KEY FINDINGS

1. **Support for abandonment is widespread but persistent social norms hamper discontinuation**: 95% of women in eastern Uganda support abandonment of FGM but strong social influences and peer pressure limit women’s ability to abandon the practice and influence others against it.

2. **Male circumcision as a driver of FGM**: Women’s desire to participate at male circumcision ceremonies and celebrations – a key community social event that only mutilated women are allowed to attend – remains an important driver of FGM, especially among older married women.

3. **Age at cutting**: Nowadays, girls tend to be mutilated at a younger age than in the past. Age at cutting appears to be lower among Pokot communities in Karamoja (around 14–15 years) than among the Sabiny in Sebei (17–19 years). Among Pokot women, FGM is still being carried out mostly on adolescent girls as a rite of passage before marriage. Among the Sabiny, FGM is increasingly performed among older uncut married women.

4. **Changes in the practice**
   Nowadays, girls undergo the (illegal) practice in secret, often in remote locations and unsafe conditions. Cross-border FGM is also becoming increasingly common given perceived weaker anti-FGM law enforcement on the border with Kenya.

   In Sebei, where older married women are increasingly likely to undergo FGM, the practice is often performed by traditional birth attendants (TBAs) during antenatal visits or at childbirth.

5. **Protective factors against FGM**: The probability of a woman being mutilated decreases with both her educational attainment and access to information (frequent use of media channels such as TV and radio). Higher education levels and mobile phone ownership are predictors of increased awareness of FGM. Religion, and participation in church- or mosque-promoted activities, also emerged as an important driver of abandonment.

6. **Potential intergenerational effects**: Mutilated women are less supportive of abandonment than uncut women and more likely to support their sons’ marriage only with mutilated girls. Mothers also play a key role in influencing their daughters’ decision to undergo FGM. This may result in some form of intergenerational perpetuation of FGM whereby mutilated women act as promoters for the continuation of the practice among younger generations.

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Female genital mutilation (FGM) is an internationally recognised violation of the human rights of girls and women and, although globally the prevalence of FGM is declining, the practice still affects around 200 million women across the world. According to the latest Uganda Demographic and Health Survey (UDHS) data (2016), the prevalence of FGM in Uganda remains one of the lowest in East Africa at 0.3% among women aged 15–49 years. FGM primarily affects disadvantaged women from poor households, who have low levels of education and who reside in rural areas.

However, national prevalence rates are not representative of the whole country due to high geographical variation. FGM is deeply rooted in local norms and traditions in eastern Uganda. Despite the practice having been made illegal by the 2010 Prohibition of Female Genital Mutilation Act, it is still prevalent in some districts in Sebei and Karamoja, where FGM prevalence among women aged 15-49 years reaches more than 50% in some sub-counties.

In December 2016, the Uganda Bureau of Statistics (UBOS) and UNICEF conducted the first ever FGM survey to collect detailed district and sub-district level data on FGM in Uganda. The survey targeted a representative sample of households and women aged 15–49 years across six districts in eastern Uganda (Kapchorwa, Bukwo and Kween in Sebei, and Nakapiripirit, Moroto and Amudat in Karamoja), all of which practise FGM extensively. The survey targeted sub-counties with high levels of FGM, therefore only Moruita sub-county was selected in Nakapiripirit District and only Katikekile and Tapac sub-counties in Moroto District. Results are therefore not representative of the whole of Nakapiripirit and Moroto districts.

The average prevalence rate of FGM across the six districts in eastern Uganda was 26.6% in 2016, much higher than the national average for the same period (0.32%) found in the 2016 UDHS. FGM district-level prevalence ranged from 13% (in Kapchorwa District) to 52% (in Katikekile and Tapac sub-counties of Moroto District). High prevalence rates were accompanied by high awareness rates, with an average of 97% of women having heard of FGM.
While most women reported holding positive views towards the discontinuation of FGM, social pressure and norms still play a major role in defining attitudes and practices. Despite holding supportive views towards abandonment, many women seem reluctant to express these views publicly and to openly advocate against FGM within their communities.

Both educational attainment and access to information (frequent use of media channels such as TV and radio) appeared to be protective factors against FGM. Access to education together with access to information and knowledge about the consequences of FGM are therefore key to any programming effort to accelerate progress towards abandonment. The results also suggest that being cut is a leading factor influencing whether women held supportive views towards abandonment of the practice: women's own experience of FGM was a predictor of lower levels of support for abandonment.
EVIDENCE FROM THE FIELD

THE DECISION TO UNDERGO FGM

The belief that girls autonomously decide to undergo FGM is widespread among practising communities in both Sebei and Karamoja. Women, men and community leaders repeatedly stated that “a teenage girl at some point will feel ready to be cut and will demand her parents to undergo FGM.” However, social norms and strong peer pressure limit girls’ ability to make free and independent choices about FGM. The influence of friends and other women in the community emerged as a particularly strong factor in the decision to undergo FGM.

OPINIONS AND ATTITUDES TOWARDS FGM

The vast majority of women across the six eastern districts were supportive towards the abandonment of FGM. Access to education and the influence of religion emerged as the main drivers for support for discontinuation, together with increased awareness of the negative health consequences of mutilation. Women reported that peer pressure and social acceptability, rather than traditional beliefs linked to fidelity to partners and control over women’s sexual urges, are the main drivers for the continuation of FGM.

FGM TODAY

The criminalisation of FGM, together with socioeconomic developments, has produced changes in how and why the practice is performed today.

- Since it has been banned, FGM has been practised secretly, without any ceremony or celebration. Girls tend to travel away, either alone or in small groups, to be mutilated in remote areas where they are less likely to be seen and reported to the authorities. This carries increased health risks for girls and women as the practice is often performed in a rush and in unsafe and unsanitary conditions. FGM is increasingly practised in secluded areas on the border with Kenya.

- Generally, girls tend to be cut at a younger age – in their early to late teens rather than in their early twenties. The disappearance of months-long traditional preparatory rituals has potential negative consequences for their overall health and wellbeing. FGM is linked closely to early marriage.

- In practising sub-counties in Karamoja, FGM was, and still is, primarily performed among young unmarried girls. In Sebei, the mutilation of older married women – during antenatal visits or during childbirth – is becoming more common. This is closely linked to the mockery and shaming that uncut married women experience from peers and other wives (in polygamous communities) and to their not being allowed to attend male circumcision ceremonies.

- While FGM is illegal and performed mostly in secrecy, male circumcision is legal, still takes place publicly, and is surrounded by big celebrations. Only mutilated women can attend male circumcision ceremonies. This results in feelings of isolation and humiliation for uncut women and brings shame and dishonour to their whole family. As a result, uncut married women increasingly decide to undergo mutilation at an older age to be able to join male circumcision rituals.
FGM is not an issue that affects only girls and women but is a practice that has contributed to shaping the identity of entire communities. Therefore, programming efforts should combine individual and community-based approaches to achieve elimination.

1 **Community-led approaches to shift social norms**: Community-based approaches, designed on principles of diffusion of innovation theory, aimed at addressing the social dynamics underpinning the continuation of FGM and other harmful practices (such as SASA! and Tostan’s Community Empowerment Programme) should be considered. These could be integrated through community dialogues and public announcements targeted at influential community members such as older women and traditional cutters.

2 **Education programming**: The expansion of affordable education opportunities (including those provided by church and religious bodies) and the creation of safe spaces for girls should 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 already shown promising results in preventing and reducing FGM.

3 **Alternative rites of passage (ARPs)**: Exploring the creation of alternative rituals to replace the social role of FGM ceremonies is recommended. However, existing evidence on the effectiveness of such strategies is limited. The implementation of ARP interventions should therefore be coupled with rigorous evaluation efforts aimed at understanding which design options and in which contexts these programmes can be successful. These approaches should keep in consideration the important role of male circumcision rituals as a driver of FGM.

4 **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. There is a need for rigorous impact evaluations designed to assess the causal mechanisms of change that affect outcomes.
REFERENCES


