

# FEMALE GENITAL MUTILATION: EVIDENCE FROM UGANDA



THE REPUBLIC OF UGANDA



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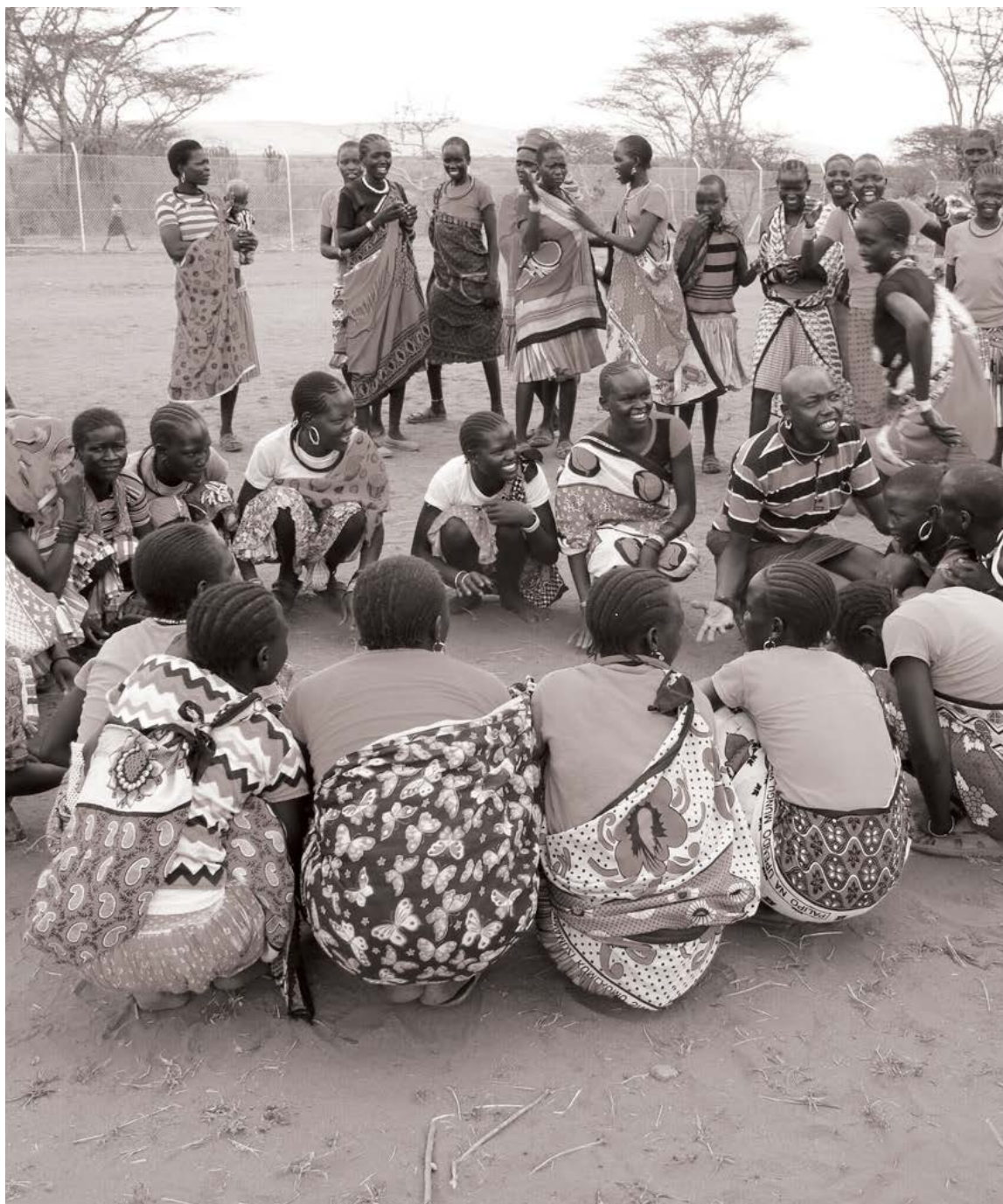
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# 1

## BACKGROUND

Female Genital Mutilation (FGM), also known as female circumcision, excision or genital cutting, is a gross violation of human rights and a direct manifestation of gender inequalities and discrimination. Although Uganda's national prevalence rate is low, it is still practised widely in some parts of eastern Uganda, with prevalence rates higher than 50% in many sub-counties of Karamoja region and Sebei sub-region.

Women and girls who have undergone FGM suffer both short- and long-term physical and psychological health risks. From a human rights and health perspective, it is unacceptable, and the Government of Uganda has strengthened its efforts to end the practice. Addressing the practice of FGM is an important strategy in ensuring the full participation of all women and girls in the socioeconomic development of the country. Data on the current situation with respect to FGM in Uganda is essential for informing strategies to tackle the issue effectively, with the aim of eliminating the practice.

To address the limited availability of reliable data to shape programmes that will accelerate the elimination of FGM in Uganda, a pioneering survey was conducted to measure the prevalence of the practice. It covered key indicators on knowledge, attitudes and practices related to the continuation of FGM. The survey was conducted with a representative sample of households in the FGM-practising districts of eastern Uganda. The number of households selected from each sub-county was sufficient to allow for the generation of indicators at sub-county level. A report was published in 2017.

The current study builds on the 2017 FGM Report and contributes to strengthening our understanding of FGM in Uganda by reviewing the existing literature and government policies, by summarising evidence on FGM from the 2006 and 2016 Uganda Demographic and Health Surveys (UDHS), and by presenting further analyses and interpretation of the data from the Uganda Bureau of Statistics and UNICEF 2016 FGM survey.





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# 2 INTRODUCTION

Female genital mutilation (FGM) is an internationally recognised violation of the human rights of girls and women (Khosla et al., 2017), and, although the prevalence of FGM is declining, globally the practice still affects around 200 million women across the world (Lancet, 2018). UNICEF estimates showed that more than one in three girls between 15 and 19 years of age were affected as of 2016. Female genital mutilation refers to all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons.

The World Health Organization (WHO) classifies FGM into four types:

**TYPE 1:** the partial or total removal of the clitoris and/or the prepuce (clitoridectomy);

**TYPE 2:** the partial or total removal of the clitoris and the labia minora and/or the labia majora (excision);

**TYPE 3:** also known as infibulation, the narrowing of the vaginal opening through the creation of a covering seal, formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris; and

**TYPE 4:** all other non-medical and harmful procedures to the female genitalia, such as pricking, incising, piercing, scraping, and cauterisation (WHO, 2014).

FGM has no health benefits. Rather, it carries severe short- and long-term risks to the physical and psychological health of women and girls (Berg et al., 2014). The most immediate physical complications of FGM include pain, excessive bleeding, swelling, problems with wound healing and urine retention (Rigmor and Vigdis, 2014). Long-term

consequences include both gynaecological and obstetric issues such as infections, genital scarring, menstrual difficulties, complications during pregnancy, labour and in the post-partum period (Reisel and Creighton, 2015). FGM can also lead to adverse mental health outcomes such as depression, acute anxiety and post-traumatic stress disorder (Reisel and Creighton, 2015; Abdalla and Galea, 2019).

The international community severely condemns all forms of FGM and this position is exemplified by the adoption by the United Nations General Assembly of a resolution calling on the international community to intensify efforts to end the practice in 2012 and by the inclusion of a target (under Goal 5 of the Sustainable Development Goals (SDGs)) to eliminate all harmful practices, such as child, early and forced marriage and FGM by the year 2030 (UNICEF, 2016; UNFPA-UNICEF, 2017). Both commitments are evidence of the political will by the international community and national partners to work together to accelerate action towards a total, and final, end to the practice in all continents of the world. UNICEF and partners recently called for more and better data to measure progress towards this common goal (UNICEF, 2016). Attitudes towards the practice are also shifting among women and girls. According to UNICEF's recent estimates in countries affected by FGM, 7 in 10 girls and women between 15 and 49 years of age believe that the practice should be discontinued (UNICEF, 2020a). In the last 20 years, the proportion of girls and women who are against the practice in high-prevalence countries has doubled (UNICEF, 2020a).

A recent study showed that East Africa experienced the most striking reduction in the prevalence of FGM among girls in recent decades, with the prevalence among girls aged 0–14 years having decreased from 71.4% in 1995 to 8.0% in 2016 (Kandala et al., 2018). According to the latest UDHS data (2016) (UBOS and ICF, 2018) the prevalence of FGM in Uganda remains among the lowest in East Africa, with the most recent estimates at 0.3% among women aged 15–49 years. However, since FGM is deeply rooted in local norms and traditions, national estimates do not accurately reflect the severity of the situation. In Uganda, FGM is concentrated in six (out of 135) districts, with prevalence rates among women aged 15–49 reaching more than 50% in some of the sub-counties in those districts, and as high as 67% in one sub-county (UBOS and UNICEF, 2017).

FGM was made illegal in Uganda by the adoption in 2010 of the Prohibition of Female Genital Mutilation Act (GoU, 2010). The FGM Act is a comprehensive piece of legislation that clearly defines FGM and sets out the offences and punishments related to the practice. The Act defines FGM as 'all procedures involving partial or total removal of the external female genitalia for non-therapeutic purposes' (Government of Uganda, 2010) and criminalises the performance, procurement, attempting, aiding and abetting of all forms of the practice. Many countries in sub-Saharan Africa have passed specific anti-FGM national laws and many others have included a ban on FGM in other national legislation, manifesting a widespread interest by national actors to join the fight towards its eradication (28 Too Many, 2018).

In December 2016, the Uganda Bureau of Statistics (UBOS) in collaboration with UNICEF Uganda conducted the first ever survey to address the lack of detailed district and sub-district level data on FGM practices in Uganda. The survey targeted a representative sample of households and women aged 15–49 years across six districts in eastern Uganda (Kween, Bukwo and Kapchorwa in Sebei sub-region<sup>1</sup> and Moroto, Nakapiripirit and Amudat in Karamoja region), which are known to be practising FGM extensively. The 2014 National Population and Housing Census sampling frame was used to select the sample, and a total of 4,500 households were interviewed.

The 2017 survey report (UBOS and UNICEF, 2017) revealed an FGM prevalence rate among women aged 15–49 across the six districts ranging from 13% in Kapchorwa to 52% in Moroto. Nearly all (95%) of women interviewed supported the discontinuation of FGM and the majority of respondents believed that abandoning FGM would reduce adverse health outcomes such as fistula, HIV infection and maternal and newborn deaths. This study builds on the survey report and attempts to deepen our understanding of current FGM practice in Uganda, its drivers, and how they relate to other contextual and socioeconomic factors.

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<sup>1</sup> Because of changes in statistical regions, in the 2006 UDHS Kapchorwa, Kween and Bukwo were in Eastern region, in the 2016 UDHS they were in Bugisu, and in the 2016 FGM survey they were in Sebei sub-region. For the purposes of this report, Sebei is used when referring to the sub-region.

## 2.1 OBJECTIVES OF THE STUDY

The analysis of data on FGM seeks to highlight trends and patterns within the data and to inform policy, advocacy and programmatic efforts to contribute to the elimination of the practice. This study also examines historical trends in the practice of FGM in Uganda, exploring how and why FGM is currently practised in eastern Uganda, and attempts to identify the risks and protective factors linked to the practice.

The specific objectives of the research were to:

- review existing literature and policies on FGM practice in Uganda
- conduct further analyses of the Uganda FGM Survey data in combination with other data sources with a view to produce a national report on FGM and to understand data gaps and issue recommendations to UBOS and UNICEF to inform future data collection efforts
- conduct qualitative research to enhance understanding of the Ugandan context around FGM and support the interpretation of quantitative findings
- make recommendations for key stakeholders to guide future efforts to end FGM in Uganda.

## 2.2 STRUCTURE OF THE REPORT

The report begins with a brief review of the relevant literature on FGM with a focus on East Africa in Section 3. The results of UDHS analyses of FGM practice in Uganda in the decade 2006–2016 are presented in Section 4. Section 5 illustrates results from a mixed methods analysis of qualitative and quantitative data on FGM in six districts of eastern Uganda. Section 6 briefly discusses some of the limitations of the present study. Section 7 concludes by summarising the main findings of the study and providing some recommendations for stakeholders. Finally, Appendix 1 provides detailed profiles of each of the districts, while Appendices 2–4 explain the methodology used.





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# 3

## LITERATURE REVIEW

Uganda has a very low national level prevalence rate of FGM compared with some other African countries and one of the lowest rates in East Africa. The prevalence of FGM among women aged 15–49 decreased from 0.6% in 2006 to 0.3% in 2016 (UBOS and ICF, 2018). However, these national prevalence rates are not representative of the overall country situation due to the high geographical variation. The practice of FGM is deeply rooted in ethnic and cultural norms and its prevalence varies greatly across areas. North-eastern Uganda is where the practice is more common. According to the 2016 UDHS, FGM prevalence reached 6.4% in Karamoja and 2.6% in Bugisu (in which Sebei sub-region fell). Certain ethnic groups in these eastern areas, such as the Pokot and the Sabiny, present high prevalence rates, with more than 50% of women aged between 15 and 49 years having undergone FGM (28 Too Many, 2013). The UBOS 2017 FGM report found an average FGM prevalence rate of 26.7% among a representative sample of women aged 15–49 in the six districts in eastern Uganda where FGM is most prevalent. However, many sub-counties had prevalence rates higher than 50%, such as Kortek (50.8%) in Bukwo district, Tapac (67.3%) in Moroto district, and Amudat (55%) and Loroo (56%) in Amudat district. Among these ethnic groups, FGM is considered a rite of passage for girls into adulthood/womanhood and the practice is known to be associated with early marriage and bride price levels (28 Too Many, 2013). In sub-Saharan Africa, ethnicity appears to be one of the main determinants of whether or not girls and women are subjected to FGM (Wagner, 2011/9).

### 3.1 DRIVERS OF FGM GLOBALLY

The practice of FGM is linked to a variety of contextual and individual factors. Social norms, culture and traditions contribute to shaping gender norms that associate the practice of FGM with notions of identity (Glover et al., 2017), femininity, purity (Gamel Eldin et al., 2018), and marriageability (Barstow, 1999; Foulcroy et al., 2006; Mackie et al., 2009). It is also aimed at controlling a woman's sexual behaviours, and ensuring her monogamy in marriage and exclusive availability to her male partner (Barstow, 1999; Whitehorn et al., 2002). Infibulation is said to be performed to reduce lust and sexual pleasure which, it is presumed, would otherwise lead women to engage in sexually promiscuous activities (Rigmor and Denison, 2013). The mutilation is also considered a rite of passage for girls into adulthood/womanhood and is celebrated with strict rituals and ceremonies. Its observance has implications for the honour and respectability of the whole family (Rigmor and Denison, 2013). In many contexts, failure to follow norms around FGM can result in ostracism and lack of protection by the community (Rigmor and Denison, 2013; Rahman and Toubia, 2000). FGM is also strongly related to the promotion of social continuity and is seen as a way to venerate ancestors and of "passing down the wisdom of elders" (Shell-Duncan et al., 2018). FGM is also associated with bride price and dowry (28 Too Many, 2013) and age at marriage (Chikungu and Madise, 2015; Karumbi et al., 2017). Education level and area of residence (urban/rural) are also factors commonly associated with FGM (Inungu and Tou, 2013; Karmaker et al., 2011; Elduma, 2018. Chikungu and Madise, 2015; Karumbi et al., 2017; Inungu and Tou, 2013; Karmaker et al., 2011). Although there is suggestive evidence that FGM might be more common among Muslim populations (Williams and Sobieszczyk, 1997), it is practised across religious groups.

### 3.2 THE DYNAMICS OF FGM IN EAST AFRICA

A qualitative study conducted in Kenya confirmed existing evidence on the drivers of FGM, which is primarily practised to control women and girls' sexuality, conform to cultural traditions and social pressure, enhance girls' marriageability and respectability, and promote a sense of identity and belonging (Kimani and Kabiru, 2018). A recent study conducted in Sudan explored the factors influencing the decision-making process around FGM and confirmed that sociocultural factors, gender norms and power relations are the primary drivers to the continuation of FGM (Gamal Eldin et al., 2018). The authors found that families go through a long and complex decision-making process influenced by extended family members and external influencers. Mothers are the main decision makers and their decisions are influenced by their own personal experiences with FGM (women who have undergone FGM are more likely to have their daughters circumcised). However, decisions are also strongly influenced by older women in the family, as well as by fathers and other men (Elgin et al., 2018; Kimani, 2018). Beyond ethnicity and cultural norms, education (including educational attainment and education on FGM) seems to be the main factor influencing prevalence and attitudes towards FGM in most East African countries (Kimani and Kabiru, 2018; Van Bave et al., 2017).

UBOS' 2017 report revealed that in eastern Uganda the majority (95%) of women aged 15 –49 living in FGM-practising sub-counties are in favour of ending the practice of FGM, with the lowest level of support for abandonment (90.6%) found among women 45 years of age and over. The main drivers of FGM in eastern Uganda seemed to be peer pressure and the desire to be accepted by the surrounding community, with 21% of women reporting this as the main benefit of FGM and 17% of women believing that it makes a woman ready for marriage. Other common reasons for practising FGM given by Ugandan women in the FGM practising districts and frequently cited in the literature referred to the notion of purity and identity and to the idea that FGM enables women to sexually gratify their partners.

FGM practice is influenced by longstanding traditions and norms, but changes in social dynamics and socioeconomic development have led to changes in both how the practice is carried out and the type of mutilation. In many communities there has been a shift in the type of cut from infibulation to 'sunna', which involves less severe cutting, nicking and pricking for faster healing and fewer health complications. The shift from infibulation to the sunna cut is attributed to increasing education and awareness of the health complications of FGM (Kimani and Kabiru, 2018). Girls are being cut at a younger age and increasingly the



mutilation is being performed in a secretive and hidden way rather than during open and public ceremonies. These changes have been documented in Tanzania (Van Bavel et al., 2017), Kenya (Dennis et al., 2018; Shell-Duncan et al., 2017), and Sudan (Gamal Eldin et al., 2018).

Across many East African settings there is also evidence that FGM is being medicalised, with health providers often involved in the decision-making process and providing counselling to girls and families to help them make informed decisions about FGM. Medicalisation is perceived by communities as a way to modernise and normalise FGM (Eldin et al., 2018; Kimani et al., 2020). However, despite being framed as a harm-reduction strategy (Bettina Shell-Duncan, 2001; Leye et al., 2019), there is no evidence that medicalisation reduces the negative health outcomes of FGM and the practice is condemned by UN agencies and medical associations and is seen as a threat to international efforts to eradicate FGM (Zolotor et al., 2009).

Medicalisation of FGM is a global trend that disproportionately affects adolescent girls (UNICEF, 2020b), who at the same time are more likely than older women to oppose the practice (UNICEF, 2020a). Some studies have shown that communities and individuals might be in the process of reassessing their beliefs and ideas towards FGM, although a complete shift has not yet taken place. Qualitative evidence from Narok and Nisii counties in Kenya suggests that increased educational attainment along with school-based programmes providing girls with information might have contributed to changes in cultural norms (Dennis et al., 2018). The study also reported that men in these regions may now prefer uncut wives who can enjoy sexual relations. Men's preferences for educated women and for fulfilling sexual experiences were also documented among Pokot communities in Western Kenya close to the border with Uganda as justifications for supporting the abandonment of FGM. A generational gap has been documented among Masai populations in Tanzania where elders are still in favour of the practice while younger generations are increasingly opposed to it (Van Bavel et al., 2017).

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### 3.3 STRATEGIES TO ELIMINATE FGM

Rigorous evidence on the effectiveness of programmes aimed at eliminating the practice of FGM is scant (Nour, 2010). A systematic review of interventions aimed at reducing the prevalence of FGM in Africa concluded that all eight effectiveness studies identified were of poor quality and called for more rigorous evaluations of interventions in this field (Rigmor and Denison, 2013). A more recent review reiterated the lack of thorough evaluations of FGM abandonment programmes (Johansen et al., 2013). In Kenya, a behavioural change intervention combining advocacy and education was implemented by Care international. While the programme was found to be successful in improving knowledge of the harmful effects of FGM, it did not increase support for abandonment nor reduce the proportion of individuals intending to cut their daughters (Chege et al., 2004). In Uganda, UNICEF and partners have been implementing the Grandmother approach – a programme that provides training and information to parents and grandparents of girls in Nakapiripirit district. However, this strategy of using grandparents as agents of change has not been rigorously evaluated. Health education has been a popular strategy to reduce and prevent FGM, but its success is strongly influenced by the sociodemographic and economic characteristics of targeted communities, together with local norms and beliefs (Waigwa et al., 2018). An information campaign implemented in eight villages in Arusha region in Tanzania improved knowledge on the health risks of FGM and produced some changes in attitudes towards it (Galukande et al., 2015). However, the observational nature of the study did not allow the authors to establish causal pathways between the intervention and the observed outcomes. The creation of alternative rituals, known as alternative rites of passage (ARPs), has also been used as a tool to reduce and prevent FGM. ARPs aim to replicate the initiation rituals to mark girls' transitioning into adulthood, but without the cutting (Graamans et al., 2019; Droy et al., 2018). These ARP programmes, such as those implemented by Amref Health Africa, PATH and World Vision, have shown some positive effects on awareness of reproductive health issues and on attitudes towards gender equality, but appear to have had no impact on contraceptive use and sexual behaviours (Chege et al., 2001). None of these interventions has been rigorously evaluated (Graamans et al., 2019) and their effectiveness in reducing and preventing FGM prevalence has not been measured. A campaign implemented in Sudan, which focused on creating and branding an alternative narrative and identity around remaining uncut, showed some success in reducing pro-FGM norms (Evans et al., 2019). In Uganda, programmes to prevent and eliminate FGM and child marriage targeted at in- and out-of-school girls and boys are being implemented across three districts in Karamoja and three in Sebei sub-region. While monitoring of these activities suggests that the interventions are successfully contributing to protecting girls in these areas, no formal evaluation results are yet available.

### 3.4 FGM IN UGANDA

Evidence specific to Uganda is very limited, which might be due to the fact that, because of its low national prevalence, the country does not feature among priority countries for the abandonment of FGM. Nonetheless, since the early 2000s Uganda has been working towards the elimination of FGM with district-level prohibition (28 Too Many, 2013) and, in 2010, the Prohibition of Female Genital Mutilation Act (Gou, 2010). This was followed in 2017 by the East African Community Prohibition of Female Genital Mutilation Act, a regional bill designed "to promote cooperation in the persecution of perpetrators of female genital mutilation and develop common measures, strategies and programmes for effective implementation" (EAC, 2016).

A qualitative study that examined the effectiveness of advocacy and legal interventions to reduce FGM among Sabinu populations in Uganda concluded that the law has had limited effect on the elimination of the practice and that enforcement is poorly planned and implemented. Moreover, criminalisation of the practice might have negatively affected victims' access to health care services (CEHURD, 2015). However, no rigorous evaluation of the effectiveness of these legislative changes on the prevalence of FGM has been conducted.



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# 4

## NATIONAL LEVEL ANALYSES OF UDHS DATA

### 4.1 FGM PREVALENCE OVER TIME

The national level analyses of FGM rely on cross-sectional analyses of UDHS survey data from 2006 and 2016, which provide evidence of changes that may have taken place in Uganda over one decade. National prevalence rates were estimated using women's self-reports on their FGM status at the time of the UDHS survey. First, a comparison of prevalence rates across the two waves of UDHS at a 10-year interval is shown. Then, results of the age cohort analysis, which computes prevalence rates for groups of women defined by five-year age groups, are reported (Shell-Duncan et al., 2017). Results are presented both at national and regional level.

FGM prevalence among women aged 15 to 49 years in 2006 was 0.64% and had decreased to 0.32% by 2016 (Figure 1). UDHS data showed a consistently higher FGM prevalence in rural areas, this is coherent with the literature describing FGM as a traditional practice performed among specific tribes and ethnic groups that inhabit predominantly rural areas. As argued by Shell-Duncan et al. (2017), in communities where FGM is common and largely supported, it may be difficult to escape social pressure and norms around mutilation. In urban settings, where culture and traditions are mixed and more diverse, women may be subject to different, and at times more modern, norms

and conventions deriving from other environments such as school or the workplace. Only in 2016 were women asked whether they were forced into FGM, with 82% reporting that they were.

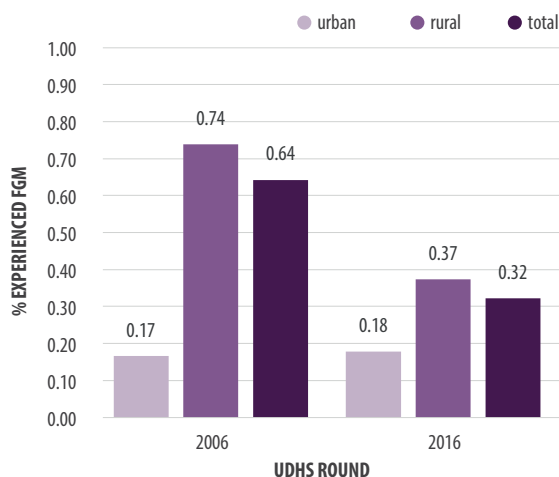
Prevalence data were also compared across a number of social and economic variables. Figure 2 shows the prevalence of FGM across surveys by education level and by wealth quintile.<sup>2</sup> Prevalence of FGM was higher among less educated women. While in 2006 FGM was more equally spread across women with various levels of educational attainment, in 2016 FGM was clustered primarily among women with no education or with only primary education. In 2016, prevalence was also higher among poorer women, while in 2006 FGM was more equally spread across wealth quintiles. Taken together, these figures show that over the course of a decade FGM has decreased and that nowadays it affects primarily more disadvantaged and less educated women.

The age-cohort method provides further insights into the FGM trends over time (Figure 3) and may help in understanding when a certain trend started.

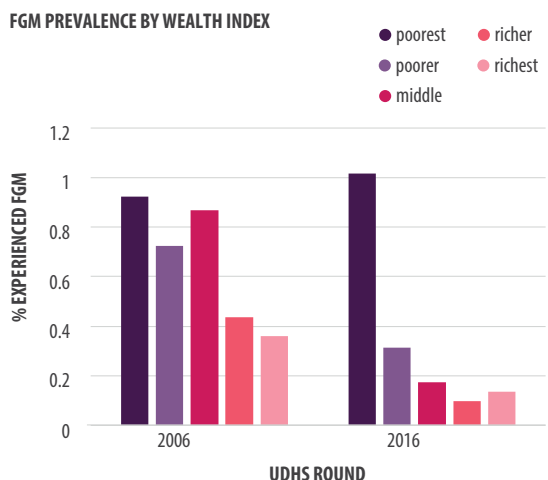
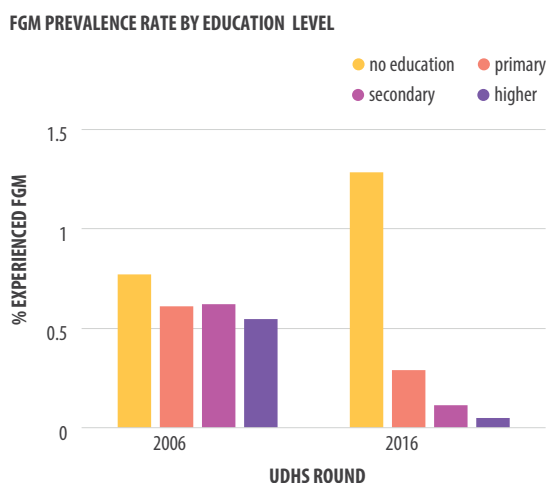
For example, we would expect the prevalence of FGM among women aged 35–39 in 2006 to be similar to that found among women aged 45–49 10 years later in 2016 (since these would be the same women grown older). Figure 3 confirms that the trend between the two rounds of UDHS is fairly consistent and that the steady decrease in prevalence observed in UDHS 2016 seems to have started in the late 1990s. This is also when the highest prevalence is recorded among women aged 40–44 in 2006, which may be attributed to an increase in the practice in the late 1990s (assuming that girls were cut at around 15 years of age). This is consistent with reports of spikes in the practice among Sabinu populations as a backlash to against the REACH programme’s anti-FGM campaigns.

As frequently reported in the literature, national prevalence rates can hide important regional differences. In Uganda, FGM is deeply rooted in ethnic and tribal traditions practised by specific groups that inhabit the north-eastern regions of the country, close to the border with Kenya. It is therefore necessary, even more than in other countries, to explore regional patterns to understand changes in FGM that might have taken place over time.

**FIGURE 1 NATIONAL FGM PREVALENCE RATE IN WOMEN AGED 15–49 YEARS BY PLACE OF RESIDENCE (UDHS 2006 AND 2016)**



**FIGURE 2 NATIONAL FGM PREVALENCE RATE BY SOCIOECONOMIC FACTORS AMONG WOMEN AGED 15–49 YEARS (UDHS 2006 AND 2016)**

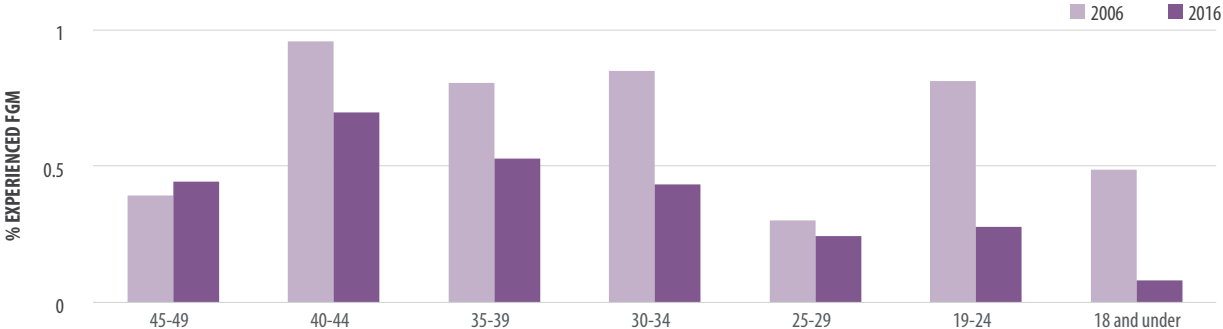


<sup>2</sup> The wealth index divides the sample in quintiles (where the first is the lowest 20% and the fifth is the richest 20%) and is built using a list of household assets (such as ownership of a television or refrigerator, as well as material living conditions, such as type of toilet, materials of walls and roof, etc.).

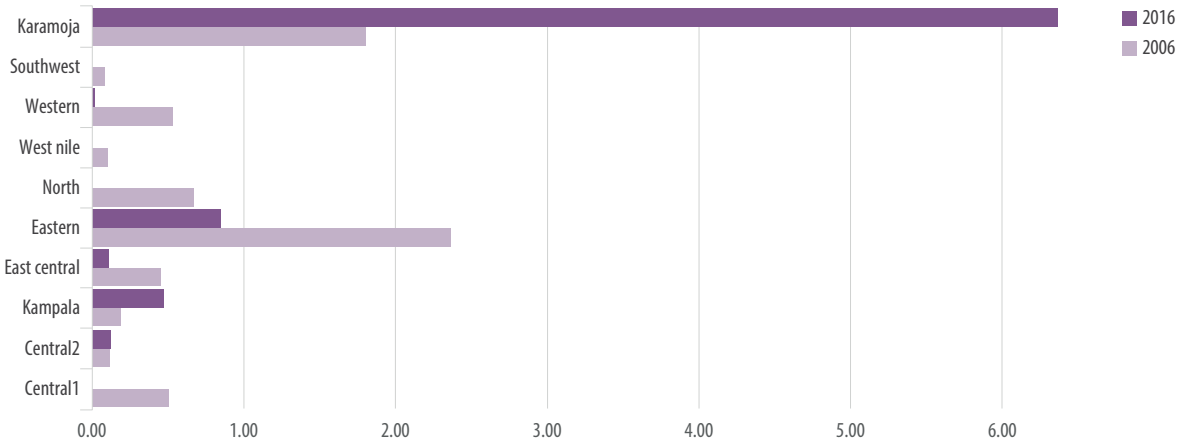


As can be observed in Figure 4, Karamoja<sup>3</sup> and the Eastern<sup>4</sup> regions showed a consistently higher prevalence rate of FGM than the rest of the country. While Eastern region has seen a decline since 2006, FGM in Karamoja appears to be on the rise, with an increase of more than 4 percentage points between 2006 and 2016. However, observed through the age-cohort method, a slow decline among younger generations is observed in Karamoja as well (Figure 5).

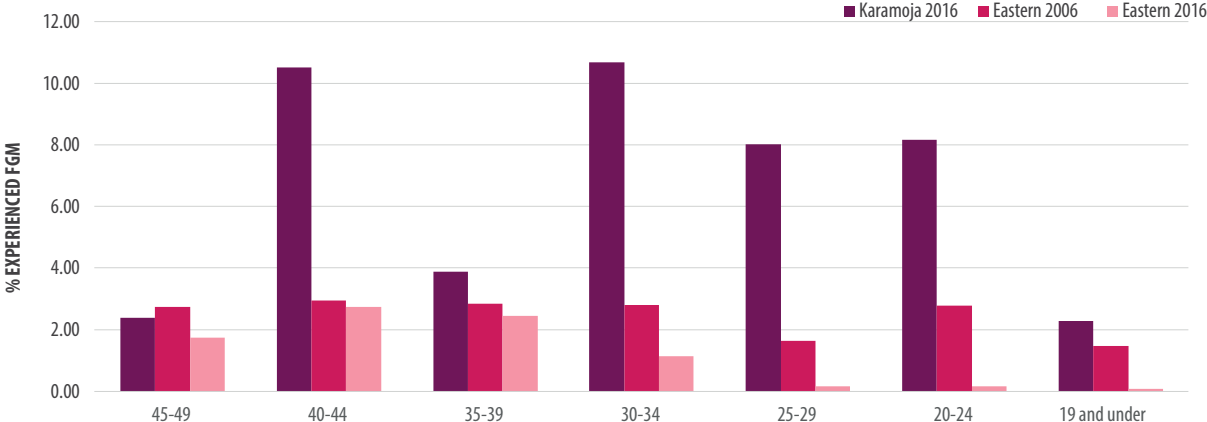
**FIGURE 3 FGM NATIONAL PREVALENCE RATE BY AGE GROUP AMONG WOMEN AGED 15–49 YEARS (UDHS 2006 AND 2016)**



**FIGURE 4 REGIONAL FGM PREVALENCE RATE AMONG WOMEN AGED 15 –49 YEARS (UDHS 2006 AND 2016)**



**FIGURE 5 AGE-GROUP-BASED FGM PREVALENCE RATE IN KARAMOJA AND EASTERN REGIONS (UDHS 2006 AND 2016)**



3 In UDHS 2006 Karamoja was included as a North sub-region. While the FGM prevalence rate for Karamoja in 2006 was provided in the UDHS 2006 report, data for women aged 15–49 was not accessible in the UDHS 2006 dataset. Therefore, data for Karamoja could not be included in Fig 5.  
 4 The regions of Bukedi, Bugisu and Teso from UDHS 2016 were collapsed into what is referred to as Eastern region in analyses that include UDHS 2016 data. The three regions together are consistent with the Eastern region of 2006.

## 4.2 AWARENESS OF FGM OVER TIME

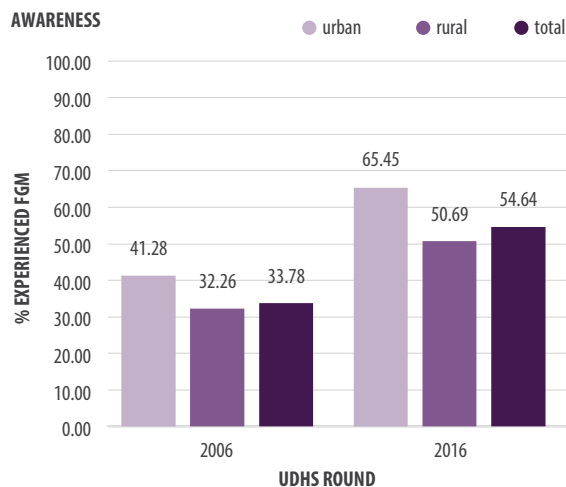
Awareness in the UDHS is measured by asking women whether they have ever heard of female circumcision. However, in the 2016 UDHS, this question was complemented by asking women “*In some countries, there is a practice in which a girl may have part of her genitals cut. Have you ever heard about this practice?*” (see Appendix 2). For this UDHS, the binary outcome awareness of FGM was therefore calculated as positive if women provided a positive answer to either one of these questions.

Awareness of FGM increased by more than 20 percentage points between 2006 and 2016 (Figure 6). This large increase might be attributed to the adoption of the national anti-FGM law in 2010, which was widely discussed in national and local media outlets.

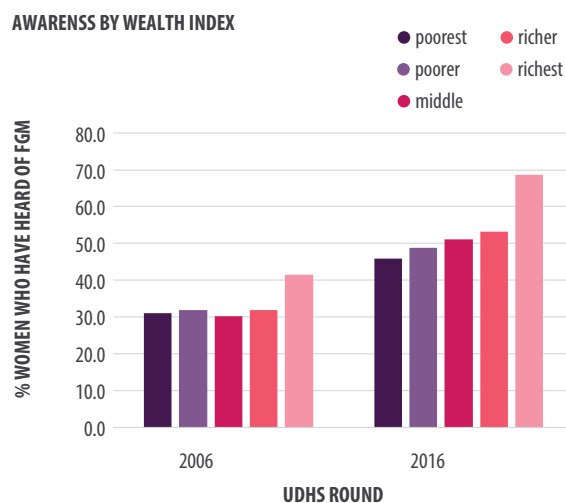
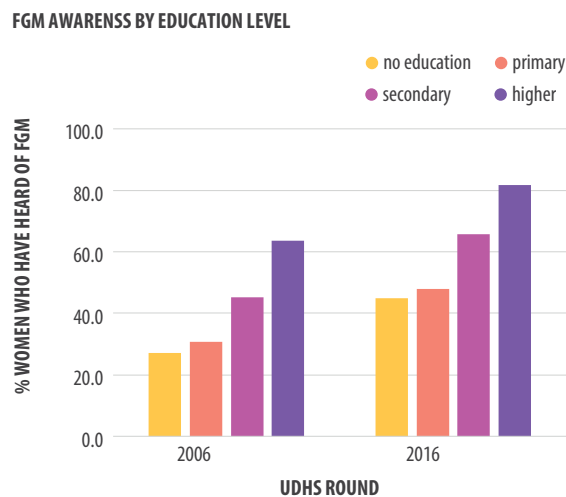
In both 2006 and 2016, awareness of FGM was higher among women living in urban areas. This can be explained by the fact that urban women are exposed to more diverse norms and conventions and may have better access and higher exposure to media and other information channels such as schools and workplaces.

Awareness of FGM was consistently higher among women with higher educational attainment across all UDHS waves and was also higher among wealthier women, as shown in Figure 7.

**FIGURE 6 NATIONAL FGM AWARENESS RATE AMONG WOMEN AGED 15–49 YEARS (UDHS 2006 AND 2016)**



**FIGURE 7 NATIONAL FGM AWARENESS RATE BY SOCIOECONOMIC FACTORS AMONG WOMEN AGED 15–49 YEARS (UDHS 2006 AND 2016)**





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### 4.3 MULTIVARIATE ANALYSES

Further analyses were conducted to explore what individual and contextual factors were associated with FGM status and with awareness of FGM among Ugandan women. Descriptive statistics for the UDHS sample across the two rounds of survey and the results on the association between women's background characteristics and FGM status and between women's background characteristics and awareness of FGM are shown in Appendix 3.

The findings from the multivariate analyses show that traditional protective factors such as education and wealth status were not significantly associated with FGM. Rural residence was associated with higher risks of being cut across both rounds of the UDHS, but similarly the results were not significant.<sup>5</sup> Awareness of the negative impact of FGM<sup>6</sup> increased with higher levels of education and higher levels of wealth. Women in rural areas appeared to be less knowledgeable about FGM (2016).

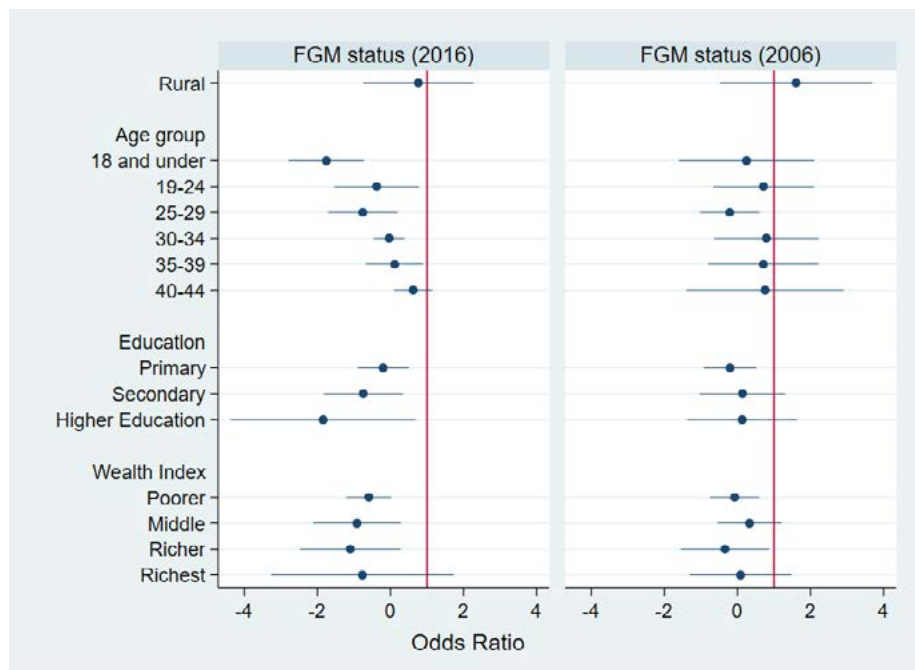
Overall, variables that according to the literature are common risk or protective factors to FGM did not appear to be relevant in Uganda from a national level perspective. This may be explained by the fact that the practice is specifically clustered among certain ethnic groups in eastern sub-regions. In this context, national level analyses are unlikely to be the most effective way to explore what are the main drivers of FGM. The following section therefore presents analyses using data from six districts of Uganda where FGM is prevalent.

<sup>5</sup> The likelihood of being circumcised appeared to be higher among certain religious groups but results did not show a consistent pattern over time, suggesting that this may be the effect of some spurious association.

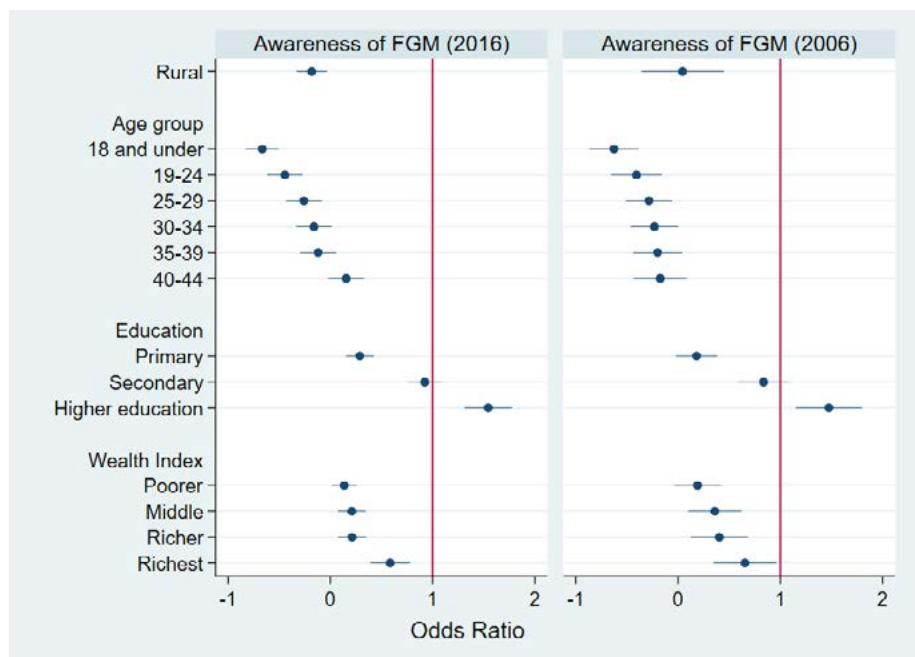
<sup>6</sup> For a description of how awareness is calculated in UDHS see section 4.2..



**GRAPH 1 RESULTS OF MULTIVARIATE MODELS FOR FGM STATUS (UDHS 2016 AND 2006)**



**GRAPH 2 RESULTS OF MULTIVARIATE MODELS FOR AWARENESS OF FGM (UDHS 2016 AND 2006)**



**UDHS ANALYSES FOR EASTERN UGANDA**

When we restricted the multivariate analyses to Karamoja and Eastern, some of the traditional associations between background demographic and the socioeconomic characteristics of women who have been circumcised and awareness of FGM emerged. Higher levels of wealth and lower age (being young) were associated with lower odds of being circumcised in both regions. Educational attainment did not appear to influence FGM status. Higher levels of wealth and education were associated with higher odds of having heard about FGM and younger age was associated with lower odds of being aware of FGM.

(Regression results are shown in Appendix 4)



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# 5

## FGM IN EASTERN UGANDA

This section presents findings from the FGM survey conducted in six districts of eastern Uganda (Kween, Bukwo, Kapchorwa, Moroto, Nakapiripirit and Amudat) and from qualitative interviews conducted with women, community members and other stakeholders in two of these districts (Kween and Amudat). For detailed profiles of each district, see Appendix 1.

It is important to mention that these results are not fully representative of Moroto and Nakapiripirit districts because the sample strata were purposively selected to ensure that only sub-counties where FGM is practised were included in the sample. Only one out of five sub-counties<sup>7</sup> of Nakapiripirit district, and only two out of six sub-counties of Moroto district<sup>8</sup> were included in the sample. Therefore, the data from these areas is not representative of the whole district. For Kween, 11 of 13 sub-counties were included in the sample and for the remaining three districts (Bukwo, Kapchorwa and Amudat) all sub-counties were included in the sample, so for these the results are representative of the full district.

<sup>7</sup> Only Moruita sub-county was selected in Nakapiripirit district.

<sup>8</sup> Only Katikekile and Tapac sub-counties were selected in Moroto district.

## 5.1 WOMEN'S BACKGROUND CHARACTERISTICS

The UBOS survey was designed to be representative at sub-county and district level and included 3,699 women aged between 15 and 49 years.

As shown in Table 1 below, the age distribution was similar across the six districts, with a large proportion (more than 70%) of the female population being under the age of 35 and only about 5% being over 45 years of age. Women in these districts were primarily self-employed (probably in agriculture or farming as these are the main income-generating activities practised in these regions) across all districts with the exception of Amudat, where most women reported no source of income. Women had low levels of educational attainment, with more than 60% having received no education or just primary education. Educational attainment was particularly low in Amudat and Moroto districts, where around 80% of women reported having no education at all. Age at marriage varied between 17 and 20 years, with a mean age across the region of 18.8 years.

Data on other demographic and socioeconomic characteristics was limited. However, the survey included a number of questions on women's access to and use of media and communication channels. The FGM survey report (UBOS and UNICEF, 2017) showed that 59% of the women reported listening to the radio at least once a week, while only 10% and 9% reported reading newspapers and watching television at least once a week, respectively. Overall, across all surveyed districts, one in five women reported owning a mobile phone, although ownership in Moroto was around 3%. The UBOS report showed that both mobile phone ownership and overall exposure to all media channels increased with educational attainment.

**TABLE 1: CHARACTERISTICS OF WOMEN IN SIX DISTRICTS OF EASTERN UGANDA**

CHARACTERISTICS (%)	DISTRICT						
	TOTAL	KWEEN	BUKWO	KAPCHORWA	MOROTO	NAKAPIRIPIRIT	AMUDAT
<b>AGE GROUP</b>							
15–24	43.9	45.8	41.7	44.1	39.6	48.4	44.1
25–34	31.8	29.4	31.6	31.1	34.9	34.4	34.3
35–44	19.3	19.2	20.8	19.3	19.3	9.4	18.1
45+	5.0	5.6	5.9	5.5	6.2	7.8	3.6
<b>INCOME SOURCE</b>							
Paid salary	3.3	3.7	1.8	5.1	0.0	7.8	2.64
Self-employment	57.0	60.1	66.1	57.5	79.7	48.4	34.0
Allowance from husband	8.3	11.2	6.2	12.4	0.5	7.8	3.6
Allowance from family	13.1	20.3	16.4	15.0	1.6	6.2	1.0
None	18.2	4.64	9.5	10.0	18.2	26.7	58.7
<b>EDUCATION LEVEL</b>							
None	19.6	9.2	9.1	15.8	82.8	60.9	78.3
Primary or pre-primary	42.0	43.1	52.1	39.3	16.2	23.4	13.9
Secondary	33.9	40.5	35.5	39.9	1.0	14.1	6.9
Higher	4.5	7.2	3.3	5.0	0.0	1.6	0.9
<b>OTHER</b>							
Age at marriage	18.8	19.6	19.0	19.4	18.0	19.0	17.1
Owns mobile phone	21.8	26.8	19.2	30.2	3.1	12.5	12.3

*Note: Only Moruita sub-county was selected in Nakapiripirit district. Only Katikekile and Tapac sub-counties were selected in Moroto district.*





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## 5.2 THE ORIGIN OF THE PRACTICE

FGM in eastern Uganda is rooted in ancient cultural traditions. Communities interviewed during focus group discussions across the two regions consistently reported that the practice originated as a way to reduce women's sexual desire during long periods of absence of their male partners. According to respondents, the Pokot (Amudat district) were pastoralist and men used to be away from home for long periods for cattle herding. Similarly, the Sabinu (Kween district) were originally warriors and hunters, and men used to travel far away in search of prey and food. As a result, in both ethnic groups women were often left at home alone for extended periods of time. Participants in qualitative research reported that FGM was practised to reduce women's sexual desire. The communities believed that this would minimise the risk of women engaging in extra-marital relationships with other men. They stressed that it was aimed at improving women's wellbeing, by making them better able to patiently and peacefully wait for their men to return home. According to reports from one community in Amudat district, "*Uncut women would be forced to hold a goat's bone in their mouth to refrain them from speaking with men and getting aroused.*" Many stories and legends, such as this one, are related to the belief that uncut women have uncontrollable sexual urges that can only be appeased by the cutting.

Participants in focus groups and during in-depth interviews across the two districts cited a number of other reasons to justify the origin of FGM.

**FGM AS A RITE OF PASSAGE:** Women participating in focus groups reported that mutilation of girls was seen as a rite of passage into adulthood through which they would become "real women" and ready for marriage. Uncut women would be seen as "children" by their communities and not worthy of respect. Different traditional names were used to refer to women cut in different years. This helped in marking their difference from uncut women, who would still be considered as "girls" and not as adult women.

**FGM AS ECONOMIC GAIN:** The practice of FGM was also strongly related to bride price. Respondents explained that the ritual would not only bring pride and visibility to the girl's family, but relatives and community members would bring valuable gifts (such as cattle, goats, hens and other gifts) to the girl's parents. During the public ceremonies, girls were the focus of the celebrations and the centre of attention of the whole community. People would travel far to celebrate the event and the girls undergoing the cut were awarded the "power" to ask for any gift they wanted from the FGM ceremony participants, who would not be able

to deny their requests. Mutilated girls would also receive a higher dowry at the time of marriage: the bride price was mainly composed of heads of cattle, which in the Pokot culture was associated with social status and prestige.

**FGM AS A MEASURE OF WORTHINESS:** Another recurring explanation listed by focus group participants related to the idea that the mutilation would make a woman clean. Especially among the Pokot, the association between FGM and cleanliness appeared to be very strong. Uncut women would be heavily stigmatised and frequently mocked by other community members as “dirty” and “smelly.” Participants reported that mutilated women would show tattoos and marks on their skin (mostly on their arms) that would signal their FGM status to potential partners and other community members, making it easy to distinguish them from the less respectable uncut women. Both community members and key local stakeholders who were interviewed reported that uncut women would also be prevented from performing a number of daily activities, such as fetching water from the well, picking up cow dung for smearing the floor and walls of the house (to keep away dust), and climbing the granary to collect millet or corn or other grains used for food because they were considered not clean. Sabiny women reported that the corpse of an uncut deceased woman could not be carried into the house through the main door as she would not be worthy of respect. Instead, she would be carried in through the back entrance. Some respondents also reported superstitions such as, “if a man is touched by the clitoris of a woman he would die” or that “if an uncut woman married she would die.” Such stories and beliefs reinforced the stigmatisation of uncut women. Peer and societal pressure were also mentioned as strong contributing factors to the perpetuation of the practice. In both ethnic groups, men would frequently have more than one wife and uncut women would not be allowed to join their husbands in important village ceremonies. They would therefore be considered less important than mutilated wives.

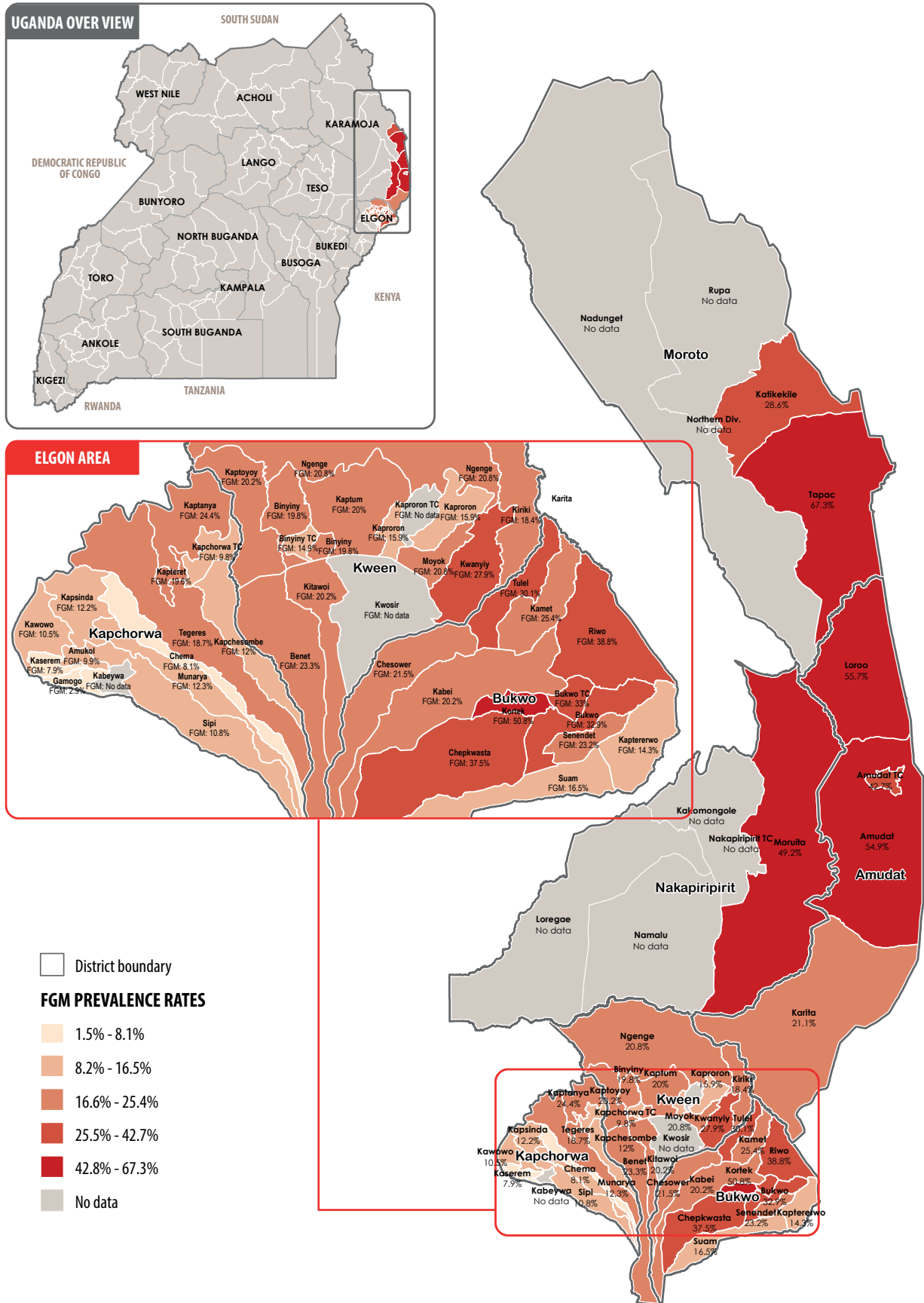
**FGM AS A SOCIAL EVENT:** Finally, the mutilation ceremony was seen as a social event that brought together the whole community and would provide an opportunity to strengthen social ties and build long-lasting relationships between families. The ceremony marked an important moment in the lives of girls and their families. Many respondents compared the feelings of pride and excitement experienced by families during the FGM rituals to those experienced nowadays at the graduation of a son or daughter. The FGM ceremony was also seen as an opportunity for exchange and interaction between older and younger generations – a way for older mutilated women to mentor and pass down to younger women their knowledge and experiences and to pass on traditions and teachings.

### 5.3 PREVALENCE AND AWARENESS OF FGM

The average prevalence rate of FGM in eastern Uganda was 26.6% in the 2016 FGM survey, much higher than the UDHS national average for the same period (0.32%). The FGM district-level prevalence across the six eastern districts where the FGM survey was carried out ranged between 13% (in Kapchorwa) and 52% (in Katikékile and Tapac sub-counties of Moroto) among women aged 15–49 years. Many sub-counties had prevalence rates higher than 50%, including Kortek (50.8%) in Bukwo district, Tapac (67.3%) in Moroto district, and Amudat (55%) and Loroo (56%) in Amudat district. Figure 8 shows the prevalence at sub-county level.

Higher prevalence rates were observed in Karamoja than in districts in Sebei. This confirms a trend that was previously observed in the UDHS regional data (Figures 4 and 5). Age at cutting was also consistently lower in Karamoja than in Sebei. The average age at cutting in Karamoja was around 14–15 years, while in the Sebei sub-region it ranged between 17 and 19 years (Table 2). This finding was confirmed by qualitative interviews with Pokot women who reported that in Karamoja FGM was, and still is, primarily performed among young unmarried girls whereas in Sebei the mutilation of older, sometimes already married, women is more common. Previous analyses (UBOS and UNICEF, 2017) of this data have shown that FGM prevalence increased with age across both Karamoja and Sebei, with prevalence of nearly 68% among women aged more than 45 years and only 8% among girls aged 15–24 years. This may suggest a progressive abandonment of FGM among younger generations. Nearly all women reported being cut by a traditional cutter.

**FIGURE 8 FGM PREVALENCE RATE BY SUB-COUNTY IN UGANDA**



Source: Female Genital Mutilation/Cutting Survey Report. 2017.  
 This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.



High prevalence rates were accompanied by high awareness rates across all six districts, with an average of 97% of women having heard of FGM (Table 2). Given the high FGM prevalence rates in these districts, it is not surprising that the vast majority of women have heard of the practice. FGM is a deeply rooted tradition in these areas and plays a central role in the community's social life. Reported awareness was similar across age groups, with no substantial difference between younger and older generations. High levels of awareness may also be linked to the level of community sensitisation happening in various areas. Table 2 shows clearly that the overall level of community engagement around FGM in Karamoja was much higher than in Sebei, which is likely to be due to intense anti-FGM programming in this region aimed at eliminating the practice. UDHS analyses have shown that Karamoja has not experienced the downward-sloping trend in prevalence that has been observed in Sebei sub-region over time (Figure 4).

According to the FGM report (UBOS and UNICEF, 2017), awareness levels around the anti-FGM law were also very high, with 84% of women reporting that they knew about the law. Among those who knew about the law, nearly 97% knew that the practice is illegal in Uganda and 99% knew that the law requires perpetrators to be reported to the authorities.

**TABLE 2 FGM PREVALENCE AND AWARENESS RATE IN SEBEI AND KARAMOJA (UBOS 2017)**

	CIRCUMCISED (%)	MEAN AGE AT CIRCUMCISION	HEARD OF CIRCUMCISION (%)	IN PAST 12 MONTHS HEARD OF FGM AT COMMUNITY EVENT (%)
<b>SEBEI</b>				
Kween	21.0	19.45	99.1	54.4
Bukwo	27.7	17.72	96.7	24.9
Kapchorwa	12.9	17.73	93.9	26.4
<b>KARAMOJA</b>				
Moroto	51.5	15.19	97.4	82.4
Nakapiripirit	49.2	14.48	98.4	71.9
Amudat	43.0	14.47	99.1	51.1
<b>TOTAL</b>	<b>26.6</b>	<b>16.7</b>	<b>97.0</b>	<b>40.8</b>

*Note: Only Moruuta sub-county was selected in Nakapiripirit district. Only Katikekile and Tapac sub-counties were selected in Moroto district.*

## 5.4 THE DECISION-MAKING PROCESS

There is very limited information about the process through which it is decided that a girl is ready to undergo FGM, and how different people are involved in the decision. Respondents consistently reported that before the practice was made illegal, FGM would be the subject of teenage gossip and chat in the same way as other topics that girls become interested in when they become adolescents. Girls would see older girls (usually aged between 18 and 22 years) go through the FGM ritual, how it earned them the respect of community members, and made them ready for marriage. They would therefore see it as a natural step in their lives.

Respondents consistently said that a girl at some point "would feel ready" and, after discussing it with friends and peers, would decide to ask for permission from her parents. At this point parents, primarily fathers, would challenge their daughter to test whether she was "really ready". This could include asking a girl to perform certain activities to prove her strength and commitment and demonstrate that she was ready to be an adult, or could revolve around conversations to explain the details of the procedures to make sure that the girl understood what she is getting into. If a girl cried, screamed or showed any discomfort during the FGM ceremony, she would bring dishonour to her family. A father's main concern, therefore, was to ensure that his daughter would only undergo the cutting when she was mature enough to understand the consequences of her decision and serious enough not to "misbehave" during the ceremony. A girl who

cried or showed weakness during the mutilation ritual would be considered “cursed” and could easily be rejected by her future husband. This idea of showing strength during the ceremony was mentioned more often by the Pokot from Karamoja than among the Sabinu.

These suggestions that the decision to get cut was, and somehow still is, mostly a personal choice made voluntarily by girls should be interpreted in the context of societal conventions and peer pressure, which strongly influence adolescents’ choices. In a context where FGM is illegal, these reports also appear as a way for parents and community members to deny responsibility for the perpetuation of the practice. It was also reported by some respondents, particularly among the Sabinu, that if a girl did not ask to be cut by a certain time, the parents and family members would start to actively push her to undergo the procedure.

The 2016 UDHS showed that the majority of mutilated women reported being forced into circumcision. The FGM survey data provided further detail about the decision-making process to undergo FGM. While the data below (Table 3) should not be interpreted under the assumption that the women were necessarily forced into the practice, it does provide a clearer picture of the key actors involved in the decision to get cut.

Overall, 35% of women were encouraged to undergo FGM by their mothers and 24% were influenced in their decision making by friends. Fathers and husbands also appear to be frequently involved in the decision, confirming that the practice is not experienced as an individual choice but as a community affair that requires the involvement of multiple family and community members. It is worth noting that the proportion of women encouraged to get cut by their partners and husbands is particularly high in Kween. Across all other districts it is close to zero, confirming that in Sebei sub-region it is more common for married women to get cut, while among Pokot communities in Karamoja it is still carried out predominantly on unmarried girls.

**TABLE 3 LIST OF INDIVIDUALS INVOLVED IN THE DECISION TO UNDERGO FGM (UBOS 2017) (%)**

	WHO ENCOURAGED YOU?					
	MOTHER	FATHER	HUSBAND/ PARTNER	SISTER	GRANDMOTHER	FRIEND
<b>SEBEI</b>						
Kween	12.5	23.4	39.3	0.3	7.0	16.6
Bukwo	33.4	9.6	10.0	2.0	8.3	33.7
Kapchorwa	54.1	10.7	2.7	0.0	4.1	28.4
<b>KARAMOJA</b>						
Moroto	41.0	22.0	0.0	0.0	0.0	36.9
Nakapiripirit	63.0	7.4	0.0	3.7	0.0	25.9
Amudat	33.3	30.9	0.0	7.4	17.1	11.4
<b>TOTAL</b>	<b>35.1</b>	<b>18.9</b>	<b>9.8</b>	<b>2.6</b>	<b>8.3</b>	<b>24.3</b>

*Note: Only Moruita sub-county was selected in Nakapiripirit district. Only Katikekile and Tapac sub-counties were selected in Moroto district.*

## 5.5 OPINIONS AND ATTITUDES ABOUT FGM

Women were asked about their beliefs and attitudes towards FGM both qualitatively and quantitatively. Women and other community members who participated in focus groups and interviews were generally positive towards abandonment of the practice. Education and religions were often mentioned as the primary factors that have contributed to changing individuals’ and communities’ views on FGM, together with increased awareness of the negative short- and long-term health consequences of mutilation. Increased health risks faced by women during childbirth were a recurrent argument for supporting the discontinuation of FGM.

In the FGM survey, two sets of questions about attitudes towards FGM were asked. The first inquired about women’s views towards abandonment, while the second asked about women’s attitudes under hypothetical scenarios. The first question on abandonment asked “Do you think this practice should be continued or should it be discontinued?” Because of social pressure and social desirability bias, women were likely to show support for discontinuation in a context like Uganda, where FGM is illegal. Table 4 indeed shows that 95% of women said the practice should be discontinued. On average, women in Karamoja, which has higher prevalence, showed greater support for abandonment than women in Sebei. Support for abandonment was equally spread across age groups, with a slightly lower proportion among women aged over 45 years (91%). This is in line with findings from qualitative interviews with communities in these regions where most women showed support for abandonment. However, the qualitative fieldwork has also revealed that women are more likely to support FGM abandonment when they see FGM being “substituted” by other benefits such as expansion of education and increased government investments in the region. Women, and other community members, often seemed to view their commitment to discontinuation as a bargaining chip to obtain better health and education services.

Two additional questions were asked in the FGM survey, both attempting to capture women’s individual beliefs by asking whether they would be likely to engage in behaviours demonstrating their support for abandonment. Women were first asked whether they would encourage relatives and community members who have daughters not to undergo FGM – this measured women’s willingness to sensitise other community members against the practice. Table 4 shows that across all districts the proportion of women who would advise others against circumcision (72%) was lower than that of women who said that FGM should be discontinued. When asked whether they would only support the marriage of their son, or another male family member, to a cut woman, only 4% of women agreed. This was fairly consistent with the answers to the first question on abandonment. Taken together, these results suggest that, despite the high FGM prevalence rates in these sub-regions, there is widespread support for abandonment among women. However, it is also evident that social pressure plays an important role in influencing individual actions around FGM. Women across the six districts seemed more willing to support abandonment when their actions are not visible to other community members. While fewer than three in four women would be willing to advise and sensitise others about abandoning FGM, more than 95% would be happy to support unions with uncut women within the family.

Social norms play a crucial role in shaping decisions and attitudes towards abandonment of FGM. Even when women recognise the health risks and tend to support discontinuation of the practice in private, peer pressure and the threat of social exclusion and ostracism can determine behaviours that perpetuate the practice.

**TABLE 4 WOMEN’S ATTITUDES AND OPINIONS TOWARDS FGM (UBOS 2017) (%)**

	OPINIONS ON ABANDONMENT OF FGM				
	FGM SHOULD BE CONTINUED	FGM SHOULD BE DISCONTINUED	IT DEPENDS	WOULD ENCOURAGE RELATIVES/ COMMUNITY MEMBERS AGAINST CUTTING GIRLS	WOULD SUPPORT SON TO MARRY ONLY A CUT WOMAN
<b>SEBEI</b>					
Kween	3.0	94.8	1.6	89.3	3.4
Bukwo	4.4	91.5	2.7	45.6	5.8
Kapchorwa	3.1	93.8	1.9	71.1	3.5
<b>KARAMOJA</b>					
Moroto	1.1	97.9	0.5	58.3	4.3
Nakapiripirit	4.7	93.8	1.6	71.9	3.5
Amudat	0.0	99.6	0.4	90.5	1.1
<b>TOTAL</b>	<b>2.8</b>	<b>94.8</b>	<b>1.7</b>	<b>72.1</b>	<b>4.0</b>

*Note: Only Moruita sub-county was selected in Nakapiripirit district. Only Katikekile and Tapac sub-counties were selected in Moroto district.*



Overall, three-quarters (74%) of women believed that abandonment of the practice would result in benefits for their community. Women were also asked whether they believed that abandonment would bring specific reductions in negative outcomes for women and girls. Table 5 shows that 60% of interviewed women believed that abandoning FGM would reduce the number of women with fistula and with HIV/AIDS, while 53% believed that it would lead to reductions in maternal and newborn mortality and health expenditure for women and girls. A slightly lower proportion of women (less than 50%) reported thinking that discontinuing FGM would result in lower rates of early marriage, early pregnancy, and school dropout among girls. There is widespread knowledge among communities that, despite FGM being a core aspect of their culture, the practice carries significant short- and long-term health risks for girls and women. Qualitative data confirmed that the increased access to education and the influence of religious groups has contributed to the spread of knowledge and information about the negative effects of FGM.

**TABLE 5 WOMEN'S OPINIONS ON POSSIBLE IMPACT OF ABANDONMENT OF FGM (%)**

ABANDONING FGM WOULD REDUCE...	THE NUMBER OF GIRLS GETTING MARRIED BEFORE 18	THE NUMBER OF GIRLS GETTING PREGNANT AT A YOUNG AGE	THE NUMBER OF GIRLS DROPPING OUT OF SCHOOL	THE NUMBER MATERNAL AND NEWBORN DEATHS	THE NUMBER OF WOMEN WITH FISTULA	THE NUMBER OF WOMEN GETTING INFECTED WITH HIV	THE EXPENDITURE ON HEALTHCARE FOR WOMEN AND GIRLS
<b>SEBEI</b>							
Kween	38	33	40	41	59	52	35
Bukwo	68	69	68	69	71	77	69
Kapchorwa	16	15	15	19	23	24	20
<b>KARAMOJA</b>							
Moroto	55	54	60	65	65	65	71
Nakapiripirit	61	53	61	72	83	75	89
Amudat	66	64	65	98	100	99	99
<b>TOTAL</b>	<b>45</b>	<b>43</b>	<b>46</b>	<b>53</b>	<b>60</b>	<b>60</b>	<b>53</b>

**Note:** Values represent proportion (%) of women who answered yes to each statement. Only Moruuta sub-county was selected in Nakapiripirit district. Only Katikekile and Tapac sub-counties were selected in Moroto district.

Table 6 provides evidence that the large support for FGM abandonment is coupled with an increasing belief that FGM only partially defines a woman's identity. Overall, only 12% of women believe that FGM makes a woman complete and less than 1 in 10 thought that it makes a woman clean and faithful. A higher proportion of interviewed women (around 20%) believed that FGM makes a girl acceptable to her peers and acceptable for marriage, while less than 15% believed that FGM is an effective way to ensure women's loyalty to their husband. This was in line with reports by women that what motivates the current continuation of the practice is primarily related to social norms and peer pressure and to ideas of social acceptance rather than to reasons such as ensuring fidelity to partners and controlling women's sexuality. FGM seemed to be particularly linked to concepts of social acceptability and marriageability in districts in Karamoja.

**TABLE 6 WOMEN'S OPINIONS ON BENEFITS OF FGM (UBOS 2017) (%)**

FGM...	MAKES A WOMAN COMPLETE	BRINGS ECONOMIC BENEFIT TO THE FAMILY	MAKES A GIRL ACCEPTABLE FOR MARRIAGE	MAKES A GIRL ACCEPTABLE BY HER PEERS	MAKES A WOMAN CLEAN	MAKES A WOMAN FAITHFUL TO HER HUSBAND	MAKES A WOMAN ABLE TO PRODUCE CHILDREN	MAKES A WOMAN ABLE TO SEXUALLY SATISFY HER HUSBAND
<b>SEBEI</b>								
Kween	13	7	25	22	8	5	5	27
Bukwo	9	6	10	9	6	8	5	16
Kapchorwa	7	6	6	8	5	5	2	3
<b>KARAMOJA</b>								
Moroto	15	13	21	48	10	18	28	17
Nakapiripirit	17	20	25	22	13	16	3	13
Amudat	24	9	31	51	14	16	2	10
<b>TOTAL</b>	<b>12</b>	<b>7</b>	<b>17</b>	<b>21</b>	<b>8</b>	<b>8</b>	<b>5</b>	<b>14</b>

**Note:** Values represent proportion (%) of women who answered yes to each statement. Only Moruita sub-county was selected in Nakapiripirit district. Only Katikekile and Tapac sub-counties were selected in Moroto district.

Women across all districts were also asked about whether they believed that abandonment would bring benefits to their family and/or community. On average across districts, 74% of women answered positively to this question. However, in Kapchorwa and Moroto only around 60% of women expected positive outcomes from abandonment.

## 5.6 THE INFLUENCE OF BACKGROUND CHARACTERISTICS ON FGM OUTCOMES

The results of the multivariate analyses that investigate the association between background individual characteristics and FGM outcomes across the six districts in eastern Uganda (shown overleaf in Table 7) were more coherent with the literature on FGM than those conducted at national level on UDHS data. These analyses relied primarily on the FGM survey data but additionally included a sub-county level indicator of child poverty obtained from the UNICEF-UBOS-World Bank report on Household and Child Poverty (UNICEF, UBOS and World Bank, 2019). Findings were also in line with themes that emerged from the qualitative interviews conducted in Amudat and Kween regions discussed in previous sections of this report.

Background characteristics such as belonging to a younger cohort and having achieved secondary or higher education level were significantly correlated with lower odds of being cut. Interviews with women and community leaders also confirmed the central role of education as one of the main influencing factors for the abandonment of FGM practices. Active use of media channels also appeared as a potential protective factor, with women who reported listening to the radio or watching TV almost every day being less likely to be cut. Improved education, not only formal school attainment but also increased knowledge about women's health and wellbeing, was frequently mentioned by focus group participants as an essential component of anti-FGM strategies implemented by religious leaders and other local stakeholders to achieve abandonment of the practice. On the other hand, being married, or having been married in the past, together with a high poverty indicator appeared to be significant risk factors.

The results also suggest that women who had themselves been cut were less likely to support abandonment of the practice. Circumcised women also were also more likely to support a son's marriage only with a mutilated woman. These results suggest an intergenerational effect of the practice, whereby mutilated women are more likely to support the continuation of FGM. Higher education levels and ownership of a mobile phone significantly increased the odds of someone being supportive towards the abandonment of FGM. Mobile phone ownership might reflect a woman's higher level of autonomy or empowerment or better access to media and information about the practice. Frequent use of media channels was not signifi-

cantly associated with attitudes towards FGM. Although poverty appeared as a risk factor for FGM, high levels of child poverty were also a driver of support for discontinuation. This may reflect women’s belief that discontinuation of the practice may lead to socioeconomic benefits for their communities.

Having a daughter was associated with higher odds that a woman would encourage others not to cut girls. Sources of income – in the form of a salary, self-employment or allowances from family and partners – were all associated with lower odds that women would encourage others not to get girls cut.

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**TABLE 7 ASSOCIATION BETWEEN BACKGROUND CHARACTERISTICS OF WOMEN AND FGM OUTCOMES (UBOS 2017)**

	<b>CIRCUMCISED</b>	<b>SUPPORTS ABANDONMENT</b>	<b>WOULD ENCOURAGE RELATIVES/COMMUNITY MEMBERS AGAINST CUTTING GIRLS</b>	<b>WOULD SUPPORT SON TO MARRY ONLY A CUT WOMAN</b>
<b>ADJUSTED ODDS RATIO (SE)</b>				
Circumcised		0.254*** (0.0555)	0.857 (0.168)	2.504*** (0.701)
Age = 15–24	0.0287*** (0.0106)	0.874 (0.311)	1.409 (0.359)	1.128 (0.499)
Age = 25–34	0.117*** (0.0312)	0.744 (0.252)	1.062 (0.193)	1.143 (0.436)
Age = 35–44	0.495*** (0.0998)	1.286 (0.362)	1.113 (0.180)	1.062 (0.372)
Education: primary or lower	1.082 (0.239)	0.987 (0.293)	1.215 (0.263)	0.736 (0.258)
Education: secondary	0.477*** (0.128)	1.967** (0.669)	1.243 (0.296)	0.499* (0.209)
Education: higher	0.355** (0.177)	4.591 (5.812)	1.882 (0.782)	0.224 (0.277)
Marital status: married	4.853*** (2.132)	1.477 (0.583)	1.443** (0.213)	1.075 (0.557)
Marital status: separated	4.343** (2.563)	1.048 (0.370)	1.757 (0.743)	1.512 (1.308)
Marital status: widowed	6.120*** (3.403)	2.443 (1.534)	1.513 (0.469)	1.431 (1.021)
Has a daughter		0.843 (0.297)	1.424* (0.298)	1.404 (0.419)
Source of income: paid salary	0.842 (0.406)	1.404 (1.544)	0.372*** (0.129)	0.421 (0.427)
Source of income: self-employment	0.900 (0.312)	0.790 (0.389)	0.344*** (0.0962)	0.964 (0.338)
Source of income: allowance from husband	0.656 (0.257)	0.949 (0.673)	0.508** (0.156)	0.675 (0.301)
Source of income: allowance from family	0.437* (0.220)	1.265 (0.589)	0.429** (0.154)	0.867 (0.432)
Owns mobile phone	0.849 (0.140)	1.784** (0.418)	0.947 (0.114)	0.689 (0.225)
Listens to radio: less than once a week	1.063 (0.255)	0.943 (0.332)	1.020 (0.281)	1.446 (0.515)
Listens to radio: at least once a week	1.058 (0.272)	1.228 (0.363)	1.156 (0.283)	0.696 (0.214)
Listens to radio: almost everyday	0.617** (0.151)	1.233 (0.315)	1.182 (0.316)	0.779 (0.223)
Watches TV: less than once a week	1.035 (0.240)	0.606 (0.283)	1.466 (0.404)	0.613 (0.227)
Watches TV: at least once a week	0.789 (0.320)	0.758 (0.350)	1.835* (0.629)	0.955 (0.351)
Watches TV: almost everyday	0.296* (0.199)	0.716 (0.501)	1.720 (0.953)	0.851 (0.661)
Reads newspaper: less than once a week	0.875 (0.226)	1.542 (0.735)	0.843 (0.196)	1.124 (0.545)
Reads newspaper: at least once a week	0.969 (0.303)	1.024 (0.365)	1.322 (0.286)	0.861 (0.535)
Reads newspaper: almost everyday	0.374 (0.253)	1.597 (0.988)	0.491 (0.242)	2.066 (1.865)
Child Poverty	17.08*** (14.06)	22.12*** (23.15)	1.194 (0.950)	0.206* (0.194)
<b>NUMBER OF WOMEN INTERVIEWED</b>	<b>3,561</b>	<b>3,534</b>	<b>3,507</b>	<b>3,436</b>

**Notes:** The standard error (SE) of each estimate is in parenthesis below it, analyses control for region. \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$ . Reference group for age is above 45 years. Reference group for education is no education. Reference group for marital status is single status. Reference group for source of income is no income. Reference group for all use of media channels is never.

## 5.7 FGM TODAY

Uganda's banning of FGM has produced some changes in how and why the practice is performed. Pokot women reported that FGM is still being conducted mostly on adolescent girls as a rite of passage before marriage. Among the Sabiny, however, the cut is increasingly performed among uncut married women. Medicalisation has also been reported in Sebei, especially among elite community members who are aware of the potential health risks of FGM. Local stakeholders confirmed reports of FGM being conducted by midwives during birth or antenatal visits upon request from women and their husbands.

Many community members reported that since the law criminalising all forms of FGM was adopted, people are less willing to talk about the practice for fear that they will be reported to the police. There are also rumours of girls running away to a remote place in small groups to cut each other. However, most respondents said that they do not believe these stories, and that they are being told to protect the cutters, who, if identified, could be arrested under the FGM Law. Several respondents pointed out that the health risks for girls are higher than they used to be because of where and when the practice is performed nowadays. The need for secrecy puts pressure on girls and cutters to perform the procedure quickly and in unsanitary conditions, possibly affecting the precision and hygiene of the cut and the healing process. Some respondents also reported that girls are now getting cut at a younger age and that the inability to follow the traditional rituals, which included months of preparation and mentoring by older mutilated women, makes girls less ready and less prepared for the procedure and for marriage and married life.

A difference that consistently emerged from all conversations is that the timing of the practice has changed. Whereas in the past FGM would be performed only once a year during the harvest season (so that there would be plenty of food to feed the girls during recovery and everyone would have an abundance of resources to bring gifts to the celebration), nowadays it happens at all times of the year. (Since the practice is conducted in secret, no precise data are available on where and when this happens.) Moreover, girls are no longer being cut in big groups. Usually one or two girls run away together (either to the bush or to some remote caves) to be cut.

Male circumcision emerged as the main driver for the persistence of FGM. Male and female circumcision have always been strongly interlinked, with the two rituals taking place at a similar time of year and girls tending to be married to boys initiated in the same cohort. Nowadays, only male circumcision takes place publicly and is surrounded by big celebrations, while FGM is performed in secret. During male circumcision ceremonies (which celebrate the circumcision of boys), families organise big parties and invite friends and relatives. At each ceremony, the boy's father invites three special male friends tasked with bringing specific gifts, one of them the guest of honour. Being invited to one of these ceremonies as the guest of honour brings pride and visibility to the invited man and his family. The male guest of honour is expected to bring along a partner (usually one of his wives) and to sit with her at a high table during the celebration. However, only mutilated women are allowed to join their partners as guests of honour to these ceremonies. The husband of an uncut woman must hire another mutilated woman in order to join the ceremony and participate as a friend's guest of honour. In polygamous communities, a man will only take one of his mutilated wives. For uncut women, the inability to participate in these important social events is perceived as a disgrace and their absence brings shame and dishonour to the couple and their family. Uncut married women therefore experience incredible social pressure and ostracism because they are not allowed to assist and participate in their own sons' circumcision ceremonies and those of other boys in their community. As a result, uncut married women may decide to undergo FGM at a later age. This phenomenon of older married women getting cut is particularly common among the Sabiny and is perceived by women as the only way to become respected members of their communities. Often the cutting of older married women is performed by traditional birth attendants (TBAs) during or after delivery.

## 5.8 DRIVERS OF CHANGE

Uganda, along with many other sub-Saharan African countries, is experiencing rapid changes in the dynamics and culture surrounding FGM. The main factors that have influenced shifts in the FGM practice in eastern Uganda are discussed below.

### THE FGM LAW

The Government of Uganda's 2010 law making FGM illegal has produced changes in how the practice is performed. The law was often acknowledged by respondents as one of many contributing factors to positive changes in attitudes towards FGM abandonment. However, most communities expressed disappointment in how the law was designed and implemented. Respondents claimed that local communities did not feel involved in the decision-making process and did not feel that they had an opportunity to bring their perspective to the discussion. The law was often perceived as a central government decision that did not take into consideration the culture of these populations, who have felt neglected by the Government for a long time.

According to respondents, the main effect of the law has been to put FGM underground. It is now carried out in hiding rather than at public ceremonies. The practice now takes place in remote areas hidden away from the police and from other community members who may report it to the authorities. There are numerous accounts of girls running away to get cut in "the bush". In both Karamoja and Sebei, the cutting now happens primarily on or across the border with Kenya. The formal banning of the practice has also resulted in increased difficulties in collecting reliable data on the prevalence and incidence of the practice, with potential negative consequences on the ability to adequately target programmes.

### THE INFLUENCE OF RELIGION

All respondents agreed that religion was one of the main drivers of change in relation to the practice of FGM in these communities, having reached nearly the entire population in even the most remote and disadvantaged areas. The Christian church has brought baptism, catechism training and the idea that the human body is a gift of God and should not be altered. According to respondents, the church has made efforts to expand education opportunities for girls in rural areas and strongly advocates against FGM. Mosques also engage in sensitisation campaigns and community activities and promote education for girls. Many representatives of religious groups who participated in the focus groups and interviews expressed optimism regarding the abandonment of FGM. There is a widespread belief that a generational change is taking place and that the main tool that churches and mosques can use against FGM is to generate education opportunities for girls and alternative opportunities for communities to gather. Replacing FGM ceremonies with alternative activities that can foster a sense of belonging was frequently mentioned by the religious leaders who participated in data collection. Similarly, engaging boys, girls and young people in activities that keep them busy during school holidays and during their free time was also seen as a key way to promote abandonment.

### THE EXPANSION OF EDUCATION OPPORTUNITIES

The role of religion is closely linked with that of education, since in very remote areas where the practice of FGM is still common churches and mosques are often the primary providers of schooling. Education has influenced the practice of FGM in different ways. On the one hand, it has brought about a change in mindset among schoolgirls who are more focused on improving their future economic outcomes. They have higher aspirations and therefore dedicate less time and have less interest in traditional practices and gossip (which is seen as the starting point in girls' decision to undergo FGM). On the other hand, education keeps girls away from their community and parents, and therefore reduces their exposure to societal pressures and delays the age at which they marry. The main concern raised by religious leaders was around school holidays, when girls travel back to their villages and communities and are at risk of being pressurised into getting cut by less educated peers and relatives. Increases in school enrolment and educational attainment for girls are directly related to bride price. Although educated girls are more likely to marry later and (if they



remain uncut) receive a lower dowry, they are more likely to find paid work and may even move to urban areas. If this happens, they may be able to buy cows for their parents (especially important to the Pokots) and contribute to improving the socioeconomic status of their family.

Many religious and political leaders mentioned that the most immediate and effective way to prevent girls being subjected to FGM could be the creation of boarding schools where girls can stay during school holidays and rescue centres where they can take refuge from local traditions and pressures, and where they can grow up free from the risk of mutilation. Community members seemed to generally have a positive attitude towards increased schooling and education. However, in all discussions there were complaints about expensive school fees and the lack of schools in remote areas.

## **OTHER FACTORS**

Local engagement, sensitisation campaigns and community dialogues are also important in moving towards the abandonment of FGM. Change in social norms is fostered by engaging community members (including adolescents, men and women, religious leaders, cultural leaders, etc.). The realisation that mutilation often leads to negative health consequences for women and their babies has also contributed to attitudes supportive of abandonment of FGM. Respondents told numerous stories of girls who had died due to haemorrhaging after the cut and of other negative outcomes, including complicated childbirth and occasionally death for mutilated women and their babies.

## **5.9 THE FUTURE OF FGM IN EASTERN UGANDA**

Among respondents who participated in the qualitative interview, there was a widespread feeling that FGM is decreasing and that long before the law came into effect some communities had made steps towards abandonment thanks to sensitisation campaigns, community dialogues and the spread of religion and education opportunities. However, FGM remains a central cultural characteristic of these eastern Ugandan populations and is strongly associated with social pressure and stigma towards uncut women. Some clear trends have emerged from discussions with community members in these areas. First, the elimination of FGM will be difficult as long as male circumcision is practised and its rituals continue to exclude uncut women. Second, many communities perceive that there has been a slow but steady decrease in the prevalence of FGM among unmarried girls thanks to increased education opportunities and faith-based beliefs, but at the same time cutting during childbirth has increased among married women who feel they are not respected within their community and within their family. Third, the fact that the practice is now done in secret and that women have fewer ways to signal their FGM status to potential partners and other community members may reduce some of the social pressure to get cut and the ostracism of uncut women. However, secrecy may have made the practice more dangerous for those women who are cut.



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## 6 LIMITATIONS

This report contributes to expanding evidence about the practice of FGM in eastern Uganda. However, a number of limitations should be considered when appreciating its findings. First, the quantitative analyses of UDHS data rely on only two rounds of data to generate time trends over the decade 2006–2016. Further analyses could explore trends in more detail by using a larger number of UDHS datasets. Second, the 2016 FGM survey was conducted in a selected number of FGM practising sub-counties across six districts of eastern Uganda. Results are therefore not representative of all the district areas for Moroto and Nakapiripirit. Finally, both the qualitative data collected in 2019 and the FGM survey data are likely to suffer from misreporting and the concealing of information by respondents due to a combination of social desirability bias deriving from the sensitivity of the topic and the criminalisation of FGM, which exposes those enabling and performing the practice to prosecution.

## 7 CONCLUSIONS

The present study was carried out to shed light on the practice of FGM in eastern Uganda. Despite low national prevalence, FGM is still common in certain eastern parts of the country. UBOS' 2016 FGM survey of six districts across Karamoja region and Sebei sub-region confirmed high regional and sub-regional variations, with prevalence rates higher than 50% in some sub-counties. While the origin of the practice and the main motivations for its continuation are similar across Karamoja and Sebei, both UDHS and FGM survey data show much higher rates in Karamoja than in Sebei. The data suggest that a slow but consistent decrease in the practice has been taking place in the latter.

Both quantitative and qualitative analyses suggest that in both regions there is widespread support for abandonment of FGM, which has been fostered by the realisation that it can result in serious negative health outcomes during childbirth, by increased access to education, and finally by the embracing of religious beliefs among local populations. Quantitative analyses have confirmed that educational attainment and access to information are protective factors against FGM. Any future programmes should therefore use these channels to achieve progress towards discontinuation of the practice.

While most women report holding positive views towards the discontinuation of FGM, social pressure and norms still play a major role in defining attitudes and practices around mutilation. Findings from the 2016 FGM survey seem to suggest that even when women support abandonment, they are reluctant to express these views publicly and to openly advocate against FGM. Targeted efforts to improve access to education and information for women and girls should therefore be complemented with community-based interventions aimed at challenging these widespread social norms. Nowadays, women and girls undergoing FGM do so primarily to conform to peer pressure and to avoid being ostracised by their community. Qualitative findings have also highlighted the link between male circumcision rituals and the perpetuation of FGM. It appears that increasingly uncut married women are undergoing FGM during childbirth to conform to social pressures and be permitted to join male circumcision ceremonies as honourable and respected guests.

The introduction of the anti-FGM law has certainly accelerated progress towards abandonment but it may also have contributed to making the practice more dangerous (since it is now mostly performed in hiding) and more difficult to measure. Members of FGM-practising communities felt neglected by the policy process and perceived the law as an attack on their cultural identity. While the international community supports legislative changes that make the practice illegal, it also calls for continued community engagement to shift the norms that allow FGM to continue.

Based on these findings, the following sections present a series of recommendations for future research and programmes aimed at eliminating FGM in Uganda.

## 7.1 RECOMMENDATIONS FOR FUTURE RESEARCH AND DATA COLLECTION

Data on FGM in Uganda is scant. The FGM survey implemented in 2016 was the first attempt to collect representative detailed data on FGM. Despite these efforts, there are still data gaps that hinder our ability to fully understand how contextual, demographic and socioeconomic factors are associated with the practice of FGM. Future data collection efforts could attempt to explore the following aspects:

### HOW DO SOCIOECONOMIC FACTORS (SUCH AS RELIGION, EDUCATION AND WEALTH) INFLUENCE FGM?

**Why focus on this:** The findings of the present study have highlighted the key role of religion and education in influencing practices related to FGM.

**Action:** Collect robust household demographic and socioeconomic data such as religious affiliation, participation in religious events/ceremonies, educational attainment of household members, educational aspirations of women and girls, wealth and sources of income, economic autonomy of female members of the household, etc.

### WHAT ARE THE HEALTH AND SOCIAL CONSEQUENCES OF FGM?

**Why focus on this:** There is suggestive evidence that both health considerations and social norms play an important role in determining views and attitudes towards FGM.

**Action:** Collect data on the health status and health outcomes of women and girls with a focus on sexual, reproductive and maternal health outcomes, collect information on women's participation in social events and about women's social networks.

### IS MALE CIRCUMCISION THE MAIN FACTOR INFLUENCING FGM TODAY?

**Why focus on this:** There is suggestive evidence that male circumcision is one of the main drivers of the perpetuation of FGM in eastern Uganda.

**Action:** Collect data on male circumcision rituals and ceremonies to understand the relationship between the two practices.



## 7.2 RECOMMENDATIONS FOR FGM ABANDONMENT PROGRAMMING

FGM is deeply rooted in people's culture. Its abandonment will be the result of a slow and complex process that will require the involvement of different community groups over sustained periods of time. The findings of the present study have shown that, although FGM has a negative impact on the health and wellbeing of girls and women, it has also contributed to shaping the identity of entire communities. The recommendations listed below therefore include a combination of individual and community-based approaches that should be seen as interlinked and complementary to each other for the design of effective anti-FGM programmes.

**COMMUNITY-LED APPROACHES TO SHIFT SOCIAL NORMS:** The perpetuation of FGM is driven by strong social and peer pressures that influence women's and households' decisions, leading many married uncut women to undergo the practice in adulthood to avoid social exclusion and mockery. Community-based approaches, designed based on principles of diffusion of innovation theory (Brown et al., 2013; UNICEF, 2010), and aimed at addressing the social dynamics underpinning the continuation of FGM and other harmful practices – such as SASA! (Abramsky et al., 2014) and Tostan's Community Empowerment Programme (Cislaghi, 2019) – have shown some promising results in other contexts. These could be integrated through community dialogues and public declaration interventions.

**EDUCATION PROGRAMMING:** Education emerged as one of the key drivers of FGM abandonment and acts as a protective factor against FGM in many ways. It equips girls and boys with new skills, knowledge and ideas, and expands their economic opportunities in adulthood, making future generations less dependent on bride price and traditional income-generating activities. It also provides a safe space that keeps girls away from harmful traditional practices. Girls who undergo FGM are strongly influenced by peers and by their communities; protecting girls from traditional social pressures and allowing them to dedicate their time and energy to school can contribute to the discontinuation of FGM. The expansion of affordable education opportunities (including those provided by church and religious bodies) and the creation of safe spaces for girls will therefore be an essential component of any programming in the fight against FGM in eastern Uganda. Formal education should be complemented with health education interventions that have shown promising results in preventing and reducing FGM (Waigwa, 2018).

**ALTERNATIVE RITES OF PASSAGE:** FGM rituals represent a public and social event for communities and their elimination is likely to leave a void in the social life of practising communities. Exploring the creation of alternative rituals to replace the social role of FGM ceremonies is therefore recommended. However, since existing evidence on the effectiveness of such strategies is limited, the implementation of alternative rites of passage interventions should be coupled with rigorous evaluation aimed at understanding which design options and in which contexts these programmes can be successful. These approaches should keep under consideration the important role of male circumcision rituals as a driver of FGM.

**RIGOROUS EVALUATION AND RESEARCH:** While several interventions and programmes aimed at preventing and reducing FGM have been implemented in Karamoja and Sebei (including multimedia campaigns, community dialogues and mobilisation), no rigorous impact evaluation has been conducted to date. A systematic review (Rigmor and Denison, 2013) found only eight rigorous studies assessing the effectiveness of interventions to reduce the prevalence of FGM in Africa and all were assessed as being of low methodological quality. There is a need for rigorous impact evaluations designed to assess the causal mechanisms of change that affect outcomes.



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# APPENDICES

## APPENDIX 1: DISTRICT ANALYSIS



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This section attempts to summarise key information for each of the six districts included in the FGM survey and highlights some of the defining features of FGM in each area. These considerations can be useful to inform the design of future targeted anti-FGM efforts.

# KWEEN

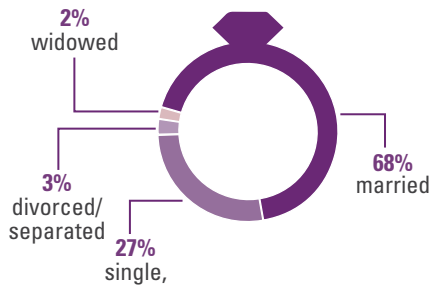
Sebei sub-region

FGM prevalence **21%**

Individuals living under the poverty line **36%**

## WOMEN'S DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS

### MARITAL STATUS

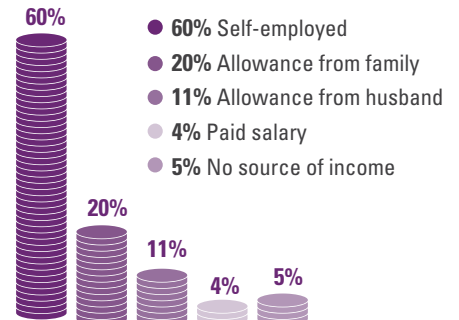


MEAN AGE AT MARRIAGE  
**19 years**



WOMEN WHO NEVER ATTENDED SCHOOL  
**9%**

### INCOME SOURCES



### ACCESS TO AND USE OF MEDIA



**27%**  
own a mobile phone



**56%**  
listen to the radio daily



**71%** never read newspapers  
**20%** less than once a week



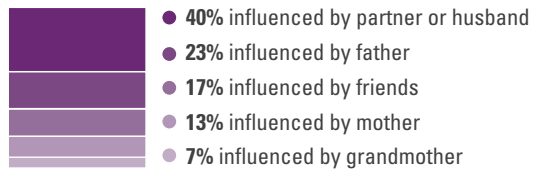
**87%** never watch tv  
**8%** less than once a week

Watching TV and reading newspapers are less common:

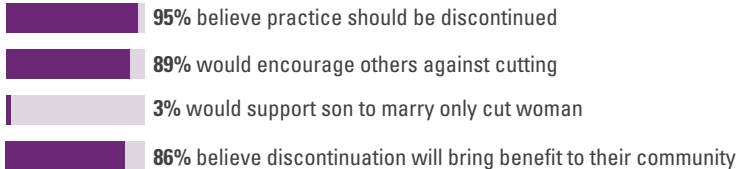
### FGM DATA

### WOMEN'S MEAN AGE AT CIRCUMCISION: 19 YEARS

#### INFLUENCES ON DECISION TO UNDERGO FGM



#### ATTITUDES AND BELIEFS



**89%**

have heard about the anti-FGM law

**11%**

thought there would be cases of FGM in their community in the next 12 months

**54%**

had heard about FGM at a sport/drama community event in past 12 months

## KEY FINDINGS AND RECOMMENDATIONS

- **1 in 3 women owns a mobile phone** – potential for mobile-based communication and sensitisation campaigns + a fairly large number of women listen to the radio and read newspapers. These could be alternative avenues for reaching individuals.
- **Strong influence of men in decision-making process (both partners/husbands and fathers)** – need for anti-FGM programming efforts to target these members of the community, who have power to influence women.
- **More than 50% of women had heard about FGM at community events in past 12 months** – suggests good level of community engagement on the topic.
- Women showed strong support for discontinuation and a commitment to influence others against FGM. **More than 1 in 10 women expect FGM to take place in their village.**



# BUKWO

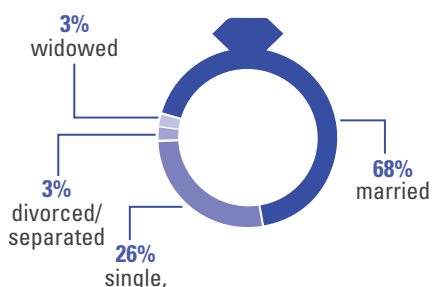
## Sebei sub-region

FGM prevalence **28%**

individuals living under the poverty line **35%**

### WOMEN'S DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS

#### MARITAL STATUS

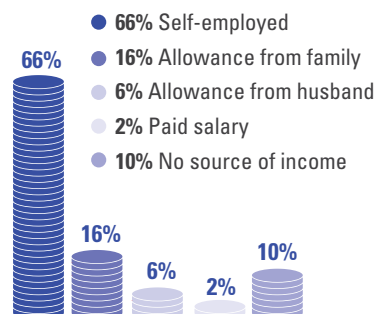


MEAN AGE AT MARRIAGE  
**19 years**



WOMEN WHO NEVER ATTENDED SCHOOL  
**9%**

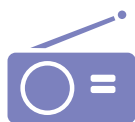
#### INCOME SOURCES



#### ACCESS TO AND USE OF MEDIA



**19%**  
own a mobile phone



**36%**  
listen to the radio daily



**88%**  
never read newspapers



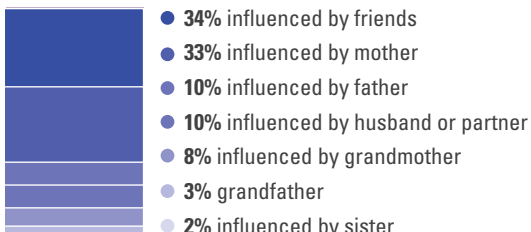
**89%**  
never watch tv

Watching TV and reading newspapers are less common:

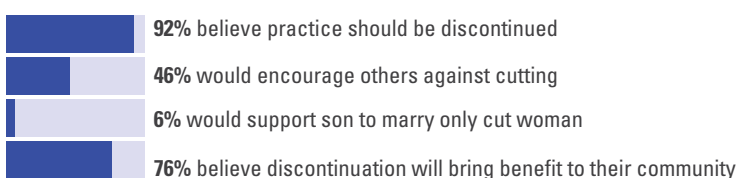
#### FGM DATA

#### WOMEN'S MEAN AGE AT CIRCUMCISION: 18 YEARS

#### INFLUENCES ON DECISION TO UNDERGO FGM



#### ATTITUDES AND BELIEFS



**73%**

have heard about the anti-FGM law

**5%**

thought there would be cases of FGM in their community in the next 12 months

**25%**

had heard about FGM at a sport/drama community event in past 12 months

The most frequently mentioned reasons for supporting abandonment were that it would reduce the number of women infected with HIV, reduce the number of maternal and newborn deaths, expenditure on healthcare, and reduce the number of early pregnancies

#### KEY FINDINGS AND RECOMMENDATIONS

- Main media channel used by women is the radio.
- Strong influence of women such as friends and mothers in decision-making process around FGM.
- Women showed strong support for discontinuation but lower commitment to influence others on the topic. Moreover, less than 80% of women believe discontinuation will bring benefits to their community. All of these suggest presence of strong community social norms around FGM.
- Around 1 in 4 women had heard about FGM at community events in the past year – suggests potential to expand community outreach.

# KAPCHORWA

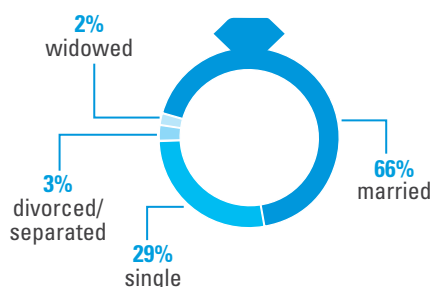
Sebei sub-region

FGM prevalence **13%**

individuals living under the poverty line **28%**

## WOMEN'S DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS

### MARITAL STATUS

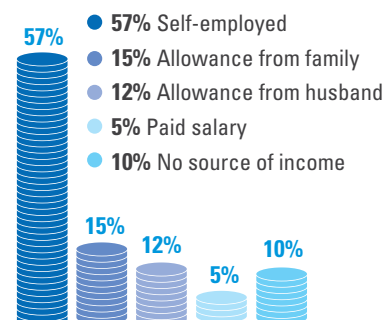


MEAN AGE AT MARRIAGE  
**19 years**



WOMEN WHO NEVER ATTENDED SCHOOL  
**16%**

### INCOME SOURCES



### ACCESS TO AND USE OF MEDIA



**30%**  
own a mobile phone



**70%**  
listen to the radio daily



**65%**  
never read newspapers



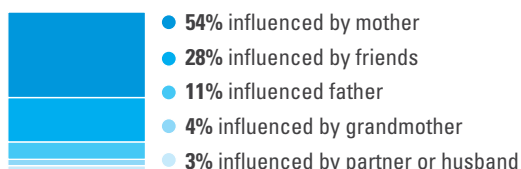
**67%**  
never watch tv

Watching TV and reading newspapers are less common:

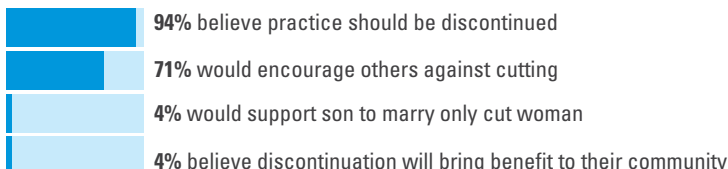
### FGM DATA

### WOMEN'S MEAN AGE AT CIRCUMCISION: 18 YEARS

#### INFLUENCES ON DECISION TO UNDERGO FGM



#### ATTITUDES AND BELIEFS



**81%**

have heard about the anti-FGM law

**3%**

thought there would be cases of FGM in their community in the next 12 months

**26%**

had heard about FGM at a community event in the past 12 months

The most frequently mentioned reasons for supporting abandonment were that **it would reduce the number of fistulae and women infected with HIV**

### KEY FINDINGS AND RECOMMENDATIONS

- Higher proportion of women with no education compared with other districts in the sub-region.
- Women not only own mobiles (30%) but seem to have access to other media channels, including radio and TV – which could be used to reach women.
- Mothers and friends are the main influencers in the decision to undergo FGM – the men in women's lives seem to have less influence on the topic.
- Strong level of support for discontinuation but less than 60% of women believe this would bring benefits to their community. This may be linked to lower prevalence rates in this district. This should not lead to de-prioritising the fight to end the practice.

# MOROTO

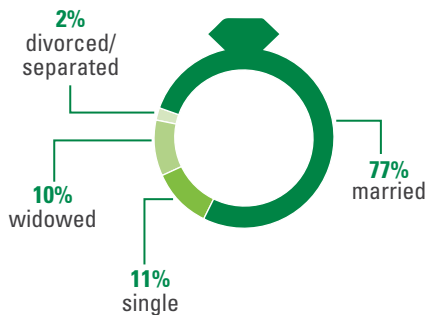
Karamoja region

FGM prevalence **52%**

individuals living under the poverty line **66%**

## WOMEN'S DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS

### MARITAL STATUS

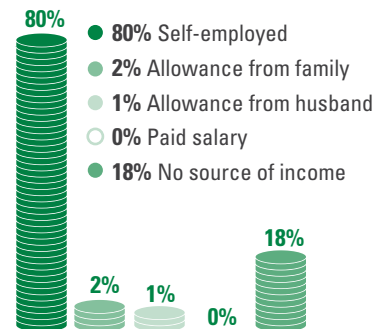


MEAN AGE AT MARRIAGE  
**18 years**



WOMEN WHO NEVER ATTENDED SCHOOL  
**83%**

### INCOME SOURCES



### ACCESS TO AND USE OF MEDIA



**3%**  
own a mobile phone



**45%**  
listen to the radio daily



**97%**  
never read newspapers



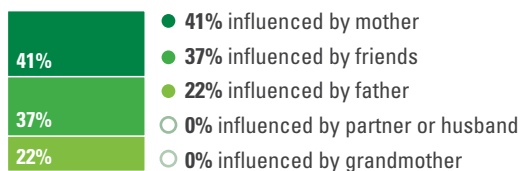
**96%**  
never watch tv

Watching TV and reading newspapers are less common:

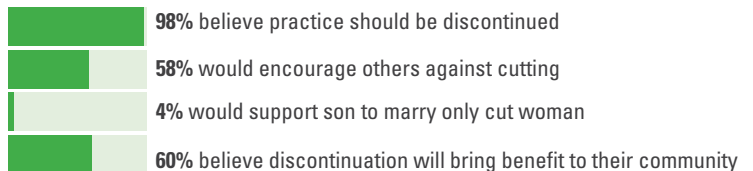
## FGM DATA

## WOMEN'S MEAN AGE AT CIRCUMCISION: 15 YEARS

### INFLUENCES ON DECISION TO UNDERGO FGM



### ATTITUDES AND BELIEFS



**94%**

have heard about the anti-FGM law

**NONE**

thought there would be cases of FGM in their community in the next 12 months

**82%**

had heard about FGM at a community event in the past 12 months

## KEY FINDINGS AND RECOMMENDATIONS

- Extremely low education levels, 3% ownership of a mobile phone, less than 50% listening to the radio on a daily basis. All these factors may compromise the possibility of reaching women with sensitisation messaging. Need for outreach efforts to be carefully crafted for this vulnerable and more isolated population of women.
- Very high FGM prevalence but high support for abandonment and willingness to influence others against the practice.
- Despite high level of media/social isolation of women in the district, data suggest that good outreach efforts are ongoing as vast majority of women had heard about FGM at community events in the past 12 months.



# NAKAPIRIPIRIT

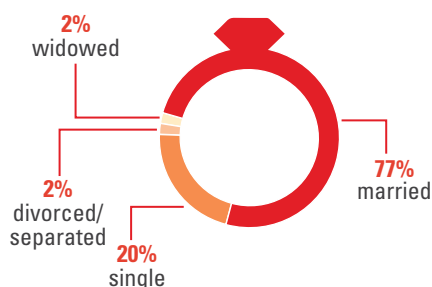
Karamoja sub-region

FGM prevalence **49%**

individuals living under the poverty line **62%**

## WOMEN'S DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS

### MARITAL STATUS

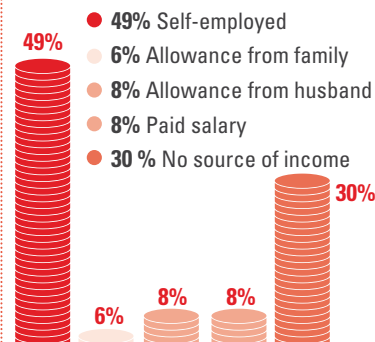


MEAN AGE AT MARRIAGE  
**18 years**



WOMEN WHO NEVER ATTENDED SCHOOL  
**61%**

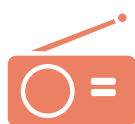
### INCOME SOURCES



### ACCESS TO AND USE OF MEDIA



**13%**  
own a mobile phone



**41%** listen to radio daily  
**20%** at least once a week



**89%**  
never read newspapers



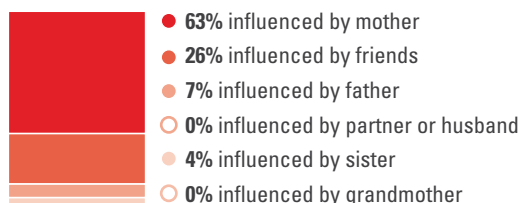
**94%**  
never watch tv

Watching TV and reading newspapers are less common:

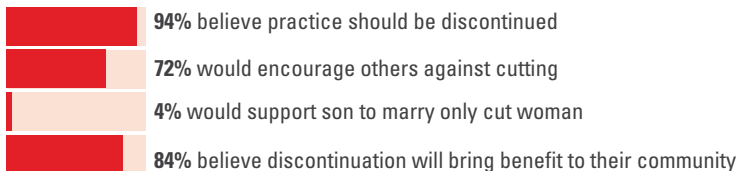
### FGM DATA

### WOMEN'S MEAN AGE AT CIRCUMCISION: 14 YEARS

#### INFLUENCES ON DECISION TO UNDERGO FGM



#### ATTITUDES AND BELIEFS



**97%**

have heard about the anti-FGM law

**NONE**

thought there would be cases of FGM in their community in the next 12 months

**72%**

had heard about FGM at a community event in the past 12 months

The most frequently mentioned reasons for supporting abandonment were that **it would reduce the number of fistulae and women infected with HIV**

## KEY FINDINGS AND RECOMMENDATIONS

- Low education levels, low mobile phone ownership, less than 50% listening to radio on a daily basis (similar to Moroto). All these factors may compromise the possibility of reaching women with sensitisation messaging. Need for outreach efforts to be carefully crafted for this vulnerable and more isolated population of women.
- High FGM prevalence but accompanied by strong support for abandonment and strong willingness to influence others against the practice.
- Despite high level of media/social isolation of women in the district, data suggest that good outreach efforts are ongoing as vast majority of women had heard about FGM at community events in the past 12 months.

# AMUDAT

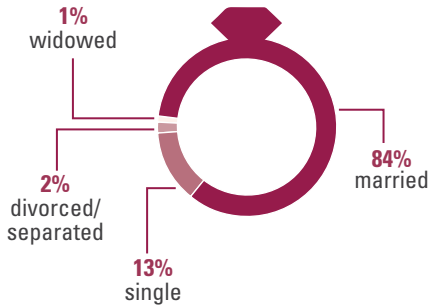
Karamoja region

FGM prevalence **43%**

individuals living under the poverty line **67%**

## WOMEN'S DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS

### MARITAL STATUS

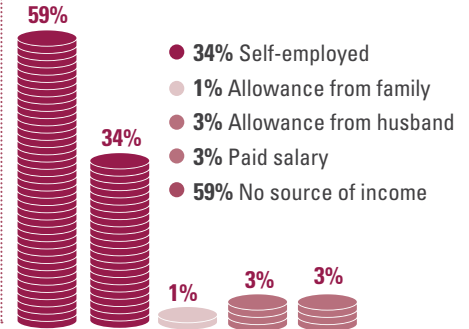


MEAN AGE AT MARRIAGE  
**17 years**



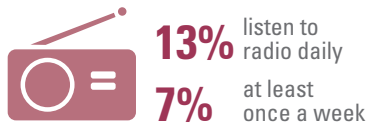
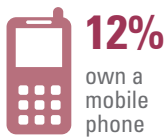
WOMEN WHO NEVER ATTENDED SCHOOL  
**80%**

### INCOME SOURCES



### ACCESS TO AND USE OF MEDIA

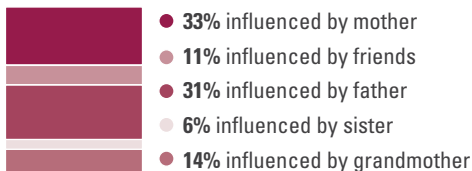
Watching TV and reading newspapers are less common:



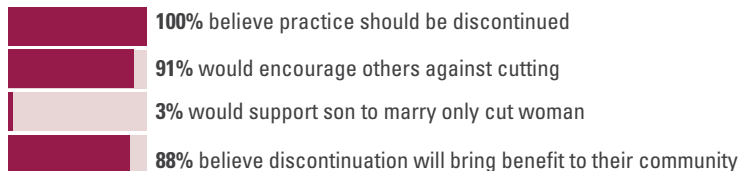
### FGM DATA

### WOMEN'S MEAN AGE AT CIRCUMCISION: 14 YEARS

#### INFLUENCES ON DECISION TO UNDERGO FGM



#### ATTITUDES AND BELIEFS



**90%**

have heard about the anti-FGM law

**NONE**

thought there would be cases of FGM in their community in the next 12 months

**51%**

had heard about FGM at a community event in the past 12 months

## KEY FINDINGS AND RECOMMENDATIONS

- Low education levels and very low access to media channels, including radio. All these factors may compromise the possibility of reaching women with sensitisation messaging. Need for outreach efforts to be carefully crafted for this vulnerable and more isolated population of women.
- The immediate family seems to have the most influence over the decision-making process around FGM.
- Very high FGM prevalence and universal support for abandonment. Strong willingness to influence others against the practice and widespread belief that abandonment will result in benefit for the community.



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## APPENDIX 2: METHODS

The study used mixed methods (quantitative and qualitative data analysis) to investigate the practice of female genital mutilation (FGM) in eastern Uganda. Quantitative analyses relied on secondary data and were aimed at exploring historical trends in FGM prevalence and at investigating which individual and contextual factors were associated with the practice. Qualitative data were collected through a small number of key informant interviews and focus groups with the aim of providing clarity on the context in which FGM is performed, on the origin of the practice, and on why and how the practice has changed over time. Qualitative data was also used to support the interpretation of the study findings that emerged from the quantitative analyses.

### QUANTITATIVE ANALYSES

#### Data sources

The study used data from the 2006 and 2016 Uganda Demographic and Health Surveys (UDHS) and data collected by the Uganda Bureau of Statistics (UBOS) and UNICEF Uganda in its FGM survey in six districts in eastern Uganda in December 2016.

The UDHS are cross-sectional, nationally representative surveys that collect information about households, children, and men and women, of reproductive age (15–to 49 years). The surveys include questions on household and individual characteristics, fertility and family planning, maternal and child health. The UDHS for the years 2006, 2011, and 2016 also included a series of questions on FGM. However, the present analyses focus on mapping progress over the course of one decade and rely primarily on UDHS data from 2006 and 2016. Further detail on the survey design, sampling strategy and tools used can be found in the UDHS Country Reports for each of the three surveys ([www.dhsprogram.com](http://www.dhsprogram.com)). The geographical definition of regions was slightly different across surveys: UDHS 2006 divided Uganda into 9 sub-national regions (Kampala, Central 1, Central 2, Southwest, Western, West Nile, Northern, Eastern and East Central) and 368 clusters (321 from the 2005–2006 the Uganda National Household Survey, 30 IDP camps, and 17 clusters from Karamoja); UDHS 2016 divided Uganda using the sampling frame of the 2014 Uganda National Population and Housing Census (NPHC) in which Uganda was divided administratively into 112 districts, grouped into 15 regions for the 2016 UDHS. The sample for the 2016 UDHS was designed to provide estimates of key indicators for the country as a whole, for urban and rural areas separately, and for each of the 15 regions (696 enumeration areas (EAs) were used from the 2014 Uganda NPHC). For analytical purposes, this study relied on the classification of regions used in the 2006 UDHS, with the addition of Karamoja. The regions of Bukedi, Bugisu and Teso from UDHS 2016 were collapsed into what is referred to as Eastern region in analyses that include UDHS 2016 data. The three regions overlap entirely with the Eastern region of 2006.

The FGM survey was conducted as a household based representative sample survey for six target districts: Kapchorwa, Bukwo, Keen, Nakapiripirit, Moroto and Amudat. Within each of the targeted districts, FGM practising sub-counties were purposively selected to allow for estimation of the key indicators for each of the domains of study. Detailed information on the sampling strategy is presented elsewhere (UBOS and UNICEF, 2017).

## Indicators and definitions

All women included in the analyses were asked about their current FGM status (whether or not they were circumcised at the time of the survey). All analyses were restricted to women aged between 15 and 49.

### FGM status in UDHS

Table A1 shows in detail which questions were included in each round of the UDHS. In neither of the two UDHS rounds were questions about FGM asked to men.

**TABLE A1 QUESTIONS IN THE 2006 AND 2016 UDHS FOR WOMEN (AGED 15–49)**

QUESTION	UDHS 2006	UDHS 2016
Have you ever heard about female circumcision? (A practice in which a girl may have part of her genitals cut).	✓	✓
In some countries, there is a practice in which a girl may have part of her genitals cut. Have you ever heard about this practice?		✓
Have you yourself been circumcised?	✓	✓
Were you forced to get circumcised or did you want to get circumcised?		✓

### FGM status in the 2016 FGM survey

Women included in the FGM survey were also asked “Have you yourself ever been circumcised?,” which is a very similar to the question in the UDHS. Questions about awareness of FGM, age at cutting, who performed the cut and the FGM status of daughters were also asked.

## Data analysis

Multivariate logistic regressions were used to examine the association between demographic, social and economic factors and FGM outcomes (FGM status, awareness of FGM, opinions and attitudes towards FGM). These analyses were conducted on both the UDHS and the FGM survey datasets. Changes in the characteristics of women included in the two waves of UDHS data were observed so the multivariate analyses of the UDHS data were conducted as a repeated cross section. Proportions, means, tables and graphs were used for data description and presentation. Measures of association are presented as odds ratios with 95% Confidence Intervals (CIs). Odds ratios are a measure of association between exposure and outcome and are defined as the ratio of the probability of an event (success) and the probability of non-event (failure). Standard errors were clustered at sub-county level in the FGM survey multivariate analyses.

Data analysis was conducted in Stata SEv16 (College Station, TX) and accounted for the survey design of each survey (sample weights, clustering and stratification). Both the UDHS and the FGM survey used a multilevel clustered sampling survey design and individual women’s survey weights were accounted for in all analyses.



## QUALITATIVE ANALYSES

Qualitative data collection was conducted between 13 and 20 October 2019 in eastern Uganda. In Karamoja, data collection was conducted in two sub-counties of Amudat district; in the Sebei sub-region data was collected in two sub-counties of Kween district. These sub-counties were selected for convenience to investigate different aspects and trends in FGM practice<sup>9</sup>. The research team held 7 focus groups (4 in Karamoja and 3 in Sebei) and 4 in-depth interviews (2 in Karamoja and 2 in Sebei). Karamoja and the Sebei are inhabited by different ethnic groups (Tepeth and Pokot in Karamoja and Sabiny in Sebei) who share a common tradition in the practice of female and male circumcision. Data collection was conducted among Pokot communities in Amudat (who practice primarily type 3 FGM (infibulation) and among Sabiny in Kween (who practise types 1 and 2, clitoridectomy and excision).

Primary data were collected through multiple methods from purposefully selected respondents to explore various aspects related to the practice of FGM. Data collection involved various focal groups at the sub-county and community level: (i) community members of both genders; (ii) political leaders such as level 5 local councillors and Resident District Commissioners; (iii) cultural and religious leaders; (iv) traditional cutters and older female community members; (v) female role models (groups of women who have abandoned FGM); (vi) district officials responsible for programme implementation. Methods included semi-structured interviews (conducted primarily with district officials), focus group discussions, and analysis of documents such as UNICEF programme monitoring documents and literature review.

Purposive selection of participants was aimed at collecting data from different community groups that would contribute different perspectives on the practice of FGM and was based on the FGM status of communities (practising communities, communities that are making progress towards abandonment, and communities that have abandoned FGM). Interviews and focus groups were not recorded. Instead, with the aid of local interpreters, notes were taken throughout the interviews by multiple members of the research team and then compared and integrated.

Data collection was aimed at: understanding where the practice originates from and what factors foster its perpetuation; exploring how decisions about cutting are made and who are the main influencers; investigating the drivers of change in the practice and therefore understanding which programming efforts for abandonment have better chances of success. FGM is (and was at the time of data collection) illegal in Uganda, with strict punishments for anyone who engages in the performance, procurement, attempting, or aiding and abetting of the practice. In order to minimise the risk to participants engaging in conversations about sensitive and illegal behaviours, and to encourage the provision of honest input, respondents were asked to not share individual and personal experiences and were not prompted to provide personal opinions. To ensure complete anonymity and confidentiality, no personal identifiable information was collected and no names were used during discussions and interviews. Nonetheless, we acknowledge that the current political and legal context of FGM in Uganda may have affected respondents' willingness to disclose truthful information and may therefore have biased the findings reported in this study.

<sup>9</sup> In Amudat district, Karita and Loroo sub-counties, which are FGM hotspots, were selected due to their proximity to the Kenyan border – where cross-border FGM is prevalent. In Kween district, Binyiny was selected due to the upsurge of FGM in 2018/2019 when over 250 women and girls were cut in sight of the police as a public demonstration in support of the FGM cultural practice. Also in Kween, Keptoyoy sub-county was selected because the sub-county includes parishes that are abandoning FGM. One focus group discussion was held in Keptoyoy Parish to learn lessons that can strengthen interventions towards FGM abandonment.

## APPENDIX 3: UDHS NATIONAL LEVEL ANALYSES

All UDHS analyses relied on two waves of UDHS data from 2006 and 2016 in order to provide an overview of trends and changes over a 10-year period.

**TABLE A2 BACKGROUND CHARACTERISTICS OF WOMEN AGED 15–49 YEARS (UDHS 2016 AND 2006)**

BACKGROUND CHARACTERISTICS (%)	2016	2006
Ever married	33.9	53.8
<b>EDUCATION LEVEL</b>		
None	9.6	19.3
Primary	57.4	59.3
Secondary	25.1	17.4
Higher	7.9	3.9
<b>RELIGION</b>		
Catholic	39.7	42.4
Protestant	31.2	34.5
Muslim	12.9	11.2
Pentecostal	13.4	8.1
Seventh Day Adventist	1.6	1.9
Other	1.1	1.9
<b>RESIDENCE</b>		
Residing in rural areas	73.3	83.1
<b>REGION OF RESIDENCE</b>		
Central 1	13.5	10.6
Central 2	10.6	9.0
Kampala	5.5	8.5
East Central	9.1	9.8
Eastern	17.2	13.5
North	10.5	15.5
West Nile	6.7	5.5
Western	12.8	14.9
South West	12.0	12.7
Karamoja	2.0	
<b>FGM STATUS AND KNOWLEDGE</b>		
Women circumcised	0.32	0.64
Women who have heard of FGM	54.6	33.8
<b>NUMBER OF WOMEN INTERVIEWED</b>		
	<b>18,506</b>	<b>8,531</b>

While the mean age of interviewed women remained similar across survey rounds (27.9 in 2016 and 28.1 in 2006), a slight increase in age at marriage was observed (18.4 in 2016 and 17.4 in 2006), together with a decrease in the proportion of women who had ever been married. Education levels improved over time, with a higher proportion of women reaching secondary and higher levels of education in more recent waves and an increasing number of women who resided in urban areas.

**TABLE A3 ASSOCIATION BETWEEN BACKGROUND CHARACTERISTICS AND FGM STATUS (UDHS 2016 AND 2006)**

BACKGROUND CHARACTERISTICS	2016	2006
	ADJUSTED ODDS RATIO (SE)	
<b>EDUCATION LEVEL (REF: NO EDUCATION)</b>		
Primary	0.820 (0.291)	0.817 (0.300)
Secondary	0.474 (0.262)	1.149 (0.686)
Higher education	0.158 (0.204)	1.139 (0.871)
<b>LOCATION (REF: URBAN)</b>		
Rural	2.146 (1.643)	4.984 (5.273)
<b>WEALTH INDEX (REF: POOREST)</b>		
Poorer	0.554* (0.173)	0.928 (0.317)
Middle	0.400 (0.244)	1.393 (0.620)
Richer	0.333 (0.232)	0.711 (0.439)
Richest	0.464 (0.589)	1.090 (0.771)
<b>REGION (REF: KAMPALA)</b>		
Central1		0.678 (1.103)
Central2	0.0788 (0.185)	0.184 (0.319)
East central	0.0552 (0.110)	0.625 (1.013)
Eastern	0.387 (0.604)	3.680 (5.343)
North		1.198 (1.792)
West Nile		0.156 (0.269)
Western	0.00796*** (0.0147)	0.907 (1.342)
Southwest		0.138 (0.245)
Karamoja	4.468 (7.993)	
<b>NUMBER OF WOMEN INTERVIEWED</b>		
	10,982	8,359

**Notes:** All models control for religion and age group. Standard Errors in parenthesis. (\*\*\*)  $p < 0.01$ , (\*\*)  $p < 0.05$ , (\*)  $p < 0.1$

**TABLE A4 ASSOCIATION BETWEEN BACKGROUND CHARACTERISTICS AND FGM AWARENESS (UDHS 2016 AND 2006)**

BACKGROUND CHARACTERISTICS	2016	2006
	ADJUSTED ODDS RATIO (SE)	
<b>EDUCATION LEVEL (REF: NO EDUCATION)</b>		
Primary	1.335*** (0.0924)	1.197* (0.124)
Secondary	2.519*** (0.214)	2.307*** (0.298)
Higher education	4.682*** (0.554)	4.366*** (0.720)
<b>RESIDENCE (REF: URBAN)</b>		
Rural	0.834** (0.0634)	1.045 (0.214)
<b>WEALTH INDEX (REF: POOREST)</b>		
Poorer	1.146** (0.0718)	1.210 (0.142)
Middle	1.233*** (0.0859)	1.432*** (0.191)
Richer	1.238*** (0.0875)	1.497*** (0.214)
Richest	1.795*** (0.177)	1.923*** (0.301)
<b>REGION (REF: KAMPALA)</b>		
Central1	0.792 (0.121)	0.721 (0.163)
Central2	0.836 (0.140)	0.738 (0.173)
East Central	1.545** (0.275)	1.080 (0.260)
Eastern	4.624*** (0.709)	5.964*** (1.739)
North	0.827 (0.124)	1.456* (0.324)
West Nile	0.475*** (0.0741)	0.560** (0.128)
Western	0.618*** (0.0896)	0.643* (0.151)
Southwest	0.553*** (0.0835)	0.694 (0.162)
Karamoja	4.114*** (0.970)	
<b>NUMBER OF WOMEN INTERVIEWED</b>	<b>18,481</b>	<b>8,524</b>

**Notes:** All models control for religion and age group. SE in parenthesis. (\*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$ )



## APPENDIX 4: UDHS MULTIVARIATE ANALYSIS RESULTS FOR EASTERN UGANDA

**TABLE A5 ASSOCIATION BETWEEN BACKGROUND CHARACTERISTICS AND FGM STATUS IN EASTERN AND KARAMOJA (UDHS 2016)**

BACKGROUND CHARACTERISTICS	EASTERN	KARAMOJA
	ADJUSTED ODDS RATIO (SE)	
<b>EDUCATION LEVEL (REF: NO EDUCATION)</b>		
Primary	1.775 (0.757)	0.433 (0.346)
Secondary	1.430 (1.267)	0.116 (0.157)
Higher education	-	-
<b>LOCATION (REF: URBAN)</b>		
Rural	-	-
<b>WEALTH INDEX (REF: POOREST)</b>		
Poorer	0.629 (0.230)	0.0443*** (0.0304)
Middle	0.226* (0.188)	1.063 (0.968)
Richer	0.133* (0.147)	-
Richest	-	-
<b>RELIGION (REF: CATHOLIC)</b>		
Protestant	1.910 (1.347)	34.55*** (28.05)
Muslim	0.619 (0.696)	-
Pentecostal	0.239 (0.306)	95.68*** (104.1)
Seventh Day Adventist	-	-
Other	6.600*** (2.641)	-
<b>AGE GROUP (REF: 45-49 YEARS)</b>		
18 years and under	0.0503*** (0.0551)	0.223* (0.194)
19-24 years	0.0804** (0.0949)	1.538 (1.030)
25-29 years	0.0868*** (0.0756)	1.771 (1.889)
30-34 years	0.647** (0.114)	1.621 (1.274)
35-39 years	1.318 (0.644)	0.412 (0.471)
40-44 years	1.788** (0.521)	1.823 (1.288)
<b>NUMBER OF WOMEN INTERVIEWED</b>	<b>2,840</b>	<b>585</b>

**TABLE A6 ASSOCIATION BETWEEN BACKGROUND CHARACTERISTICS AND FGM AWARENESS IN EASTERN AND KARAMOJA (UDHS 2016)**

BACKGROUND CHARACTERISTICS	EASTERN	KARAMOJA
	ADJUSTED ODDS RATIO (SE)	
<b>EDUCATION LEVEL (REF: NO EDUCATION)</b>		
Primary	1.127 (0.241)	1.511 (0.385)
Secondary	1.913*** (0.441)	0.860 (0.454)
Higher education	2.245** (0.894)	2.851 (1.970)
<b>LOCATION (REF: URBAN)</b>		
Rural	0.670* (0.148)	0.908 (0.284)
<b>WEALTH INDEX (REF: POOREST)</b>		
Poorer	1.283** (0.149)	2.105 (1.199)
Middle	1.517*** (0.216)	0.991 (0.379)
Richer	1.383** (0.225)	2.652* (1.278)
Richest	1.608* (0.450)	1.388 (1.540)
<b>RELIGION (REF: CATHOLIC)</b>		
Protestant	1.177 (0.130)	1.971 (1.268)
Muslim	0.943 (0.218)	0.951 (0.997)
Pentecostal	1.189 (0.171)	3.289* (2.180)
Seventh Day Adventist	4.551 (4.629)	-
Other	1.148 (0.547)	-
<b>AGE GROUP (REF: 45-49 YEARS)</b>		
18 years and under	0.457*** (0.0884)	0.210*** (0.117)
19-24 years	0.808 (0.165)	0.409 (0.248)
25-29 years	0.921 (0.194)	0.252** (0.155)
30-34 years	0.752 (0.172)	0.417 (0.225)
35-39 years	0.934 (0.206)	0.396 (0.270)
40-44 years	1.061 (0.231)	0.542 (0.378)
<b>NUMBER OF WOMEN INTERVIEWED</b>		
	<b>3,509</b>	<b>722</b>









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