

## **Part III.L**

### **Female Genital Cutting**

- Percent of population that know about FGC: legal status, religious position, health risks
- Percent of the population favorable to the continuation of FGC
- Percent of women 15-19 years old who have undergone female circumcision

## FEMALE GENITAL CUTTING

Female genital cutting (FGC) or female circumcision is a generic term for traditional practices involving the cutting of female genitalia leading to the partial removal of the female genitalia or injury to the female genital organ for cultural or any other non-therapeutic reasons (Toubia, 1995; WHO, 1995d). Another term for this practice is female genital mutilation, which emphasizes the permanent physical damage done to the female genitalia (Yoder, Camara, and Soumaoro, 1999).

Female circumcision is deeply rooted in many African societies. The practice occurs in over 16 countries, but is rare or unknown in at least 20 other African nations. National borders are less relevant to delineating zones for this practice than are transnational cultural zones (Akweongo et al., 2001). More a secular than a religious phenomenon, FGC is found in both Muslim and Christian societies. Although a number of countries have banned female circumcision, the degree of enforcement varies from one country to another. For example, in Guinea circumcision is punishable by life imprisonment, but no one has ever been indicted for this crime (Yoder, Camara, and Soumaoro, 1999). By contrast, in Ghana authorities make every effort to prosecute practitioners who are caught; the media widely publicize these cases and identify perpetrators, as a form of social humiliation intended to deter others (Reason, 2001).

The WHO (1996d) has classified four types of female circumcision:

- Type I: Excision of the prepuce with or without excision of part or all of the clitoris;
- Type II: Excision of the prepuce and clitoris together with the partial or total excision of the labia minora. This type accounts for 80 percent of all cases;
- Type III (infibulation): Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening. Infibulation is mostly found in North Africa; and

- Type IV: Includes enlargement of the vagina (introcision); the pricking, piercing, incising, or cauterizing of the clitoris; the scraping of surrounding tissue of the vaginal orifice; or the cutting of the anterior, posterior vaginal wall (gishiri cuts); and sometimes the introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing.

According to Obermeyer's review of over 400 articles and reports on FGC published since 1995, the consequences of FGC include: (1) short-term effects, such as pain, hemorrhage, shock, and infection; (2) long-term effects, such as urinary infection, scarred tissue, fertility problems, and complications during child birth; and (3) long-term effects on the woman's sexuality and her social and affective relationships (Obermeyer, 1999). Although many assume that female genital cutting often results in death or severe complications, Obermeyer's review provides little evidence to support this contention. Rather, no incontrovertible evidence on mortality exists, and the available research suggests that severe complications are relatively infrequent. Political, economic, and ethical factors at both the local and international levels may explain this apparent contradiction between popular assumptions and available empirical evidence. Obermeyer concludes, "the scarcity of evidence regarding the complication of female genital surgeries is probably due to the lack of concerted efforts to investigate harmful effects rather than to the relative safety of these operations."

The response of the international community to FGC has swung from the cultural absolutism of Christian missionaries in the first half of the twentieth century, to a cultural relativism, and more recently back to the absolutist stand advocated by most sections of the Women's Movement and increasingly by international institutions (Caldwell, Orubuloye, and Caldwell, 1999). In the 1920s and 1930s, Christian missionaries in Kenya attacked the

practice on the grounds that it conflicted with Christian mores. For the next 50 years, the prevalent view was one of cultural relativism. In the 1950s, WHO avoided taking a stand against FGC on the grounds that these were “operations based on social and cultural backgrounds.” By contrast, over the past 20 years, the women’s movement has collaborated with NGOs and brought pressure on international organizations to work for the elimination of FGC. The practice remains bewildering and abhorrent to many Westerners, who fail to comprehend the reasons this practice should exist.

The motivations behind FGC are complex. Feminist groups have attributed the perpetuation of the practice to African traditions of male dominance and of the patriarchal system. Those who support FGC believe that it purifies the girl (by reducing her sexual desire), favorably socializes her through the instruction and training she receives during her seclusion, and ensures fidelity. One widely held view in some countries is that men prefer to marry circumcised women and will pay more in brides’ wealth for them, although this is by no means consistent over countries. Caldwell, Orubuloye, and Caldwell (2000) cite respect for tradition and social conformity: “the central issues are fears of making their daughters seem outside the expectations of society and possibly unmarriageable, and making themselves also the objects of deep suspicion.”

Two aspects of FGC absent from portrayals of this practice in the Western media are (1) that women play a key role in sustaining the practice, and (2) that, in some societies, the girls “decide” whether to undergo FGC (Akweongo et al., 2001; Yoder, Camara, and Soumaoro, 1999; Caldwell, Orubuloye, and Caldwell, 2000). Traditionally, older women (including mothers, co-wives, and heads of compounds) sustain the practice by exerting enormous pressure on young girls to undergo the procedure. Social ostracism and mockery rather than physical coercion are often used to ensure that the girl gets circumcised.

Several studies to date indicate that although the practice remains deeply rooted, the seeds of change are evident among more educated, urbanized populations. In a focus group study in Northern Ghana, the predominant view still favored FGC. However, a minority believed that the negative messages once directed to the uncircumcised are now more typically expressed as negative attitudes toward the practice (Akweongo et al., 2001). In one area of Guinea, women did not seem to want to

abandon the practice, but they are ready to adopt a less severe form of FGC (Yoder, Camara, and Soumaoro, 1999).

In most countries where FGC is practiced, local groups (often NGOs) bolstered by international supporters have developed programs to combat FGC. Four intervention strategies used to reduce the practice of FGC<sup>1</sup> include: (1) raising awareness, (2) selecting some members of the community to serve as change agents (facilitators) in their communities including individuals who have resisted FGC (positive deviants), (3) integrating anti-FGC messages into development activities, and (4) strengthening advocacy (Abdel-Tawab and Hegazi, 2000).

The evaluation of such initiatives should ideally link to a model of behavior change. Specifically, evaluators can then select indicators to determine progress toward the desired outcome. Izett and Toubia (1999) describe five stages of behavior change in relation to FGC: precontemplation, contemplation, preparation, action, and maintenance. This model overlaps somewhat with the ideational change model presented in Part II.F. The indicators presented in this section reflect the components of knowledge, attitude, and behavior of the latter model. However, one important difference is that these three outcome indicators may each refer to a different player in the decision for FGC. For example, we want to measure knowledge and attitudes related to FGC among those who will decide or encourage a young girl/woman to have the procedure done (e.g., village elders, mother, mother-in-law). However, measurement of the practice – the outcome in this case – is based on the young woman who has (or has not) undergone FGC.

To date, evaluation of anti-FGC interventions has been minimal. To the extent they exist, such efforts have focused on process: participant turnout to seminars and other events, participant reaction to the seminar, and knowledge gain measured by pre- and post-tests. The observation of Abdel-Tawab and Hegazi (2000) relative to Egypt equally applies to most countries where FGC is practiced:

NGOs seldom document the process they follow in implementing interventions, the strengths and weaknesses of each approach, difficulties faced in implementation, or ways of overcoming those difficulties.

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<sup>1</sup> Although the authors based their analysis on Egypt only, these same categories appear to apply to other countries as well.

Also, there is scant empirical evidence about the impact of these various models of programmatic interventions.

One promising source of good data on FGC is the module developed by Macro International in connection with the DHS survey. To date, this research has been diagnostic in nature, conducted to better understand the extent of the practice and the conditions under which it occurs. The three indicators presented in this chapter are all population-based, and two of the three are available through the DHS module. Evaluators can use them to track change, though in most cases, they will have difficulty attributing change uniquely to program interventions (in the absence of a control group). These same population-based indicators can serve in smaller scale studies designed for the express purpose of evaluating FGC interventions. Since eradication of this practice may take years to achieve (despite notable progress in some countries such as northern Ghana), evaluators should track evidence of change in the form of knowledge and attitudes, in addition to the actual reduction in practice of FGC.

### **Methodological Challenges of Evaluating Programs to Eradicate FGC**

To date, governments and NGOs have tried different approaches for eradicating FGC. In the 1980s and 1990s, advocacy groups exposed the practice in selected countries through the mass media, in the hopes that the international community would exert pressure on local governments to ban the practice. Indeed, FGC is now illegal in numerous African countries: Burkina Faso, Central African Republic, Ivory Coast, Djibouti, Ghana, Guinea, Senegal, Tanzania and Togo (The Center for Reproductive Law and Policy - CRLP, 2001). However, these countries may or may not enforce the laws. A second wave of initiatives, beginning in the 1990s, has attempted to eliminate FGC by helping communities to understand the factors that sustain FGC and to explore alternative strategies for ushering girls into womanhood. These initiatives seek to conserve the positive cultural values associated with the traditional ceremonies, while eliminating the physical and psychological trauma of FGC (Nazzari et al., 2001; LSC, 1998a; LSC, 1998b). Few organizations have systematically evaluated these initiatives; often implementation is sufficiently daunting that organizations do not even consider evaluation. However, notable exceptions are now emerging.

For example, the Navrongo Health Research Centre is conducting a community-informed experiment in preventing female genital cutting among the Kassena-Nankana of northern Ghana. During the first phase of this four-year experiment, the research team will use qualitative data research methods to clarify the complex social rationale behind the practice of female circumcision, to identify socially acceptable strategies of responding to these traditions, and to identify outreach activities for preventing FGC. In the second phase, the team will use lessons learned from the village micro-pilot to test the impact of the Phase I strategy on a larger scale in the community. The intervention will continue for a period of four years. In contrast to many of the national-level programmatic interventions covered in this *Compendium*, this project will experiment in a single, small, isolated village in northern Ghana. This project illustrates two of the potential methodological problems that can emerge in evaluating interventions to eliminate FGC:

- **As people become increasingly aware that these practices are illegal and socially unacceptable, response bias will increase.**

As programs to prevent these practices reach an increasing number of people, those who may previously have reported the practice will become increasingly reluctant to do so. One approach to combating this problem is to obtain information from more than one source (e.g., the young woman, her parents, and other community members).

The incidence of underreporting may relate to age of the respondent, especially if younger women are more aware of the anti-FGC initiatives and/or are more motivated to appear “modern.” Thus, comparison of percentage circumcised by different age cohorts may be subject to this bias.

- **Members of the key population may leave home, creating a problem of “censoring” in the data.**

In the case of FGC research, a key population of interest is young women. However, young adults often leave their rural settings to pursue economic activities in larger cities. In areas with high levels of migration toward urban areas, studies in rural areas may have a considerable “lost to observation” rate for adolescent women

(Nazzar et al., 2001). Results will be biased if those who migrate are less likely to be circumcised than those who stay are (i.e., selectivity).

A third methodological consideration, addressed in connection with the 1995 Egypt DHS, is the following:

- **Women may not be able to accurately report if they are circumcised or not.**

Self-reported data are always subject to bias, especially in relation to a medical procedure such as the type of circumcision performed. Some FGC researchers have questioned whether women **know** whether they are circumcised; even their husbands may not know for sure.

This question arose in connection with the 1995 DHS in Egypt, a country with high prevalence of FGC (97 percent as of 1995). A special clinic-based study compared the clients' responses (self-report) to physical evidence obtained at the time of a pelvic exam performed by specially trained gynecologists. The 1,339 women included in the study – clients at the clinic for family planning or gynecological problems – were not representative of the national population, but provided a useful basis for this assessment. In 94 percent of the cases, the woman's self report coincided with the physical evidence of the amount of tissue excised during circumcision. In 5 percent of the cases, the women reported circumcision when in fact the gynecologists found no physical evidence of it. And one percent of women reported that

they were not circumcised, when in fact they were (El-Zanaty et al., 1996).

These findings from this one study suggest that women are able to reliably report the type of procedure performed. However, these findings conflict with anecdotal evidence that some women may not even know if they are circumcised, let alone the type of circumcision performed. Moreover, as promotional/informational programs on FGC become more frequent and FGC becomes less socially acceptable or “modern,” then the reliability of self-report may diminish.

The indicators that follow are all quantitative in nature. To develop a more thorough understanding of FGC, qualitative research is essential. One promising area for additional research relates to coming-of-age rituals and puberty rights. For example, as Reason (2001) has asked, “Are there changes over time in response to initiatives to eradicate FGC?” Because FGC is a new area for program evaluation, we limit the number of proposed indicators to three, with the expectation that as work in this area evolves, additional indicators may emerge. Earlier drafts of this volume contained a fourth indicator on the type of (severity of) circumcision performed, with the rationale that moving toward less radical forms of the procedure represented some type of progress. However, on the advice of reviewers, we dropped this indicator on the grounds that it may imply acceptance of less severe forms of FGC.

## Indicator

### PERCENT OF THE POPULATION THAT KNOW ABOUT FGC: LEGAL STATUS, RELIGIOUS POSITION, HEALTH RISKS

#### Definition

“Knowing about” FGC refers to possessing specific factual information about the procedure, which may or may not affect attitudes toward it. The specific items to be tested may differ from one country to another, but illustrative knowledge items include the following.

Legal: Is the practice of female circumcision legal or illegal in this country?

Religious: Does the Islamic faith require girls to be circumcised?<sup>2</sup>

Health risks: Are girls who undergo FGC at greater health risk than those who do not?

This indicator is calculated as:

$$\frac{\text{\# of respondents that know about the (legal status/religious position/health risks) of FGC}}{\text{Total \# of respondents}} \times 100$$

The local term for female circumcision is generally used in this type of question, rather than the more technical WHO classification presented above.

#### Data Requirements

Response to questions on survey

#### Data Source(s)

Representative survey of the population

#### Purpose and Issues

An important first step in eradicating FGC is to raise awareness about the procedure and to expel widely held myths. Two key points that are useful to this end are (1) that FGC is illegal in a given country and (2) that FGC is not mandated by Islam.

A third point often used by advocacy groups relates to the negative health consequences of FGC. Indeed, the

number one objection to this practice in studies conducted to date has been negative health consequences. As such, it would seem logical for evaluators to test on this knowledge item. However, the issue of the negative health consequences of FGC is not clear-cut. As indicated in the introduction to this section, the review by Obermeyer (1999) documented short-term effects (pain, hemorrhage, shock, and infection) and long-term effects (urinary infection, scarred tissue, fertility problems, and complications during child birth); however, the evidence from the review suggests that severe complications are relatively infrequent. Obermeyer concludes that negative health consequences may in fact exist, but cautions that the available evidence is less compelling than anecdotal accounts suggest. Thus, if evaluators are testing “accurate knowledge” about FGC, they must be vigilant not to overstate the frequency of negative health consequences, even if anti-FGC advocates cite such consequences as one of the primary reasons to ban the practice.

Also, information on the legal status of FGC may strengthen the resolve of community members to discourage the practice. And information on the position of the Islamic faith on FGC may dispel the widely held myth that women of Islamic faith must be circumcised.

These questions also serve as useful markers of progress in the wake of public information campaigns designed to increase awareness of FGC and to combat misconceptions about the practice.

However, even with useful and accurate knowledge of FGC, people may not change their attitudes or behavior. In areas where strong social convention affecting women’s roles keeps FGC in place, those forces may predominate despite improved knowledge.

Evaluators should break down indicators measuring knowledge by age, sex, and education to better understand differences among these subgroups.

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<sup>2</sup> The answer is no.

## Indicator

### PERCENT OF THE POPULATION FAVORABLE TO THE CONTINUATION OF FGC

#### Definition

“Continuation” refers to perpetuation of the practice of FGC. “Favorable” is operationally defined by items such as those listed below.

This indicator is calculated as:

$$\frac{\text{\# of respondents favorable to the continuation of FGC}}{\text{Total \# of surveyed}} \times 100$$

#### Data Requirements

Response to questions on survey

#### Data Source(s)

Large-scale representative survey (e.g., DHS)

#### Purpose and Issues

The question “do you think that female circumcision should be continued, or should it be discontinued?” (from the DHS module on female circumcision) provides a useful indicator of public acceptance of FGC in a given country. Evaluators can ask it of all respondents, male or female, in a survey, and can present the responses separately for men and women. A similar question, appropriate for women with daughters, is “do you intend to have any of your daughters circumcised?” or “have any of your daughters been circumcised?”

Responses to these items from representative surveys of the population serve two purposes: (1) they indicate the beliefs that public information campaigns must address the elimination of this practice, and (2) they serve as “markers of progress” if data are available over two or more surveys.

Any effort to abolish female circumcision must take into account beliefs that are widely held by members of the target population. The DHS module on female circumcision allows for the measurement of specific beliefs that support the continuation of FGC. Other sources cite the same beliefs in slightly different terms. For evaluation purposes, one can track changes in attitude regarding FGC through population-based surveys. An illustrative set of beliefs favorable to the continuation of FGC includes the following:

- Men prefer women who are circumcised (better marriage prospects);
- Islam/religion requires female circumcision;
- Circumcision is a good tradition/part of our cultural heritage;
- Circumcision is important to avoid the wrath of the ancestors;
- Female circumcision gives greater pleasure to the husband;
- Female circumcision preserves virginity;
- Female circumcision prevents adultery; and
- Circumcision is an important part of gender identity for women.

#### Gender Implications of this Indicator

FGC is a traditional practice whose basis is to control female sexuality and to make a woman “marriageable.” Although FGC violates the human rights of women and girls, women may be as likely as men to support the continuation of the practice as long as they believe the myths perpetuated to support the practice (e.g., that uncircumcised women are “unclean,” cannot give birth, and are promiscuous). Many anti-FGC groups are now trying to reach men, women, boys, and girls with information that counteracts the myths with facts, exposes the health risks, and fosters an understanding of gender equity and human rights.

## Indicator

### PERCENT OF WOMEN 15-19 YEARS OLD WHO HAVE UNDERGONE FEMALE CIRCUMCISION

#### Definition

This indicator refers to all forms of FGC described in the introduction. The question in the DHS module reads, “Have you yourself ever been circumcised?”

This indicator is calculated as:

$$\frac{\text{\# of women 15-19 who report having undergone female circumcision}}{\text{Total \# of women 15-19 surveyed}} \times 100$$

#### Data Requirements

Self-report; responses to question on survey

#### Data Source(s)

Large-scale representative survey (e.g., DHS)

#### Purpose and Issues

This indicator measures the success of programmatic initiatives in reducing the practice of FGC. Although the goal of eradication programs is to eliminate FGC entirely for all age groups, change can most readily be detected by focusing on the 15-19 year old group. In most societies that practice FGC, the procedure is performed before or around puberty; thus, any reduction in the incidence of the practice will first be apparent among this age group.

If change occurs among this age group on this variable, evaluators can further analyze this change by education levels, geographic location, religion, and other variables that may help explain the change and may identify the innovators.

One important caveat relates to the sample used for the survey. In countries where the DHS is limited to married women (e.g., Egypt), drawing conclusions about trends in the practice of FGC may be misleading because those who marry as teenagers are more likely to be circumcised than those who marry later. In populations where FGC is declining, comparisons of DHS data on FGC across age cohorts will fail to show the changes that were actually taking place. In short, the sample must include all women 15-19 in estimating the prevalence of FGC with DHS or other survey data (Mensch, 2001).

A related indicator is the age at circumcision. In Ghana, laws prohibiting the practice may drive it underground, and one outcome may be circumcision at younger ages in life. Evaluation of programs to eradicate FGC should track this variable as a possible unintended consequence.

