Genital Mutilation prevalence in Cote d'Ivoire was found in the thirty-five and thirty-nine years old category at 50.5 percent. The lowest FGM prevalence, on the other hand, was found in the fifteen to nineteen year old group at thirty-three percent, which was also the youngest reproductive age group. This meant that women in the earlier ages were excised less than those in the older ages. A negative relationship between age and level of excision was thus noticed. The reason for this phenomenon should not be attributed to the fact that some of the younger women had not had their first child yet, since women in Cote d'Ivoire did not wait until they are thirty-five before they begun their families. There was a definite increase in the percentage of excised women as they aged, except for the two oldest age groups. Figure 38 showed that the two older age groups had slightly lower FGM prevalences than the thirty-five to thirty-nine year old group. The female population could also be regarded as a young population since approximately sixty percent of the women were below thirty years old.

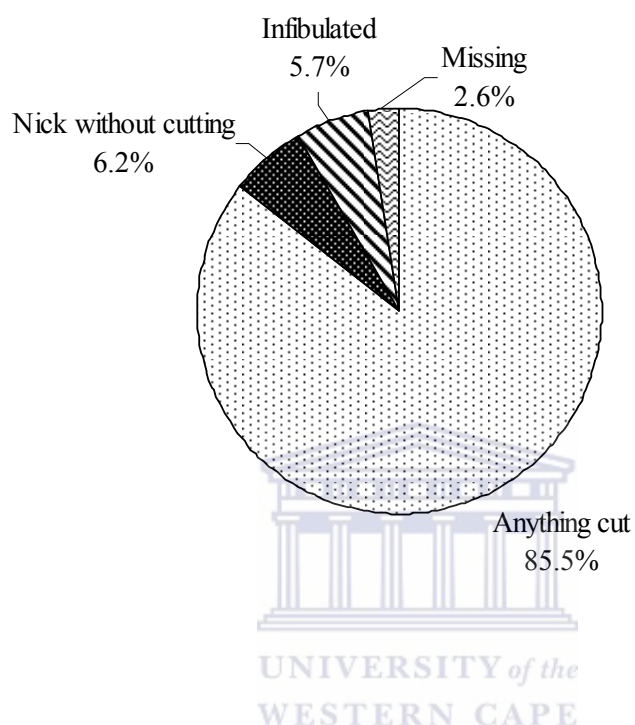
The chi-square test for association between age group and excision reported a significance level of 0.000. This meant that a significant association existed between these two variables.

5.4.2 Types of excision practiced

Upon examining the types of excision that was performed on the female respondents, it was found that three separate questions were asked. The first was whether the females had any part of her genitalia cut. The second was whether she had any part of her genitalia nicked only and thirdly, whether she was infibulated or sewn closed. Unfortunately, if the female was nicked only without being cut, the condition fell into type IV mutilation which was unclassified. If she underwent any form of cutting, the classification could either be type I (prepuce removed and clitoris partially or totally removed) or type II (clitoris partially or totally removed and labia minora partially or totally removed). Consequently, these questions pertaining to the type of mutilation were unclear since two types of mutilation had been mixed. One could, however, conclude that the majority of woman in Cote d'Ivoire have had some part of their genitalia cut. This therefore meant that almost eighty-six percent of those excised females had either

undergone type I or type II mutilation. Only 5.7 percent of excised women had been infibulated (type III), while 6.2 percent have been nicked only.

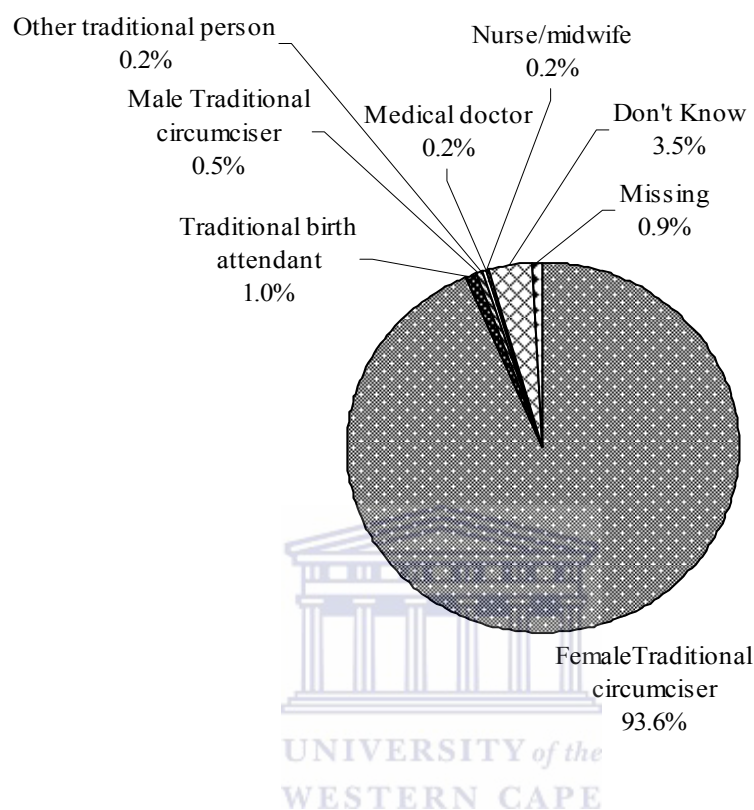
Figure 39: Distribution of the types of excision performed on the respondent



5.4.3 Person who performed the excision on the respondent

Almost all the women who had undergone some form of female genital mutilation had been excised by a female traditional circumciser at 93.6 percent. Cote d'Ivoire was the only one of the five countries that were analysed that stipulated that males in the community performed the excision operation. The proportion of excised females who had actually used male traditional circumcisers only reached 0.5 percent. This showed that male circumcisers were not the preferred practitioner. The second biggest proportion, seen in Figure 40, showed that three and a half percent of excised females did not know who performed the operation on them. This may have implied that those respondents who never knew their excisor were too young to remember who performed the excision on them. Since the age at which the operation was performed was unknown, this explanation seemed feasible.

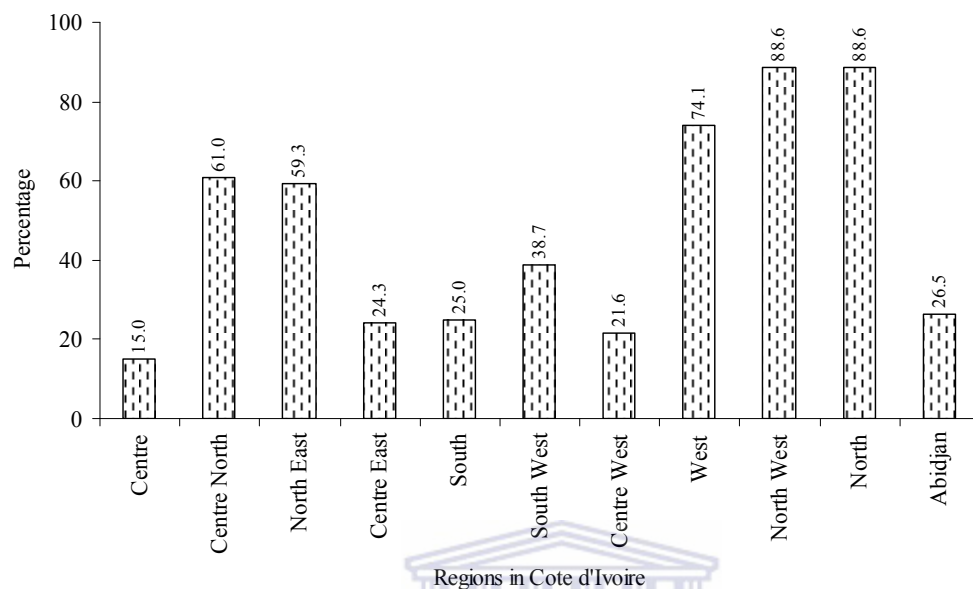
Figure 40: Distribution of the person who performed the excision on the respondent



5.4.4 Region

Cote d'Ivoire was sub-divided into eleven main regions. Upon investigating the proportion of excised females within each region, vast differences in FGM levels among the eleven regions were noticed. The chi-square test for association reported a p-value of 0.000 which indicated that there was a significant association between region and excision. Figure 41 showed that the North West and the North regions had the highest level of female genital cutting in Cote d'Ivoire reaching 88.6 percent each. Thereafter, the West region had the third highest level of excision at approximately seventy-four percent. The Centre region, on the other hand, had the lowest level of female genital mutilation at a low fifteen percent.

Figure 41: Proportion of excised females, per region



This country portrayed a definite disparity in the proportion of excised females when the regions were examined. There were five regions with prevalences below thirty percent, one region between thirty and forty percent and the other five all above fifty-nine percent. The highest prevalence occurred in the most northern regions of the country, while the lowest prevalences occurred in the central parts of the country. Therefore, women in the north of Cote d'Ivoire had the highest FGM prevalence in the country. One could thus conclude that the region in which females resided influenced whether or not she was excised.

5.4.5 Area of settlement

Cote d'Ivoire was fairly evenly distributed between urban and rural settlements at 49.2 percent and 50.8 percent, respectively. Within each of the eleven regions, it was, however, seen that all regions except Centre North and Abidjan were more rurally populated than urbanised. In fact, Abidjan was completely urbanised, while Centre North was approximately fifty-fifty. The two most rural areas were North East and North West at 87.7 percent and 80.5 percent, respectively.

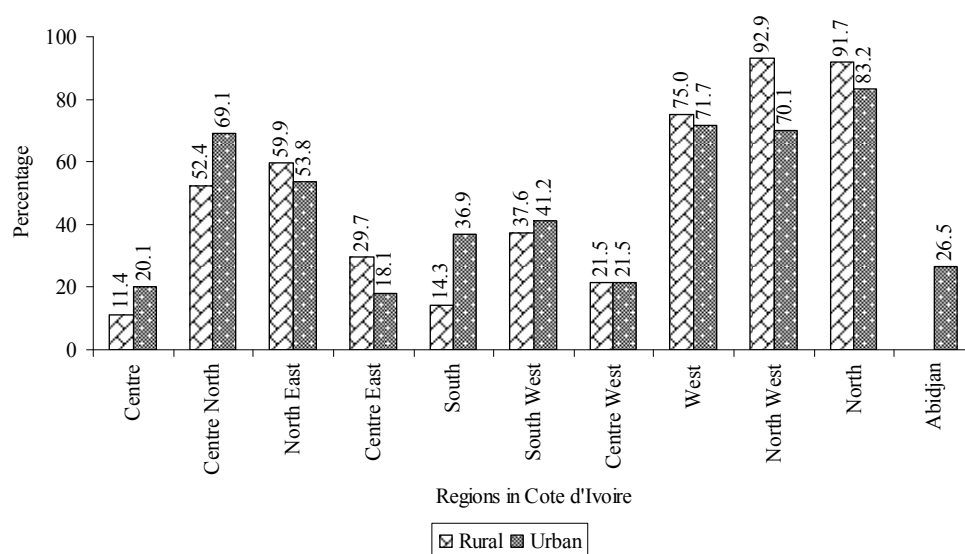
Table 16: Proportion of urbanisation in Cote d'Ivoire, per region

Region	Urban	Rural	Total	Population Size
Centre	39.7	60.3	100.0	1064
Centre North	50.7	49.3	100.0	797
North East	12.3	87.7	100.0	576
Centre East	38.3	61.7	100.0	355
South	43.1	56.9	100.0	2360
South West	29.7	70.3	100.0	1524
Centre West	44.8	55.2	100.0	1296
West	26.1	73.9	100.0	1112
North West	19.5	80.5	100.0	406
North	35.9	64.1	100.0	791
Abidjan	100.0	0.0	100.0	2607
Total	49.2	50.8	100.0	12888

When the association between area of residence and excision was calculated by means of a chi-square test, a p-value of 0.000 was found. This implied that a significant association existed between these two variables. The Centre Region was more rurally populated but the proportion of excised females according to the area of residence showed that urban females were excised more than rural females. This phenomenon occurred in two other regions, namely the South and the South West. It was also seen that in the Centre West, urban and rural females were excised exactly the same at 21.5 percent even though this region was more rural.

From Figure 42 and the cross tabulation, one noticed that on average, the rural females were excised slightly more than the urban females, even though four regions had higher urban excision than rural excision. The region with the biggest difference in excision levels was in the North West. This was also the region with the second largest proportion of rural residents and had one the two highest levels of excision. The region with the second largest difference in rural and urban excision was found in the South. This region had one of the lowest levels of excision and was only fourteen percent more rurally populated than urbanised.

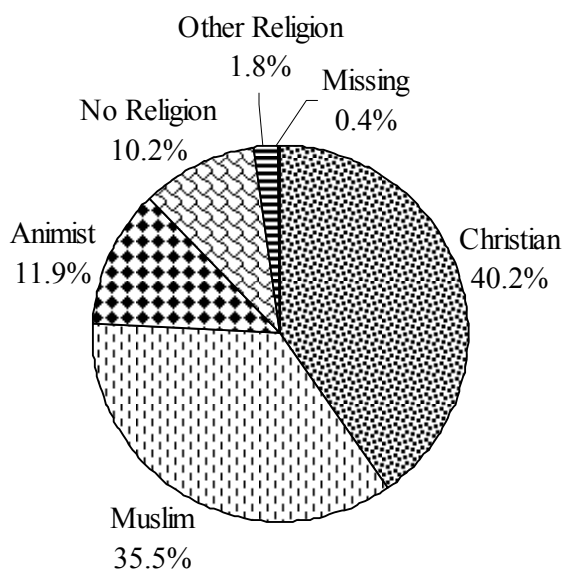
Figure 42: Proportion of excised females in each region, per area of settlement



5.4.6 Religion

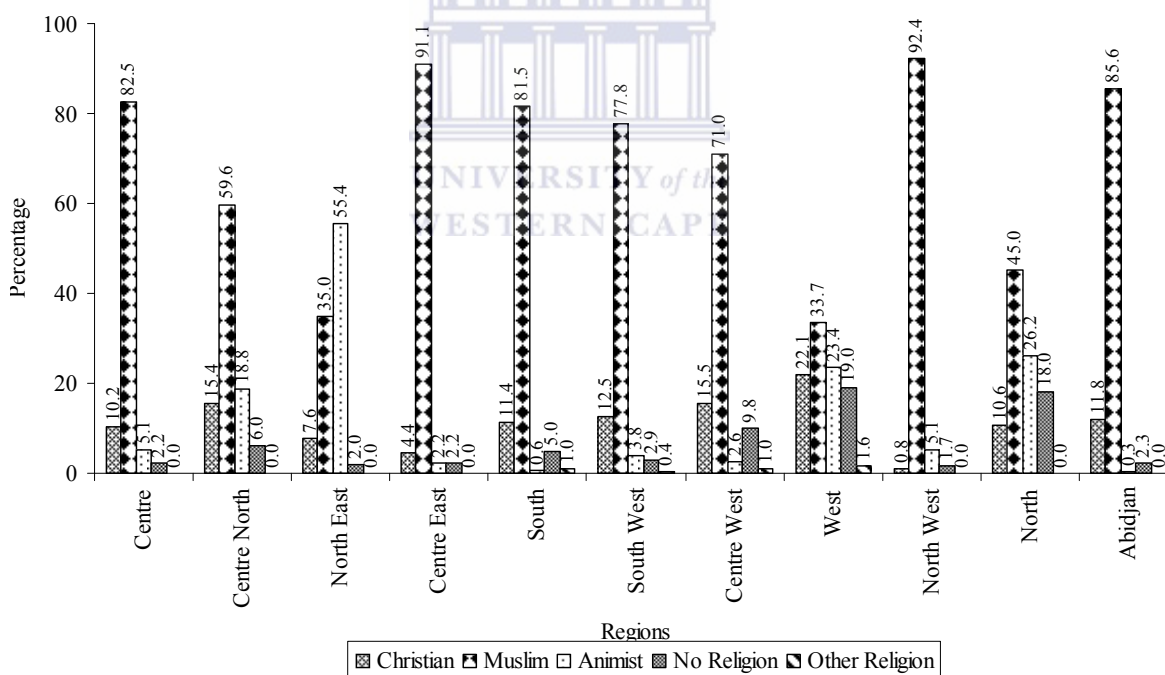
In Cote d'Ivoire, as the other analysed countries, the entire family assumed the religion of the head of the household. Therefore, the distribution of religions in Cote d'Ivoire was in relation to the head of the house (Figure 5.4.6). The three main religious groups were found to be Christian, Muslim and Animists. Thereafter, 10.2 percent of women had no religious affiliation, while 1.8 percent belonged to some other religious group.

Figure 43: Distribution of religion in Cote d'Ivoire



The chi-square test for association reported a 0.000 p-value which indicated that a significant association between religion and excision existed. Therefore, religion, in some way, influenced the level of excision in this country. This relationship could be seen in Figure 44 which depicted the proportion of excised females in each region according to their religious affiliation. In ten of the eleven regions in Cote d'Ivoire Muslim females were excised much more than any of the other religious groups. On average, approximately seventy-one percent of Muslim females had undergone some form of excision. In the North East, however, Animist females were excised the most at approximately 55.4 percent, while thirty-five percent of Muslim females underwent Female Genital Mutilation. In the Western and Northern regions, it was seen that Muslim females still had the highest FGM prevalence but the other four religions played bigger roles in these two regions than in any of the others.

Figure 44: Proportion of excised females in each region according to their religion



5.4.7 Ethnic Group

Seven different ethnicities were found in Cote d'Ivoire. According to the frequency distribution, the Akan group made up the largest part of this country at almost thirty-eight

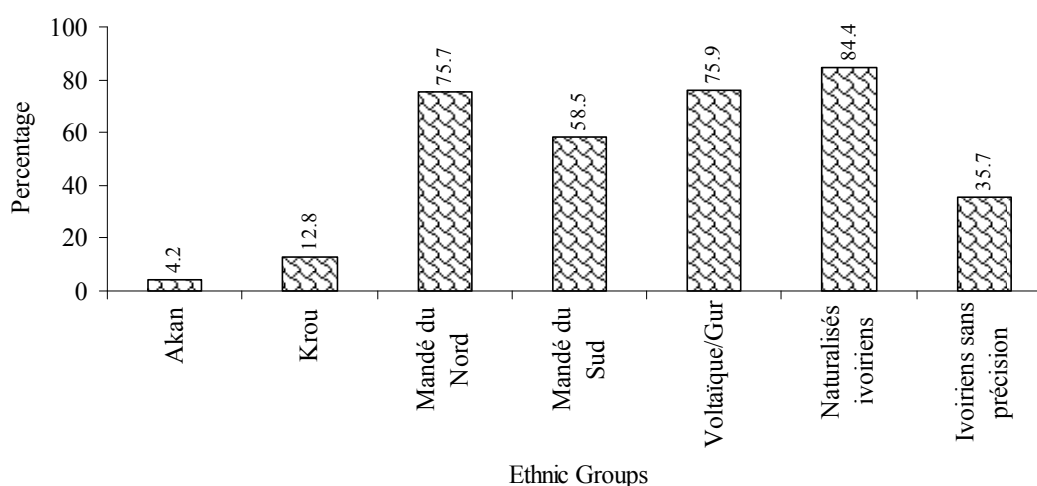
percent, followed by the Voltaïque/Gur group comprising of 19.2 percent and the Krou people consisting of 18.7 percent. The two smallest ethnic groups were the Naturalisés ivoiriens and the Ivoiriens sans précision which constitute approximately 0.3 percent each.

Table 17: Proportion of excised females by ethnic group

Ethnicity	Excised	Not excised	Missing	Total	Population Size
Akan	4.2	95.4	0.4	100	3399
Krou	12.8	86.9	0.3	100	1706
Mandé du Nord	75.7	24.1	0.1	100	1430
Mandé du Sud	58.5	41.4	0.1	100	928
Voltaïque/Gur	75.9	24.1	0.1	100	1981
Naturalisés ivoiriens	84.4	15.6	0.0	100	32
Ivoiriens sans précision	35.7	64.3	0.0	100	28

Upon investigating whether or not the ethnicity of the female influenced the excision decision, the chi-square test confirmed significance with a p-value of 0.000. Consequently, a significant association existed between ethnicity and excision. A graphic representation of the level of excision in Cote d'Ivoire according to ethnic group could be seen in Figure 45.

Figure 45: Proportion of excised females by ethnic group



The Naturalisés Ivoiriens were the ethnic group which excised their females the most at 84.4 percent, but they were also the second smallest ethnic groups found in Cote d'Ivoire. The

smallest ethnic group (Ivoiriens sans precision) however, had approximately one third of their females excised. The largest group (Akan people) did not believe in female genital cutting since less than five percent of their females had been excised. Since there was a vast difference in the excision levels among the ethnic groups, one could deduce that ethnicity influenced whether or not women underwent this harmful procedure.

5.4.8 Education level

When asked whether they could read part of a sentence, almost three quarters responded that they could not read at all, while 14.7 percent could read the entire sentence which was provided to them. Alarming, seventeen women could not respond to this question as no card was available to them to read in their home language. This implied that the literacy level of women aged fifteen to forty-nine in Cote d'Ivoire was poor. It was thus expected that the education level would be low as well. The association test proved that education and excision had a p-value of 0.000 which indicated a significant association between these two variables.

Table 18: Distribution of female school attendance aged fifteen to forty-nine

Region	Attended school (%)	Never attended school (%)	Total	<i>Population size</i>
Centre	44.3	55.7	100.0	<i>1064</i>
Centre North	32.7	67.3	100.0	<i>797</i>
North East	19.0	81.0	100.0	<i>575</i>
Centre East	48.5	51.5	100.0	<i>355</i>
South	56.0	44.0	100.0	<i>2361</i>
South West	43.6	56.4	100.0	<i>1524</i>
Centre West	61.1	38.9	100.0	<i>1295</i>
West	34.7	65.3	100.0	<i>1112</i>
North West	14.5	85.5	100.0	<i>407</i>
North	18.8	81.2	100.0	<i>791</i>
Abidjan	66.3	33.7	100.0	<i>2607</i>
Total	47.4	52.6	100.0	<i>12888</i>

The two regions with the highest levels of school attendance in Cote d'Ivoire were Abidjan and Centre West with 66.3 percent and 61.1 percent, respectively. The lowest levels of school

attendance were found in three of the four northern regions of North West, North and North East, with rates below twenty percent. This meant that the more north one went, the lower the level of school attendance, while the southern regions had the higher levels. Thereafter, a cross tabulation of the regional school attendance and the level of excision was performed. Figure 49 depicted the proportion of excised females according to their school attendance.

In each of the eleven regions, it was noticed that the proportion of excised females was greater for those females who had never attended school. The largest difference was seen in the Centre East region where 47.4 percent of females who never attended school were excised as opposed to 6.6 percent of school going females. The North and North West were the two regions which had the highest levels of excision for both school goers and non-school goers, even though these two regions had the highest proportion of non attendance. The Centre region, however, had the lowest level of excision for both school attendees and non-attendees. One thus deduced that those females who never attended school were more likely to have undergone female genital cutting than those who had attended school.

Figure 46: Proportion of excised females in each region according to school attendance

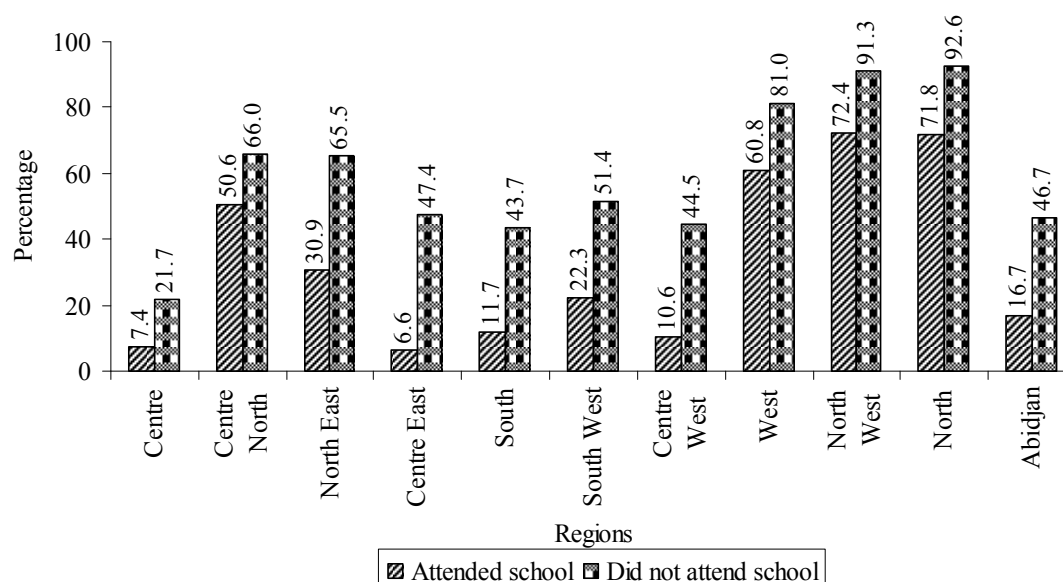
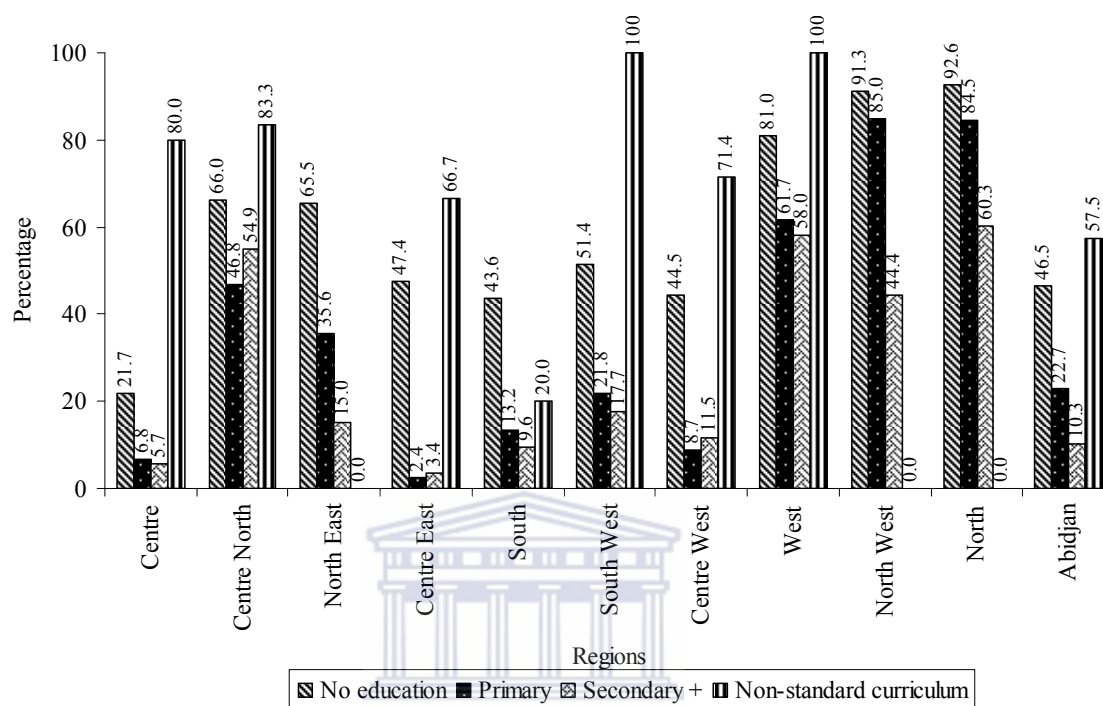


Figure 47: Proportion of excised females in each region according to their level of education

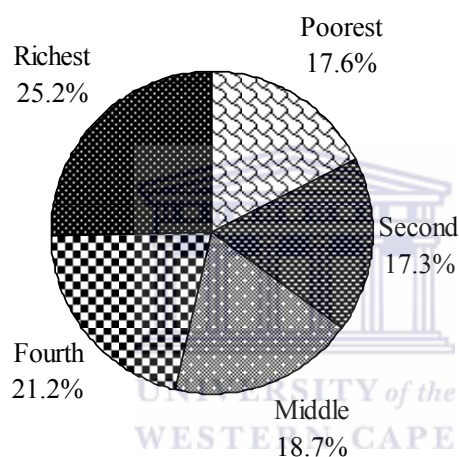


One quickly noticed that those females who have a non-standard curriculum education had the highest levels of excision, except in the three most northern regions of North, North West and North East. The reason therefore was because the non-standard curriculum was not offered in those three regions. In the South, however, those females who had no education had been excised the most at 43.6 percent. When those females who had a non-standard curriculum were excluded, it was apparent that the non educated females were excised the most as compared to the primary and secondary + females in each region. Overall, the excision level and the education level (excluding the non-standard curriculum) had a negative relationship. The more educated the females were, the less likely they were to have undergone some form of mutilation. Females with no education had an excision prevalence of 59.5 percent, while the females with a primary level and a secondary + level of education had a twenty-five percent and sixteen percent prevalence, respectively.

5.4.9 Socioeconomic status

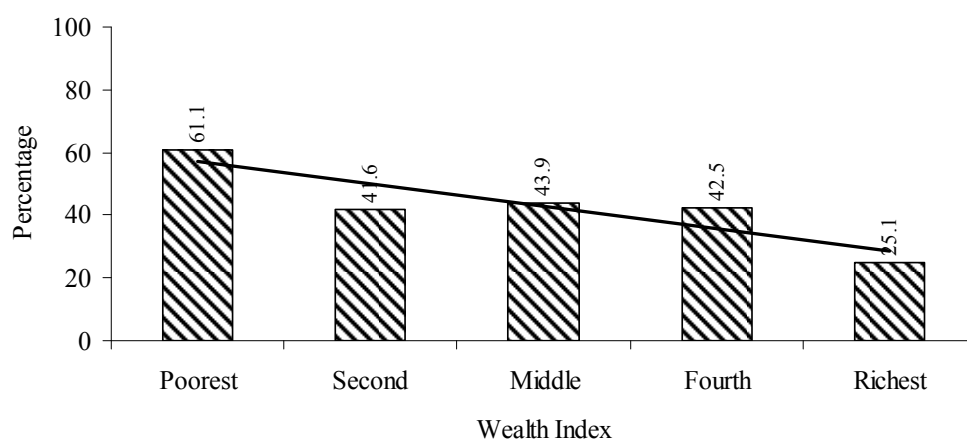
The distribution of wealth in Cote d'Ivoire was fairly evenly spread, as Figure 48 showed. The poorest and second wealth indexes had almost the same proportion of households and thereafter, a slight increase in proportion was seen as the wealth indexes increased. This meant that there were slightly more households in the richest index compared to the other four categories.

Figure 48: Distribution of socioeconomic status



The chi-square test for association produced a 0.000 p-value which indicated that there was a significant association between the wealth index and excision. The cross tabulation of these two variables thus provided a picture of which wealth index was more associated with excision. The result thereof could be seen in Figure 49. The poorest wealth index seemed to have the highest proportion of females who have undergone excision at approximately sixty-one percent. This was the group of households which was most scarcely distributed. The richest wealth index, on the other hand, had the lowest level of excision among the women and made up the largest wealth index in Cote d'Ivoire. It was therefore deduced that a negative relationship between wealth index and excision existed. Consequently, the poorer the female, the more likely she was to have been excised. And the reverse was also true. The wealthier females were excised less than any other wealth index.

Figure 49: Proportion of excised females according to their wealth index



5.4.10 Level of acceptance

Almost sixty-nine percent of the females in Cote d'Ivoire preferred the practice of female genital cutting to be discontinued, while 19.8 percent encouraged its continuation. Of those 2 255 who wanted the practice to continue, almost ninety-four percent had undergone some form of excision. Of the 7 821 females who wanted this tradition to end, 26.4 percent had been excised. This cross tabulation provided an idea as to whether or not these women would have their daughters excised. Those females who had been excised and wanted the practice to continue were expected to send their daughters for excision and only six percent of excised females were expected not to send their daughters. This rate was too low. Just over five percent of females fell into the "depends" category. Within this set of females, fifty-nine percent had not been excised and forty-nine have undergone excision.

Table 19: Level of approval according excised and non-excised females

	Excised (%)	Not excised (%)	Missing (%)	Total	<i>Population size</i>
Continue	93.8	6.1	0.1	100.0	2255
Discontinue	26.4	73.5	0.1	100.0	7821
Depend	41.0	59.0	0.0	100.0	602
Don't know	41.0	59.0	0.0	100.0	646
Missing	0.0	47.5	52.5	100.0	40
Total	41.3	58.4	0.3	100.0	11364

5.5 Ghana

UNICEF conducted the MICS 3 survey during 2005/6 in Ghana. Situated on the western coast of Africa, Ghana was home to female genital mutilation below twenty-five percent and thus fell into the final group of the four prevalence categories. Sixteen questions regarding female genital cutting were posed to each female respondent ranging from “Have you ever heard of female circumcision” to “Should this practice be continued or not”. Female respondents between the ages of fifteen and forty-nine were asked to respond to questions regarding themselves and their daughter’s excision experience. Unfortunately, not much information was obtained in relation to the respondent’s daughters. The MICS dataset reported that of the 6,240 eligible females, 5,891 were successfully interviewed. The consequent FGM prevalence level among the interviewed females in Ghana reached approximately seven percent. The chi-square test for association reported p-values below 0.005 for each of the independent variables that were analysed for Ghana. This implied that a significant association existed between each independent variable and excision in Ghana.

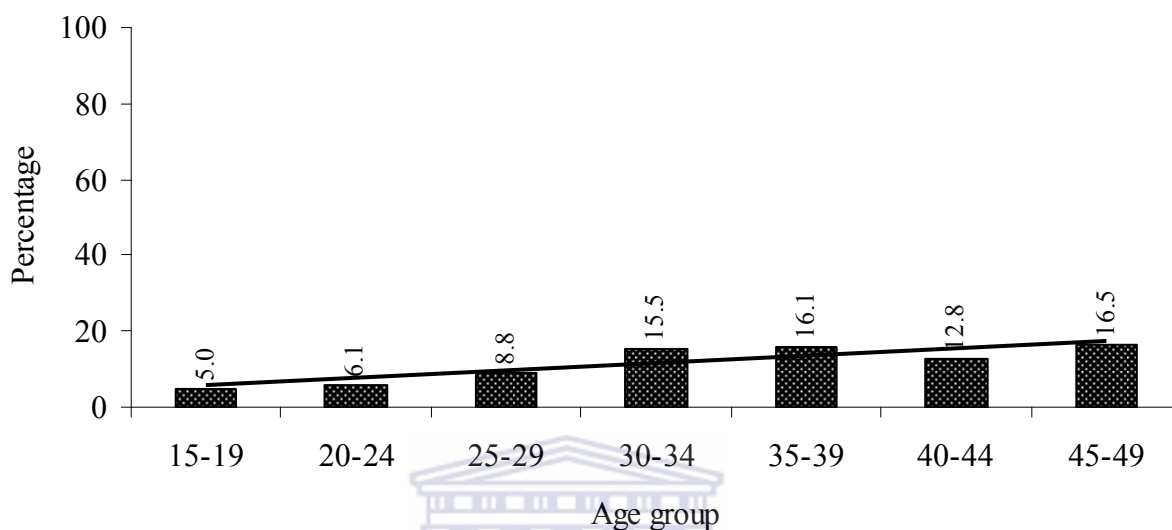
5.5.1 Age of excised females

The proportion of women aged fifteen to forty-nine in Ghana who had undergone some form of excision was depicted in Figure 50 (page 98) according to their age group. It was quite clear that the older females in Ghana had the higher FGM prevalences, while the younger females had lower levels of excision. The trend line had a positive gradient which implied that there was a positive relationship between age and excision. Therefore younger women were excised less than the older ones in Ghana. Unfortunately, due to the nature of the questionnaire, the age at which this operation was performed was not included and thus was unknown.

Approximately twenty percent of the females interviewed were between the ages of fifteen and nineteen and thereafter, the distribution of females per increasing age group, decreased. The older aged females therefore made up a smaller part of the interviewed females, while the younger ones were more weighted. The greater majority of excised females did not know which type of mutilation was performed on them which may have meant that they were very

young at time of the operation. Most of their daughters, however, were reported to have flesh removed from their genitalia, and reached seventy-two percent.

Figure 50: Proportion of excised females according to the age group

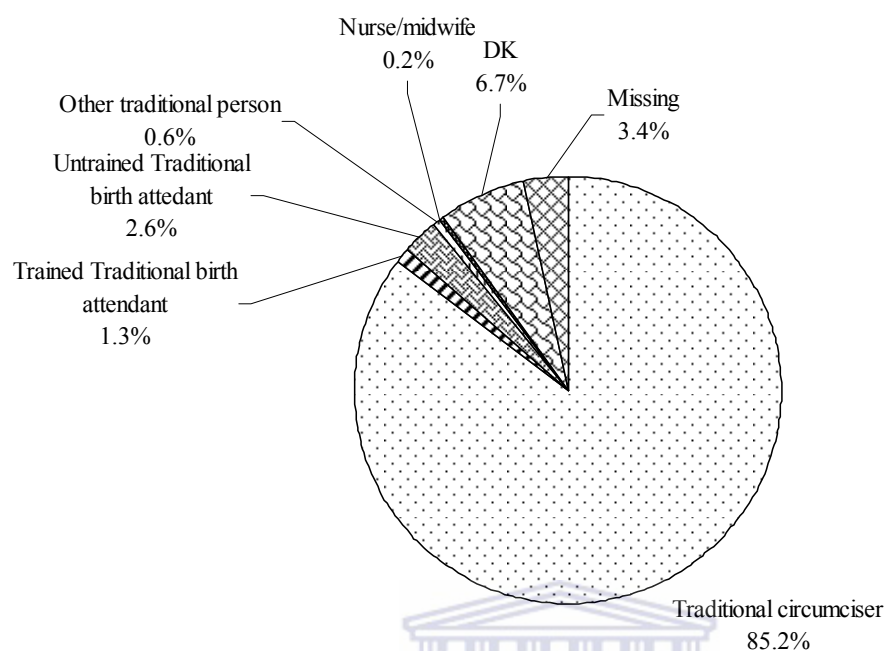


5.5.2 Person who performed the operation

Although the level of excision was fairly low in Ghana, more than eighty-five percent of excised females were excised by a traditional circumciser. Thereafter, almost seven percent of these excised females did not know who performed the excision operation on them. The women may have not remembered who performed the operation because they were very young when it occurred. The female population in Ghana was quite young, and the fact that almost seven percent could not remember who excised them lead one to believe that this operation was done on girls when they were still very young.

Since the vast majority of female respondents have been excised by a traditional circumciser, one could expect that when the decision was to be made about who would perform the excision operation on their daughter(s), the traditional circumciser would also predominantly be called upon. Upon further investigation, this was found to be true. Ninety-two percent of the excised daughters were excised by a traditional circumciser.

Figure 51: Distribution of person performing excision on the respondent



5.5.3 Regions in Ghana

Ghana was made up of ten different regions. The most populated region was that of Greater Accra which constituted fifteen percent of the female population, followed by Ashanti and Northern region at 13.6% and 13.2%, respectively.

Figure 52: Proportion of excised females according to region

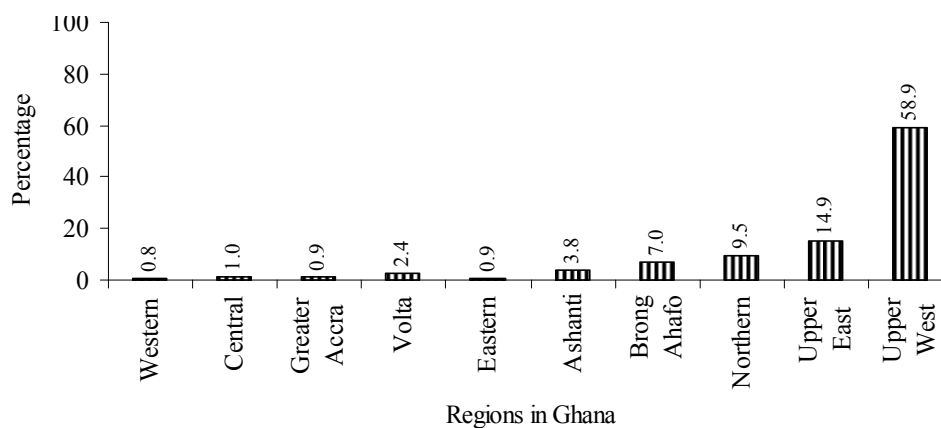


Figure 52 depicted a clear indication that the Upper West region had the highest level of female genital cutting which reached almost fifty-nine percent. The Upper East region had the second highest FGM prevalence of approximately fifteen percent, followed by the Northern region at almost ten percent of its females been excised. This Figure 52 provided a clear picture that the region of residence may have influenced the level of excision, since the Upper West houses only eight percent of all females in Ghana. The Western region had the smallest percentage of females that had been excised at less than one percent. The largest populated region of Greater Accra had less than one percent of females excised.

5.5.4 Area of Settlement

Approximately sixty percent of Ghana comprised of rural developments, while the other forty percent was urban. Greater Accra (89.5%) and Ashanti (56.8%) were the only two regions in which the urban females outweighed the rural females. The Upper West region had the largest proportion of rural women which reached approximately eighty-eight percent, followed by the Upper East region at 85.6% and the Northern region at 78.6%.

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Table 20: Proportion of urbanisation within each region in Ghana

Region	Urban (%)	Rural (%)	Total	<i>Population size</i>
Western	41.1	58.9	100	<i>560</i>
Central	40.8	59.2	100	<i>434</i>
Greater Accra	89.5	10.5	100	<i>939</i>
Volta	25.4	74.6	100	<i>414</i>
Eastern	34.5	65.5	100	<i>606</i>
Ashanti	56.8	43.2	100	<i>850</i>
Brong Ahafo	37.4	62.6	100	<i>471</i>
Northern	21.4	78.6	100	<i>824</i>
Upper East	14.4	85.6	100	<i>632</i>
Upper West	11.6	88.4	100	<i>510</i>

In order to examine whether area of settlement influenced the level of excision in Ghana, a comparison of excised females living in urban and rural areas was performed.

Figure 53: Proportion of excised female in each region according to the area of settlement

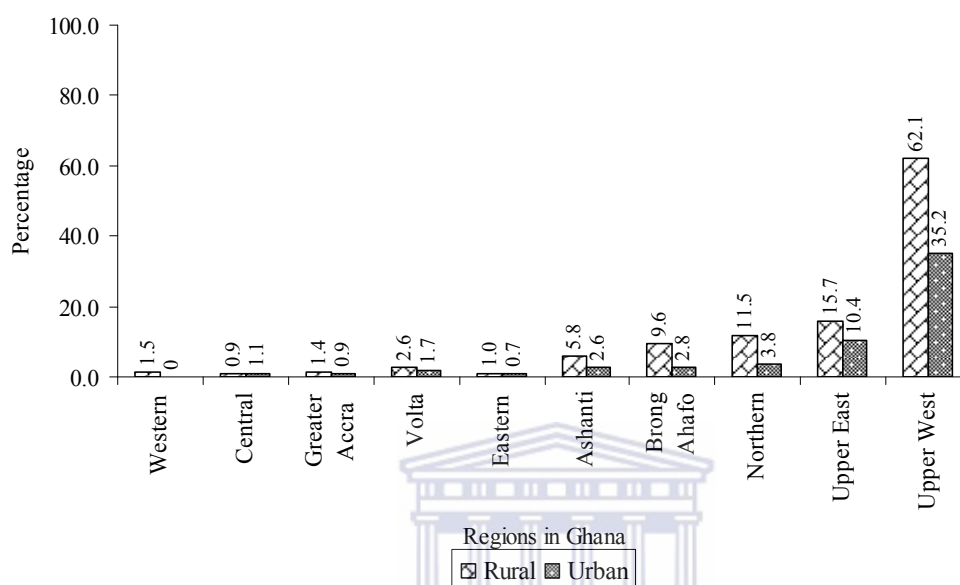
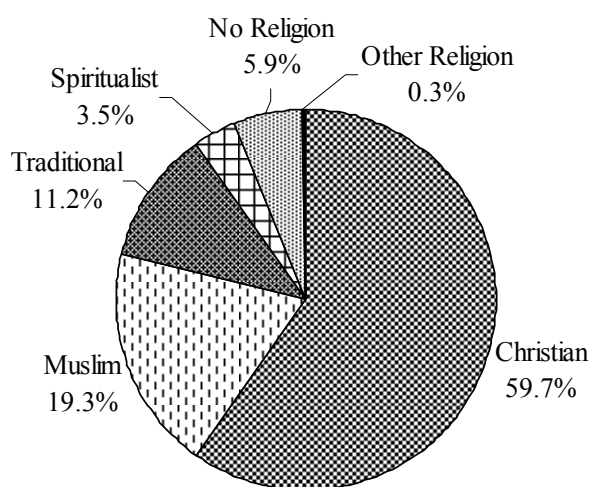


Figure 53 represented the proportion of excised females in each region according to the area of settlement. In the Upper West region of Ghana, approximately sixty-two percent of rural females were excised, while only thirty-five percent of urban females had undergone excision. In most of the regions it seemed as though the rural females were excised more than urban females, even in Ashanti, where there was only a thirteen percent difference in the level of urbanisation. Although half of these regions had extremely low FGM prevalences, the rural females were excised more than the urban ones.

5.5.5 Religion

The four main religion that were found in Ghana included Christians (59.7%), Muslims (19.3%), Traditionalists (11.2%), and Spiritualists (3.5%). As usual, the female and her children assumed the religion of the head of the household. Consequently, the majority of the families in Ghana were Christian.

Figure 54: Distribution of religions in Ghana



Since religion and excision was not statistically significant and therefore not associated, it was expected that not much variation in excision levels would be noticed according to religious affiliation. In all regions, Muslims tended to have the highest excision level except in the Northern and Upper East regions. In these two regions, Traditionalists excised their females the most.

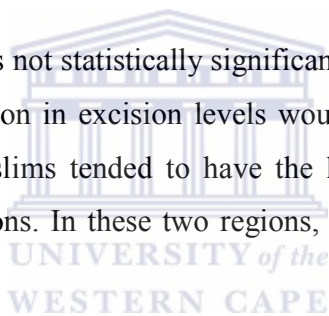
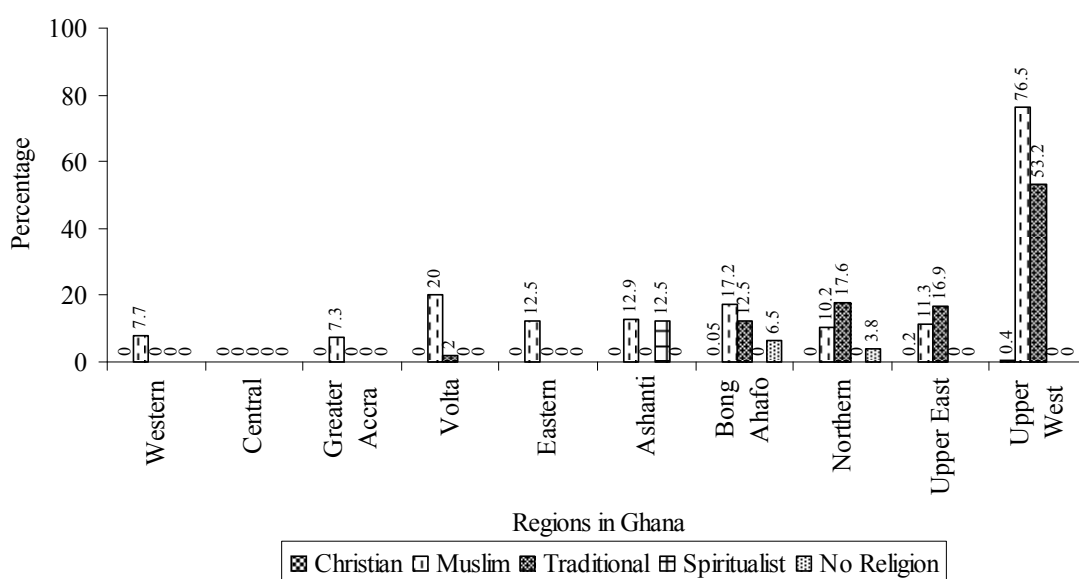


Figure 55: Proportion of excised females in each region according to religion

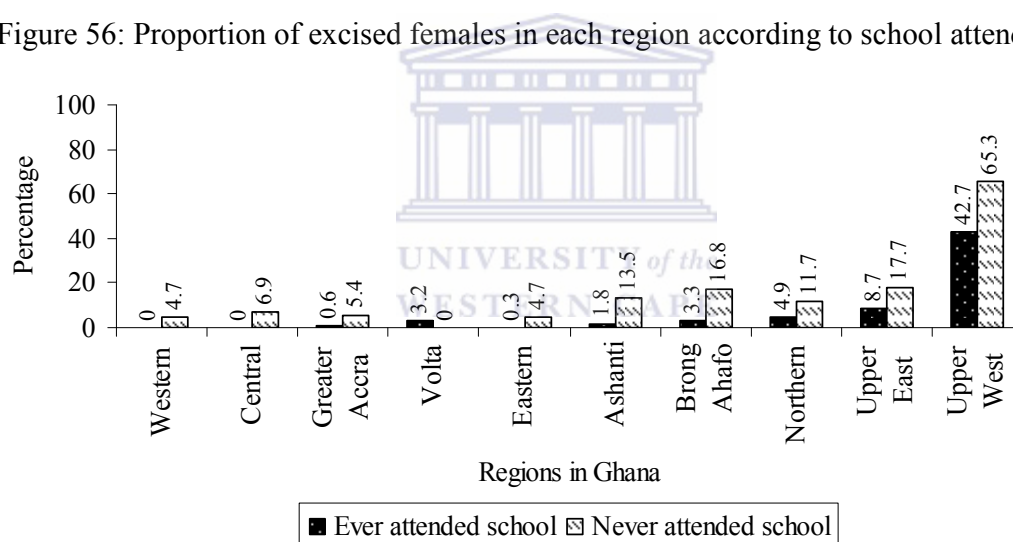


It was also noticed that none of the Christian females were excised in Ghana, while 12.5 percent of Spiritualist in Ashanti were excised. The Upper West region had the highest level of Muslim and Traditional excision at 76.5 percent and 53.2 percent, respectively.

5.5.6 Education level

Literacy levels were examined through asking the respondent whether or not they could read part of a sentence. Alarming, almost sixty-eight percent of females aged fifteen to forty-nine could not read at all, while twelve percent could read only parts of a sentence and nineteen percent could read the entire sentence. This implied that females had very low literacy levels in Ghana.

Figure 56: Proportion of excised females in each region according to school attendance

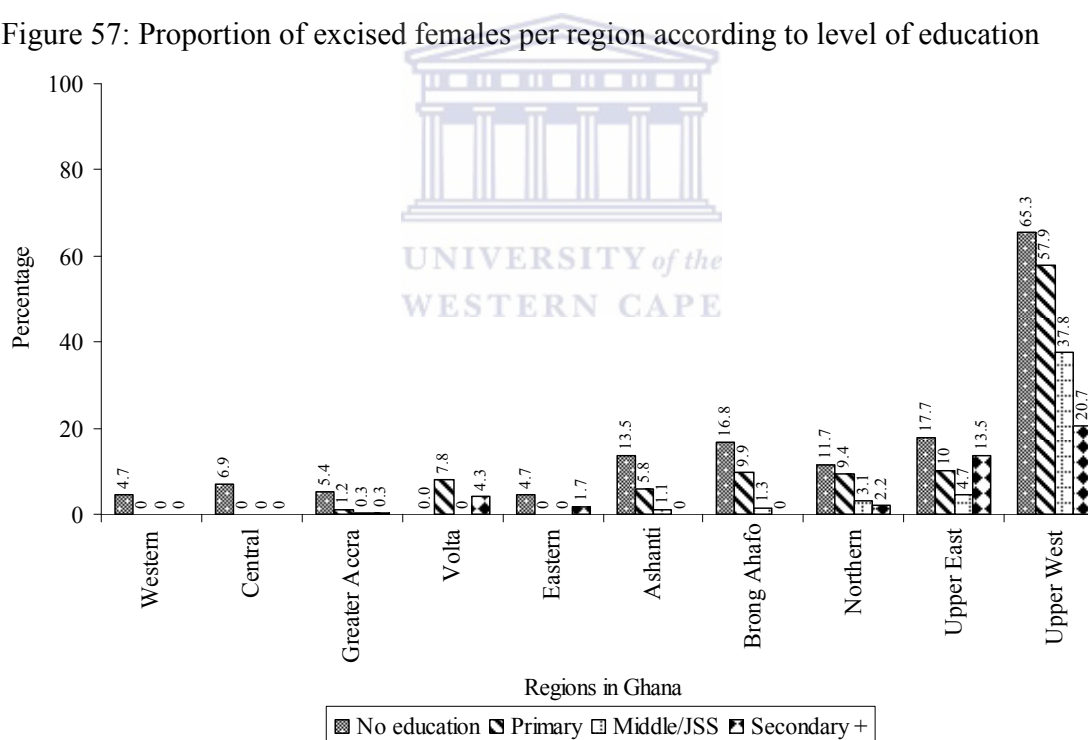


For each region the proportion of excised females was much greater for those females who had never attended school. In the Upper West region, sixty-five percent of females who had never attended school have undergone some form of excision, while forty-two percent of females who attended school were excised. The Upper West region remained the one which had the highest levels of female genital cutting. The pattern noticed in Figure 56 was that when females attend school, the possibility of being excised decreased. A further analysis of

the education level of these Ghanaian women would strengthen the expectation that education influenced the level of excision.

Approximately thirty-four percent of females in Ghana, aged fifteen to forty-nine had no formal education; nineteen percent had primary level; thirty-three percent had middle; and fourteen percent had secondary +. Figure 57 provided a representation of the negative relationship between education and FGM prevalence. It was clearly seen in the Upper West region that when the female had no education, the probability of being excised was at its highest, while females that had secondary + levels of education, the excision prevalence was at its lowest. This trend could be seen in almost all of the Ghanaian regions. Education was therefore an influencing factor regarding female genital cutting.

Figure 57: Proportion of excised females per region according to level of education

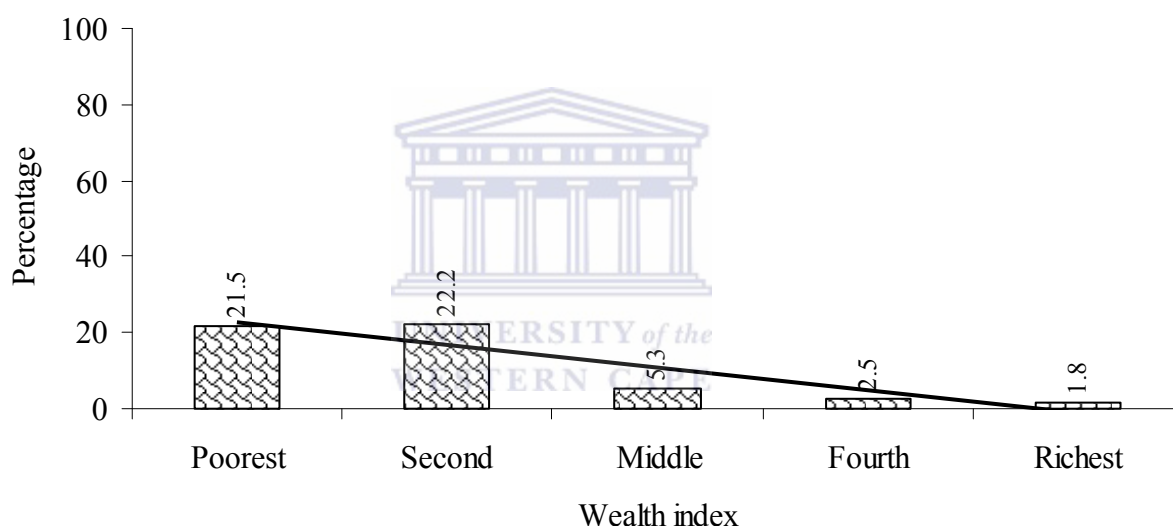


5.5.7 Socioeconomic status

Wealth seemed to be almost evenly spread across the ten regions in Ghana, but majority (twenty-one percent) of the females fell into the poorest wealth index. Figure 58 represented the proportion of excised females according to their level of wealth. One could easily have

seen that a negative sloping gradient existed. This meant that the proportion of excised females and the level of wealth were inversely proportionate. When the females were poor, the chances of her undergoing some form of excision were increased, whereas when the female was rich, the chances of her being excised were seriously diminished. One could therefore deduce that the socioeconomic status of females in Ghana may have influenced the level of female genital cutting. The binary regression analysis, however, reported the opposite. Insufficient evidence existed to conclude that statistically significance between wealth index and excision.

Figure 58: Proportion of excised females according to socioeconomic status

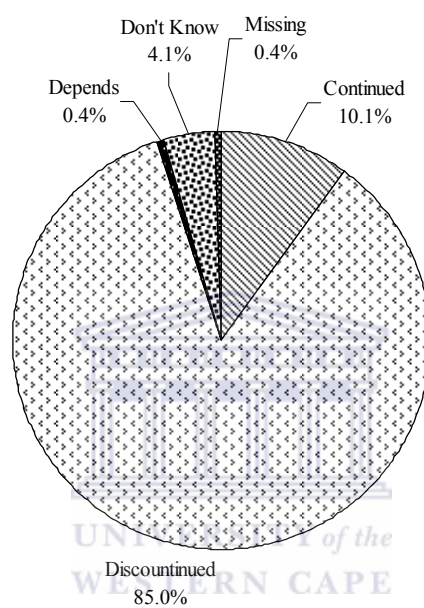


5.5.8 Level of acceptance

When the proportion of excised females was controlled for, the level of acceptance or approval could be seen as a pure phenomenon. This was depicted in Figure 59. Unexpectedly, eighty-five percent of the excised females reported that they would prefer that the practice of female genital cutting be discontinued, while ten percent were happy with the tradition. Four percent said that they did not know whether it should be continued or not. Although this was surprising, it made sense that eighty-five percent of the excised women wanted FGM to

discontinue since the excised population in Ghana was a very small minority of about seven percent. Of the non-excised females, almost ninety-three percent supported the discontinuation of female genital mutilation.

Figure 59: Proportion of excised females who wanted the FGM practice to continue or not



Chapter Six

Overall Results From the data analysis

Each of the independent variables were analysed for the five countries, along with other variables. This chapter compared each independent variable across the five countries in order to gain a better understanding as to which variable caused the most fluctuations in the excision levels. The dominant variables then formed the basis of discontinuation strategies.

6.1 Age of the excised females

Excision levels according to the age group in Sudan and Sierra Leone had similar trends. Both countries had extremely high levels of female genital cutting for each age group with the oldest age groups expressing the higher proportions of excision. Both Sudan and Sierra Leone showed that the youngest age group from fifteen to nineteen had the lowest FGM prevalence. Since these two countries have experienced FGM prevalence's above ninety percent, one could have deduced that the reason for the decrease in the excision prevalence for the youngest age group was because they had not had their first babies yet, or in the case of Sierra Leone, they had not yet reached adulthood and thus they were not "initiated" yet.

The Gambia, on the other hand, showed a fairly flat trend with regards to age group. In fact, the oldest age group from forty-five to forty-nine experienced the lowest level of female genital cutting. This lower excision level was marginal though, since the variation in excision level amongst the age group was between seventy-five and eighty-one percent. Cote d'Ivoire and Ghana showed the most variation in excision levels according to age groups. Both countries showed a positive relationship between age and level of excision. This meant that the older females had the higher FGM prevalence and the younger females had the lower levels.

Consequently, the age of the female seemed to influence the level of female genital cutting in two of the five countries that were analysed. Although the chi-square test results proved that age group and excision were associated for all countries except Gambia, age was not

considered as one of the dominant independent variables which influenced the level of female genital mutilation.

Unfortunately, the age at which the excision was performed on the female respondents was only included in the Sudanese survey, and the age at which their daughters' were excised were also not disclosed. This variable was expected to yield more variation in the level of excision, but could not be included in the analysis.

6.2 Region or State of residence

Four of the five analysed countries showed much variation in excision levels among the regions of residence. Sierra Leone showed little variation among its four regions mainly because the FGM prevalence was approximately ninety-four percent. The Western region, however, had the lowest excision level of the four regions at eighty-three percent.

The other four countries showed more variation among the regions or states. The variation was between 47.6 percent and 99.5 percent in Sudan; between 61.3 percent and 99.4 percent in Gambia; between fifteen and 88.6 percent in Cote d'Ivoire and between 0.8 percent and 58.9 percent in Ghana. The chi-square test for association validated the variation with p-values below 0.005. It was thus deduced that the region or state played a role in whether or not a female was excised.

6.3 Area of settlement

In each of the five countries that were analysed, the area of settlement exhibited differing excision levels. As a whole, the rural populations excised their females slightly more than the urban females. The size of the differences between rural and urban excision was not great in any of these countries. Each country may have had one or two regions which had large variations in excision levels but not enough to determine that the area of settlement created big differences between rural and urban excision. This independent variable was thus not

considered to be one of the leading influencing factors of excision, even though the reported p-values from the chi-square test yielded significant associations.

6.4 Religion

Sudan was not analysed according to religion because the entire North Sudan population was made up of Muslim people. Consequently, a religious affiliation did not influence the excision levels in North Sudan. Across the other four countries under analysis, the Muslim females were excised more than any other religious group. In Sierra Leone, the least difference in Muslim and Christian excision levels was noticed. The Western region of Sierra Leone showed the biggest gap between Muslim and Christian excision, while the other three regions were fairly evenly spread.

The majority of Gambia was made up of Muslims. The differences in excision levels according to religion were found to be huge. The Christian females, on the other hand, were excised very little compared to the Muslims. In Cote d'Ivoire, 70.7 percent of Muslim females were excised, while 50.6 percent of Animists and 25.1 percent of Christian female's undergone female genital mutilation. Vast differences in the excision levels according to religion therefore existed.

Ghana also displayed high levels of excision in the Muslim community, while the Christian females had an almost zero level of excision, even though they constituted approximately sixty percent of the population. Traditionalists, who made up only eleven percent of the population, were excised the second most of the four different religious groups.

The chi-square test reported 0.000 p-values for the association between religion and excision for all four countries. This meant a significant association between these two variables. One could thus conclude that religion influenced the level of excision in three of the five countries to a great extent, especially in Ghana.

6.5 Ethnicity

Ethnicity seemed to influence the level of excision when ethnic groups are distinguished in a population. Sudan, Sierra Leone and Ghana were not sub-divided into ethnic groups and therefore the excision levels in these three countries were not cross tabulated with ethnicity.

In Cote d'Ivoire and Gambia, however, vast differences existed in the female genital cutting prevalences according to the different ethnicities. Since the p-values were significant and the variations in excision levels were vast, the association between ethnicity and excision was validated.

6.6 Education level

In each of the five countries that were analysed, education level of the female respondent exhibited variations in the levels of excision. Excision prevalences in Sudan and Sierra Leone were high but definite differences in excision levels were noticed. Sudan had a slight increase in the level of excision with the increase of education level, which was not expected. Again, Sudan produced a fairly flat indicator for education level.

The other four countries, however, reported a negative relationship between education level and excision. This meant that as the female became more educated, the FGM prevalence decreased. This phenomenon was validated with below 0.005 p-values. The non-standard curriculum, however, still had extremely high excision prevalences, sometimes reaching one hundred percent. Education level could thus be used as a tool when fighting female genital mutilation based on the influencing nature of formal education.

6.7 Socioeconomic status

Sudan and Gambia were the only two countries of the five which showed a socioeconomic trend different from the rest and different to what was expected. It was expected that the level of excision would increase with the decrease of the wealth indexes. This meant that the poorer

females were expected to be excised more than the wealthier ones. Sudan, however, reported the opposite. The wealthier females were excised the most of the five wealth indexes and gradually decreased with the decreasing wealth indexes. Gambia, on the other hand, showed a flatter trend which implied that the level of excision was not exhibiting a uniform pattern. The richer females were, however, the ones that were excised the least of the five wealth indexes.

The other three countries reported similar patterns. A definite downward relationship existed between wealth index and excision. The poorer females were excised more than the wealthier females which indicated that socioeconomic status influenced the level of excision in Sierra Leone, Cote d'Ivoire and Ghana. The significance test validated this association with below 0.005 p-values.



Chapter Seven

Discussion

The sixth of February marks International Day of Zero Tolerance to Female Genital Mutilation; a collaboration by the Inter-Parliamentary Union (IPU), the Geneva Department of Institutions (DI), the International Organisation for Migration (IOM), and the Inter-African Committee on Traditional Practices (IAC) since 2003 (IPU, 2009). This chapter firstly described the current status of campaigns against FGM; and secondly, showed how the reproductive rights of the child were violated by practicing FGM.

7.1 Current status of abandonment campaigns

Many organizations including international and national, governmental and non-governmental agencies have collaborated and established programmes to eradicate FGM, for more than five decades (International Planned Parenthood Foundation, 2008). Due to their efforts, half of the twenty eight practicing countries have introduced legislation that forbids FGM (London Safeguarding Children Board, 2007). However, only four of these countries have brought forward prosecutions (International Planned Parenthood Foundation, 2008). This emphasized the need for more than just legislative action but a more holistic approach to abandon FGM completely. The United Nations Population Fund (UNFPA) has subsequently joined forces with community based human rights groups as well as national governments in a number of African countries to “develop legislation in an effort to end the practice” (2007).

7.1.1 Egypt

During 2005, WHO reported an approximate ninety-seven percent FGM prevalence rate in Egypt. In an effort to lower this almost universal practice, UNFPA collaborated with a few United Nations agencies including the Children’s Fund (UNICEF), Development Programme, Development Fund for Women, and their Office on Drugs and Crime (UNFPA, 2007). In addition to working with these offices, on a community level, the UNFPA also liaised with respected community leaders. In 2003 a FGM-Free Village Project was initiated in sixty Egyptian villages by the UNFPA and collaborators and has since spread to one hundred and

twenty villages (UNFPA, 2007). The aim of this mission was to “provide technical support to strengthen the legal, judicial and health systems in order to better respond to the issue of FGM/C” (UNFPA, 2007). Even though Egyptian government has banned this practice and local campaigns against FGM were running, monitoring and enforcing such legislation was not up to standard.

7.1.2 Kenya

One of the success stories was that of Kenya. Since 2001 Female Genital Mutilation has been illegal (London Safeguarding Children Board, 2007). Since then, the UNFPA has supported a village based project called the Tsaru Ntomonik Initiative, which demonstrated other ways in which the Maasai girls could undergo their rite of passage into adulthood (UNFPA, 2007). Not only were these girls protected from being excised, but they were also offered refuge when they escaped FGM and child marriage, counselling, education, reunification and reintegration back into their communities (UNFPA, 2007). The FGM prevalence has subsequently reduced by approximately six percent (WHO, 2005).

7.1.3 Sudan

Sudan (mainly the north) was one of the African countries in which FGM was almost entirely universal. According to the World Health Organisation in 2005, FGM prevalence was as high as ninety percent. Recognising that Northern Sudan comprised of very religious individuals, the UNFPA knew that they had to penetrate the community from the inside (2007). This meant supporting the Ahfad University for Women in such a way that data could be collected, volunteers could be trained and abandonment campaigns could be run (UNFPA, 2007).

7.1.4 The Gambia

The Gambia was reported to have an approximate seventy percent FGM prevalence rate during 2004 (London Safeguarding Children Board, 2007). For the past few years, the UNFPA has supported the Foundation for Research on Women’s Health, Productivity and

Development (BAFROW) with the main goal to reduce health problems such as the consequences of FGM (UNFPA, 2007). Not only were clinics appropriately sustained, but the UNFPA also translated important FGM documentation into local languages. One of the biggest and most successful campaign strategies was using the media to get the message of FGM abandonment across to all citizens (UNFPA, 2007).

7.1.5 Other African countries

On the West coast, Senegal was reported to have a FGM prevalence rate just below thirty percent (WHO, 2005). Although the FGM prevalence was not as high as in Egypt and Sudan, the UNFPA still decided to work with the Senegalese Parliament to incorporate specific legislation against FGM (2007). The UNFPA also has ties with local leaders in Uganda (Reproductive Education and Health Programme), Burkina Faso (socio-cultural studies), Djibouti (National Strategy agenda promoting women), Nigeria and Ethiopia (collaborating with religious leaders) (2007).

On the whole, the problem of Female Genital Mutilation cannot be eradicated via legislative acts only. If the practice of excision is not carefully monitored and enforced by law, the practice of FGM will continue to thrive in certain communities. A holistic approach, however, is also needed to encourage a different way of thinking and living on the part of the FGM practitioners. By involving the community at the local level using respected leaders, the chances of reducing FGM prevalences are greatly increased.

7.2 FGM is a violation of human rights

What reproductive health rights do young women and children have regarding Female Genital Mutilation? According to the Centre for Reproductive Rights, adolescents (aged 10 to 19) have eight basic reproductive health rights which include (2008):

1. *The right to life, liberty, and security;*
2. *The right to reproductive self-determination;*

3. *The right to consent to marriage;*
4. *The right to health;*
5. *The right to be free from discrimination;*
6. *The right to not be subjected to torture or other cruel, inhuman, or degrading treatment or punishment;*
7. *The right to be free from sexual violence; and*
8. *The right to education and information.*

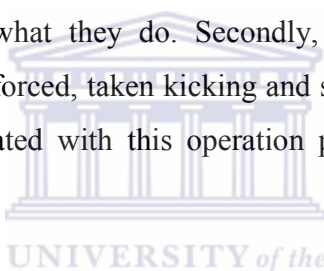
Since young children are vulnerable and dependant on their elders, realising and exercising these human rights are often difficult for the child. According to the United Nations Population Fund (UNFPA) FGM in some countries was carried out on girls at younger ages than before since the reproductive rights of the child became more publicised (2007). Parents and elders in the community were under the impression that the younger the girl was, the less likely the child will protest the ritual and consequently, it could be better hidden from authorities (UNFPA, 2007).

The human and reproductive rights of the child cannot only be set out within state legislation. They have to be monitored and strictly enforced to ensure that the adolescent would be appropriately protected. Consequently, international law dictates that state governments “respect, protect, and fulfil” basic human rights, especially those of the adolescent (Jenson, 2008). In terms of respect, the government is prohibited from abusing the rights of every man, woman, boy or girl (Centre for Reproductive Rights, 2008). Therefore, in countries where FGM is practised, the government should in fact create specific legislation banning this practice as it directly violates the eight reproductive rights of the adolescent. The government is also required to protect its citizens by putting laws in place that punish all acts of human rights violation (Centre for Reproductive Rights, 2008). Where FGM is concerned, governments should protect their young girls by enforcing illegal practices of genital cutting and in tern punish any perpetrators. This form of protection is vital for the child as she is the most vulnerable in her community. The final duty required by the government is fulfilling those basic rights (Centre for Reproductive Rights, 2008). This means that when the child requires information about FGM, it is the responsibility of the state to make sure that such

information is available to the child. Therefore, when governments execute these three duties, the children can identify what their rights are regarding FGM and be certain that the state will protect them against such cruel acts. A closer look at each of the eight basic reproductive rights of the adolescent will clearly illustrate how Female Genital Mutilation violates human rights.

7.2.1 The right to life, liberty, and security

When a young girl is a victim of genital mutilation, her right to life, freedom and safety is ripped away. Firstly, the young girls do not have freedom of choice. In countries such as Yemen, Mali, Mauritania and Ethiopia, majority of the girls undergo genital mutilation before their fifth birthday (WHO, 2005). At this age, the girls cannot refuse the operation merely because their elders control what they do. Secondly, her safety is in the hands of her community. The young girl is forced, taken kicking and screaming, to undergo this operation. The many health risks associated with this operation puts her reproductive life in danger (WHO Journal Paper, 2006).



7.2.2 The right to reproductive self-determination

The age at which the female genital cutting operation is performed creates this enormous problem. Because the young girl is so young at the time she is excised, she cannot take the decision on her own whether to consent to this operation or not (Cook, 2008). Her reproductive life is forever changed due to the consequences of this procedure and her autonomy is thus violated.

7.2.3 The right to consent to marriage

When an under aged girl is sent off to be married, she loses her free-will. Often, she can no longer attend school once she marries as she must now look after the husband and family (Centre for Reproductive Rights, 2008). She is also forced to become sexually active long before she would have if she consented to marriage at the appropriate age. In terms of FGM,

young women are believed to be marriageable only once they are excised (Cook, 2008; London Safeguarding Children Board, 2007). Therefore, if the girl is forced to marry at a young age, the probability of her undergoing genital mutilation at an early age increases. By protecting the young girl's right to consent to marriage, her innocence, autonomy, and reproductive health can be preserved.

7.2.4 The right to health

One of the most basic human rights is that of health. The state is sanctioned to provide basic health care services to those who need it. The girl child is put in harms way due to the numerous health consequences related to Female Genital Mutilation, including physical and psychological issues (WHO, 2001). By not enforcing the prevention of FGM through legislation, the child's basic right to health is violated.

7.2.5 The right to be free from discrimination

This human right includes physical, gender, sexual, social, cultural and religious discrimination. Female Genital Mutilation abuses the right to be free of discrimination in many ways. Firstly, this life-threatening procedure is practiced on females to ensure that they remain submissive and loyal (International Planned Parenthood Foundation, 2008; Bourdanne, 2005) which encourages gender discrimination. Secondly, the female is sexually discriminated against since she is not able to enjoy the privileges of sexual intimacy with her husband if she is excised (Bourdanne, 2005). Finally, should the parent and/or girl child refuse this operation, the young girl will be ostracised by her community because she is not conforming the social, cultural and/or religious norms (London Safeguarding Children Board, 2007).

7.2.6 The right to not be subjected to torture or other cruel, inhuman, or degrading treatment or punishment

Although the mother of an excised daughter does not think that she has mutilated her daughter's genitals (Cook, 2008), essentially, mutilation is exactly what is being done to

young girls. The government should protect the girl child from this procedure even if this means protection against the child's parents or elders in the family. By not preventing this cruel act of pain, the young girl's right not be tortured is completely violated.

7.2.7 The right to be free from sexual violence

All four types of Female Genital Mutilation can be seen as acts of sexual violence against women and girl children. The more severe forms of FGM, however, imply more severe levels of sexual violence. Again, the government should take the place of protecting the young girls in their country from undergoing these operations. Violating this human right through acts of excision should therefore also be punishable by law.

7.2.8 The right to education and information

Without information, young women and girls cannot make the necessary informed decisions regarding Female Genital Mutilation (Centre for Reproduction Rights, 2008). By providing the appropriate education and awareness campaigns, the abandonment process will be more easily implemented. Unfortunately, the young age at which this operation is done prevents those young girls from making informed decisions. Their parents or elders still have the final say. Consequently, by excising the girl children so young, their right to be educated and informed about the consequences of FGM are stripped from them.

These eight basic reproductive rights should not be interpreted separately as they are all interlinking especially where Female Genital Mutilation is concerned. It can easily be seen that by practicing this cultural tradition her human rights are taken away from her before she even knew she had those rights. Governments thus play a major role in the eradication of Female Genital Mutilation.

Chapter Eight

Recommendations

This chapter suggests a few recommendations in two parts. The first describes changes that need to be made regarding the female questionnaire, especially the female genital cutting module. The second uses the findings from the data analysis to improve anti-FGM programs. These recommendations may possibly encourage female genital mutilation to discontinue.

8.1 Data recommendations

The limitations that were found in the UNICEF datasets inhibited more in-depth analysis of association between the dependent variable (excision) and the independent variables. This section aims to recommend questions that should be included in future surveys regarding female genital mutilation, and also explain the necessity thereof.

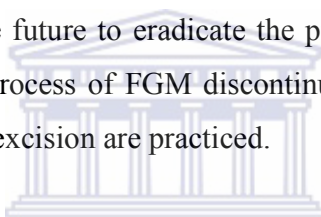
8.1.1 Age at which excision is performed

This variable will enable researchers to analyse at which age the decision is made to have oneself or one's daughter excised. This question was only asked in the Sudanese survey and the results showed that majority of the women were taken for excision between the ages of three and seven years old. By knowing this information, one is able to know that the female did not make the decision to be excised herself, because she would have been too young. If researchers are able to identify the risky age group, FGM education programmes can be drawn to suit that particular age group at risk of making the decision. This means that in Sudan, for example, the mother is the one who is assumed to have made the decision to have her daughter excised. Therefore, it is the mother who needs to be targeted before she has her first child. She will then be able to make informed decisions regarding her daughter.

8.1.2 Type of excision

Responses to this variable are more difficult to attain. The reason therefore lies in the fact that certain females do not know which type of excision she underwent. The excision operation may have occurred too far in her past that the female cannot remember; or she is unaware of the different types of female genital mutilation and thus cannot provide accurate information.

This variable is important, however, because researchers need to know whether a community practices one main type of excision or varies between the four types. If, for instance, a community practices the most severe form of excision, an initial strategy may be to educate the community as to the many dangers of type III mutilation and thus convince them to use a less brutal type of excision. Once this community practices a less severe form of female genital cutting, it may be easier in the future to eradicate the practice. When the tradition is deeply rooted in the community the process of FGM discontinuation is expected to take more time than when less severe types of excision are practiced.



8.1.3 Did the female give her consent to be excised?

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Lawful consent can only be given by a citizen when he or she becomes a major. Different countries have different ages at which this process of adulthood occurs. For the more traditional African families, a girl becomes a woman when she has her first menstruation period. In Sudan, for example, the girls aged three to seven years old could not have given their consent to be excised as they were too young. By forcing the girls to undergo this traumatic, life-changing experience, her human rights and reproductive rights, as a woman and child, are violated.

When the female is an adult over the age of eighteen, she has to be informed about the advantages and disadvantages of this process. Once cognisant of all the aspects surrounding female genital mutilation, she can make informed decisions and her rights will not be violated.

8.1.4 Excision status of the daughter

The excision status of the daughter is a vital tool that can be used to understand the level of approval of this practice. It is expected that if the mother sends her daughter to be excised, she believes in the tradition of female genital cutting and appreciates the practice. If, on the other hand, the excised mother does not send her daughter to be excised, it can be deduced that she does not appreciate the tradition and wants its practice to discontinue. Two of the five countries that were analysed include questions pertaining to their daughters but could not be analysed at all due to inconsistencies in the datasets.

This type of information is also vital when investigating the generational effect of female genital mutilation. By knowing if the level of excision among the mothers is the same as the level among daughters, researchers are able to gauge whether the tradition is reducing and staying constant.

8.1.5 The husband's role in the decision making process

Unfortunately, Sudan was the only country that included the husband's opinion regarding female genital cutting. This, however, was posed to the females who then gave their perception of what the males thought. The results from that analysis indicate that only a small portion of the Sudanese females speak to their husband's about excision. Educating the males in the community is expected to be a beneficial tool to decreasing female genital mutilation as they may prohibit their daughters from undergoing this life-threatening process. In the long run, the more males are educated about the negative reproductive consequences, the bigger role they will play in the decision making process as they are usually the head of the household.

8.1.6 Health consequences

The editor of the African Journal of Reproductive Health has reported that only one scientific research project has shed some light on the adverse effects of female genital mutilation on the

reproductive health of the female (WHO study group, 2006). It is important to gather demographic and health information regarding the complications which follow an excision operation. Medical professionals will therefore need to be trained in the appropriate areas so as to treat the conditions that females experience due to this operation as well as the life-long consequences thereof. By knowing the associated health risks, and the infant and maternal mortality rates according to the severity of the operation, more lives can be saved. This means that females and males need to understand the adverse relationship between excision and health so that informed choices can be made.

By understanding that the more severe form of FGM is associated with more the severe health implications, a community might change their way of thinking. Again, the process of altering a way of life will take a long period of time, especially when this practice is hidden and is deeply rooted in the traditions of a community.

8.1.7 Reasons for and against FGM

The benefits of understanding the reasons why females perpetuate this harmful tradition are immense. Anti-excision programmes can be drawn according to this knowledge. If it is possible to understand how people have changed their decision about continuing excision, more efficient programmes can be undertaken and more positive results will be seen.

It is worthwhile understanding that women have decided not to send their daughter for excision because she has experienced health complications, then policy makers will know that educating females about the adverse effects of excision may be the leading strategy in decreasing female genital mutilation.

If, on the other hand, respondents report that excision is an important religious belief, researchers will have to make use of more creative strategies involving religious leaders and community leaders. Religious beliefs are more difficult to change since religious teachings are the cornerstone of many African communities. It is not possible to change a perceived religious belief overnight. Many educational programmes involving these religious and

community leaders will be necessary to prove that the negative consequences of excision outweighs the cultural benefits.

8.2 Anti-FGM program recommendations

Initially, it was expected that the independent variables that were analysed across the five countries could be translated into a single anti-excision programme which could be administered in all FGM practicing countries. This train of thought no longer seems viable. Since the country's cultural traditions differ, and the reasons for and against female genital mutilation are unknown (for the five analysed countries), country specific programmes need to be improved and maintained. Two main policy recommendations are made in this section; the first being an education strategy and the second involving the males in the community.

8.2.1 Education of the female

Upon investigating the association between the education level of the female and the excision of the female, a negative relationship was exhibited. Those females in the population who had no education had the highest levels of excision, while those who had secondary and above level had lower excision prevalences. This trend is promising as it shows that more educated females make the better, informed decisions not to undergo excision. In countries where the FGM prevalences are very high, decreases in excision can be seen when education increases, even though they are small.

The female literacy levels in all five analysed countries are very low. Since the second Millennium Development Goal is to increase primary education of females, a positive spill over effect may be seen. This means that by increasing the amount of females that have primary education, without even teaching them about the negative consequences of excision, the females are able to make educated decisions.

This, however, cannot be the only form of education that will encourage the discontinuation of female genital mutilation. If primary education is in place, the education of reproductive

health and family planning will be made easier. This is the place when females are educated about the adverse health conditions resulting from female genital cutting. When these young girls are taught about their reproductive life, they should also be informed about all the aspects surrounding female genital cutting. The young girl will then be able to make informed decisions as to her sexuality and reproductive life.

This strategy will only reap rewards if the girl has a primary education level and is given the opportunity by the government (in the form of infrastructure and programmes) and her parents (by allowing her to attend these programmes and allowing her to make her own decision) to do so. Without the support of the family and the community, this transition process may never succeed.

8.2.2 Male involvement

In the African household the male, if present, normally takes the role of the head of the household. This means that decisions regarding the household and the family members must be validated by him. This strong patriarchal nature of the family, however, seems to be deviated with regards to the decision whether or not to be excised.

It would thus seem worthwhile to involve the males in the community in the reproductive health education of the female. Since Sudanese analysis reported that a small minority of females discuss this practice with their husbands, and the husbands who are not aware are indifferent, one can deduce that education and information may aid the decision making process.

If the males in the community support the programmes that will encourage the discontinuation of excision, the rest of the family members will also follow suit. Consequently, by persuading the dominant males in the community to stop the excision tradition, the females will no longer be obliged to continue with this practice.

Chapter Nine

Conclusion

The main objective of the research was firstly to compare the female genital mutilation characteristics across five countries with varied excision prevalence's. The five countries selected for analyses were Sudan (ninety percent), Sierra Leone (ninety-four percent), The Gambia (seventy-nine percent), Cote d'Ivoire (forty-five percent), and Ghana (five percent). Two countries, Sudan and Sierra Leone, fell into the highest prevalence category. It was decided to analyse two group one countries since their prevalence were extremely high, but also because Sudan produced relatively flat indicators. The second main objective was then to analyse those independent variables that were found to influence the excision decision.

The SPSS package allowed for the descriptive and cross tabulation analyses. Unfortunately, data limitations prohibited the examination of identical variables across the five countries. It was found that in each of these five countries, the independent variables influenced the excision decision differently. The most influential variable found in Sudan was region of residence, while Sierra Leone was most influenced by the education level, followed by the region of residence. The Gambia, on the other hand, was found be most influenced by their religion, which reported that Muslim females were excised more than any of the other religious affiliations. The two lower prevalence countries of Cote d'Ivoire and Ghana both exhibited education level as the predominant influential independent variable.

The independent variables which were examined were then discussed to emphasize which variables, across the five countries, were more influential to encouraging female genital mutilation. This made it possible to deduce which variables were more likely to yield decreasing excision levels. Anti-FGM campaigns were also reviewed and discussed, along with reproductive health rights violation. Once completed, two sets of recommendations were provided for future work. The first involved data recommendations which aimed to improve the quality of questionnaires and ultimately, data quality, while the second set involved strategic recommendations for anti-FGM campaigns.

The final result from this research work was that female genital mutilation was deeply rooted in traditional, cultural and religious beliefs. The absolute use of legislation and education strategies was found to be less efficient, especially when religion and culture were ignored. Unfortunately, standardised strategies to reduce the excision incidences in Africa were found not to be best. However, unique and diversified campaigns were expected to reach maximum success. Since this tradition was found to be a religious tradition, only perseverance through education of religious and cultural leaders was expected to eventually reduce FGM incidences and consequently eradicate the tradition.



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Appendices

A. Chi-square test results

A.1. Sudan

Age Group

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	1.054E2	12	.000
Likelihood Ratio	102.360	12	.000
Linear-by-Linear Association	20.475	1	.000
N of Valid Cases	22945		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 11.04.

State

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	3.555E3	30	.000
Likelihood Ratio	2867.059	30	.000
Linear-by-Linear Association	203.878	1	.000
N of Valid Cases	22945		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.11.

Area of settlement

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	85.930 ^a	2	.000
Likelihood Ratio	88.954	2	.000
Linear-by-Linear Association	27.842	1	.000
N of Valid Cases	22945		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 58.35.

Education level

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	910.943 ^a	8	.000
Likelihood Ratio	1115.337	8	.000
Linear-by-Linear Association	262.504	1	.000
N of Valid Cases	22945		

a. 3 cells (20.0%) have expected count less than 5. The minimum expected count is .32.

Socioeconomic status

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	4.623E2	8	.000
Likelihood Ratio	560.812	8	.000
Linear-by-Linear Association	169.388	1	.000
N of Valid Cases	22945		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 23.58.

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A.2. Sierra Leone

Age Group

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	2.777E2	12	.000
Likelihood Ratio	209.573	12	.000
Linear-by-Linear Association	107.755	1	.000
N of Valid Cases	7502		

a. 7 cells (33.3%) have expected count less than 5. The minimum expected count is .06.

Region

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	5.169E2	6	.000
Likelihood Ratio	383.332	6	.000
Linear-by-Linear Association	277.943	1	.000
N of Valid Cases	7502		

a. 4 cells (33.3%) have expected count less than 5. The minimum expected count is .15.

Area of settlement

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	3.506E2	2	.000
Likelihood Ratio	314.973	2	.000
Linear-by-Linear Association	312.387	1	.000
N of Valid Cases	7502		

a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is .30.

Religion

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	1.281E2	8	.000
Likelihood Ratio	108.828	8	.000
Linear-by-Linear Association	94.775	1	.000
N of Valid Cases	7502		

a. 10 cells (66.7%) have expected count less than 5. The minimum expected count is .00.

Education level

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	5.716E2	6	.000
Likelihood Ratio	437.209	6	.000
Linear-by-Linear Association	444.863	1	.000
N of Valid Cases	7502		

a. 5 cells (41.7%) have expected count less than 5. The minimum expected count is .00.

Socioeconomic status

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	3.702E2	8	.000
Likelihood Ratio	321.418	8	.000
Linear-by-Linear Association	237.205	1	.000
N of Valid Cases	7502		

a. 5 cells (33.3%) have expected count less than 5. The minimum expected count is .19.

A.3. The Gambia

Age Group

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	15.791 ^a	12	.201
Likelihood Ratio	16.582	12	.166
Linear-by-Linear Association	1.642	1	.200
N of Valid Cases	9904		

a. 7 cells (33.3%) have expected count less than 5. The minimum expected count is .76.

Region

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	1.025E3	12	.000
Likelihood Ratio	1254.904	12	.000
Linear-by-Linear Association	180.945	1	.000
N of Valid Cases	9904		

a. 7 cells (33.3%) have expected count less than 5. The minimum expected count is .71.

Area of settlement

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	1.618E2	2	.000
Likelihood Ratio	159.928	2	.000
Linear-by-Linear Association	125.483	1	.000
N of Valid Cases	9904		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.87.

Religion

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	8.273E2	6	.000
Likelihood Ratio	632.863	6	.000
Linear-by-Linear Association	133.780	1	.000
N of Valid Cases	9904		

a. 6 cells (50.0%) have expected count less than 5. The minimum expected count is .01.

Ethnicity

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	4.543E3	10	.000
Likelihood Ratio	3968.013	10	.000
Linear-by-Linear Association	14.099	1	.000
N of Valid Cases	9904		

a. 6 cells (33.3%) have expected count less than 5. The minimum expected count is .53.

Education level

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	1.260E2	8	.000
Likelihood Ratio	122.880	8	.000
Linear-by-Linear Association	17.725	1	.000
N of Valid Cases	9904		

a. 6 cells (40.0%) have expected count less than 5. The minimum expected count is .01.

Socioeconomic status

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	4.279E2	8	.000
Likelihood Ratio	406.264	8	.000
Linear-by-Linear Association	74.017	1	.000
N of Valid Cases	9904		

a. 5 cells (33.3%) have expected count less than 5. The minimum expected count is 2.48.

A.4. Cote d'Ivoire

Age Group

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	1.773E2	12	.000
Likelihood Ratio	174.227	12	.000
Linear-by-Linear Association	65.930	1	.000
N of Valid Cases	11362		

a. 4 cells (19.0%) have expected count less than 5. The minimum expected count is 1.70.

Region

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	2.661E3	20	.000
Likelihood Ratio	2797.545	20	.000
Linear-by-Linear Association	68.777	1	.000
N of Valid Cases	11362		

a. 10 cells (30.3%) have expected count less than 5. The minimum expected count is .46.

Area of settlement

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	92.393 ^a	2	.000
Likelihood Ratio	92.505	2	.000
Linear-by-Linear Association	69.082	1	.000
N of Valid Cases	11363		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 14.20.

Religion

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	3.065E3	14	.000
Likelihood Ratio	3283.448	14	.000
Linear-by-Linear Association	20.737	1	.000
N of Valid Cases	11363		

a. 6 cells (25.0%) have expected count less than 5. The minimum expected count is .12.

Ethnicity

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	4.406E3	12	.000
Likelihood Ratio	4942.269	12	.000
Linear-by-Linear Association	2432.327	1	.000
N of Valid Cases	9504		

a. 6 cells (28.6%) have expected count less than 5. The minimum expected count is .07.

Education level

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	1.810E3	6	.000
Likelihood Ratio	1895.152	6	.000
Linear-by-Linear Association	944.365	1	.000
N of Valid Cases	11364		

a. 1 cells (8.3%) have expected count less than 5. The minimum expected count is .21.

Socioeconomic status

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	6.704E2	8	.000
Likelihood Ratio	685.236	8	.000
Linear-by-Linear Association	367.120	1	.000
N of Valid Cases	11364		

a. 1 cells (6.7%) have expected count less than 5. The minimum expected count is 4.55.

A.5. Ghana

Age group

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	1.058E2	12	.000
Likelihood Ratio	108.599	12	.000
Linear-by-Linear Association	45.962	1	.000
N of Valid Cases	4338		

a. 7 cells (33.3%) have expected count less than 5. The minimum expected count is .40.

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Region

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	1.363E3	18	.000
Likelihood Ratio	986.977	18	.000
Linear-by-Linear Association	478.375	1	.000
N of Valid Cases	4338		

a. 10 cells (33.3%) have expected count less than 5. The minimum expected count is .18.

Area of settlement

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	2.265E2	2	.000
Likelihood Ratio	259.397	2	.000
Linear-by-Linear Association	141.169	1	.000
N of Valid Cases	4338		

a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is 1.78.

Religion

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	4.791E2	20	.000
Likelihood Ratio	494.002	20	.000
Linear-by-Linear Association	31.161	1	.000
N of Valid Cases	4338		

a. 13 cells (39.4%) have expected count less than 5. The minimum expected count is .01.

Education

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	4.669E2	8	.000
Likelihood Ratio	478.326	8	.000
Linear-by-Linear Association	259.337	1	.000
N of Valid Cases	4338		

a. 7 cells (46.7%) have expected count less than 5. The minimum expected count is .00.

Socioeconomic status

Chi-Square Tests

	Value	Degrees of freedom	Asymp. Significance (2-sided)
Pearson Chi-Square	3.998E2	8	.000
Likelihood Ratio	424.226	8	.000
Linear-by-Linear Association	226.751	1	.000
N of Valid Cases	4338		

a. 5 cells (33.3%) have expected count less than 5. The minimum expected count is .59.