

ACTION RESEARCH ON

FEMALE GENITAL MUTILATION

In The Bawku Municipality
Upper East Region

Research by: BEWDA
in collaboration with

act!onaid

Revised: January, 2013

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Acknowledgement

On behalf of the Board of Directors of BEWDA, we are particularly grateful to ActionAid Ghana (AAG) for providing the necessary funding for the research on Female Genital Mutilation (FGM) in the Bawku Municipality.

We also want to acknowledge the invaluable contributions of respondents, especially the women and the young girls. We very much appreciate their willingness and boldness to share their experiences with us to enable us to complete this research.

We would also like to acknowledge with gratitude the contributions of all individuals and institutions such as Ghana Health Service – Bawku (Directorate and Sub-Health Centers), Department of Community Development – Bawku, Dept. of Social Welfare - Bawku, and the Bawku Traditional Council particularly the Paramount Queen Mother.

List of Abbreviations

AAG: ActionAid Ghana

ACDEP: Association of Church Development Association

BEWDA: Bawku East Women Development Association

CEDAW: Convention on the Elimination of All Forms of Discrimination against Women

CHRAJ: Commission on Human Rights and Administrative Justice

COMBAT: Community Based Anti-Violence Team

CSO: Civil Society Organisation

DEVAW: Declaration on the Elimination of Violence against Women

FGM: Female Genital Mutilation

GTZ: German Technical Service

IAC: Inter-African Committee

JHS: Junior High School

NCCE: National Commission on Civic Education

NGO: Non-Governmental Organisation

SHS: Senior High School

TECH: Technical School

US: United States of America

WHO: World Health Organisation

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EXECUTIVE SUMMARY

ActionAid Ghana (AAG) and BEWDA have been working in partnership on women's rights issues since the creation of Bawku Development area (DA12) in 2005. The focus of the women's rights work has been on reducing violence against women, including cultural practices that condone violence or in themselves are injurious to the physical and mental wellbeing of a woman.

Female Genital Mutilation is a practice that has been internationally and nationally outlawed as criminal and a rights violation with very serious short and long term health effects on women. This research on FGM was conducted by BEWDA with support from ActionAid Ghana in five selected communities, namely Mognori, Bardo, Mandago, Widana and Waanre.

RESEARCH OBJECTIVES

The research sought to find answers in the following areas;

1. To assess the practice of FGM in 5 communities in the Bawku Municipality
2. To determine the rationale or reasons for the practice of FGM, in the communities
3. To examine the actors involved in the practice of FGM and where they come from.
4. To determine the categories of girls/women most affected
5. To examine the level of awareness of the law prohibiting FGM, to ascertain the effects of FGM on women and girls.

METHODOLOGY

Qualitative research methods were employed to gather data from respondents. 100 questionnaires were administered to a cross section of women resident in the selected communities. Ten key informant interviews were conducted as well as four focus group discussions for men and women separately in the selected communities. These communities were selected based on information received from the Municipal Director of the Department of Social Welfare during a partners' review meeting organised by ActionAid Ghana. A combination of purposive and snowballing sampling techniques was employed to ensure adequate representation of respondents.

The research team also interacted with the Bawku Municipal Health Directorate and three Community Health Centres in Mognori, Pusiga and Widana, all in Pusiaga District of the Upper East region of Ghana

MAIN FINDINGS

The research revealed that FGM is still a practice in some communities in the Bawku Municipality. 56% of respondents acknowledged that the practice of FGM still happens in their communities. Furthermore, 61% of respondents strongly agree with and support the practice of FGM. The research further revealed that 68% of respondents had undergone FGM.

The reasons given for the practice of FGM in some communities included the following: Women who have undergone FGM stay faithful to their partners: IT prevents married women who have not had FGM from being ridiculed by co-wives and increases girls' chances of getting married (as they are seen as more likely to be faithful); FGM

prevents deaths of first babies born to the woman. It is also believed that girls and women who have undergone FGM would avoid diseases of the clitoris. FGM is practiced in communities in the Bawku Municipality as well as in neighbouring communities in countries in Burkina Faso and Togo.

The peak period for the practice of FGM is between October and December every year, when the weather is cold. However it also happens between January and March when the weather is not too hot - to facilitate healing of the wounds as after the removal of the genitalia.

Girls between the ages of 10 and 15 years are the primary victims. 88% of women who reported being subjected to FGM, had it done between the ages of 10-15.

Recommendations

1. State agencies, particularly the Ghana Health Service, and NGOs/CSOs need to intensify both health and legal education on FGM in the affected communities to enable community members to appreciate the health and legal consequences of their actions.
2. State agencies such as the CHRAJ, NCCE and the Department of Social Welfare should be adequately resourced by the government to educate the people on the health consequences and legal implications of FGM.
3. CSOs/NGOs should facilitate the formation and operations of community based child protection networks like the Community Based Anti-Violence Teams (COMBATs) to provide a watchdog role and to inform statutory agencies of girls at risk.

4. NGOs to undertake advocacy campaigns to advocate for a change to the FGM legislation to act as more of a deterrent.
5. BEWDA and ActionAid Ghana should network with organizations like the Gender Center and ACDEP who have conducted similar researches in northern Ghana, to advocate for stiffer sanctions to deter perpetrators.
6. AAG should facilitate the formation of cross-border initiative among Ghana, Togo and Burkina Faso to check the incidence of cross border activities of FGM.

CHAPTER ONE: BACKGROUND

1.0: Introduction

It is estimated that between 100 to 140 million girls and women worldwide have undergone female genital mutilation/cutting (FGM/C) and more than 3 million girls are at risk each year on the African continent alone. FGM poses serious physical and mental health risks for women and young girls, especially for women who have undergone extreme forms of the procedure.

According to the World Health Organisation (WHO), “Female Genital Mutilation (FGM), often referred to as ‘female circumcision’ ‘comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons” (global consultation on FGM, 2008)

The WHO classifies FGM practiced into four types or categories. These include;

Type I:

Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)

Type II:

Partial or total removal of the clitoris and the labia minora, with or without the excision of the labia majora (excision)

Type III:

Narrowing the vaginal orifice with creation of a covering seal by cutting and positioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)

Type IV: Unclassified

All other harmful procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping, and cauterization

The practice of FGM has both short term and long term effects on girls and women. Some of the short term effects of FGM include severe pain, hemorrhage, shock, infection and death. Long term effects include keloid scarring, urine retention, menstrual disorders, obstructed labour, Vesico Vaginal fistula and Recto Vaginal Fistula, prolonged labour and increased perinatal mortality. Other side effects include psychological and sexual problems.

According to a 2006 WHO study, all types of FGM/C can be linked to increased complications in childbirth, increased deaths of babies and increased maternal deaths.

FGM is practiced in at least 28 countries in Africa as well as in countries in Asia and the Middle East. It is patronised by all social classes and occurs among many religious groups (Muslims, Christians and animists), although no religion mandates it. Prevalence rates vary significantly from country to country (from nearly 98 percent in Somalia to less than 1 percent in Uganda (Population Reference Bureau, 2010) and often varies significantly within countries if the practice is restricted to specific ethnic groups in a country.

1.2: Population

The estimated total population of Bawku Municipality is 205,849. Its population density is 169 persons per square kilometer. The population of the Municipality constitutes about twenty percent of the Upper East Region's population and 0.99 percent of Ghana's population. The population is 20 percent urban and 80 percent rural.

1.3: Ethnicity

The predominant tribes in order of size in the municipality are Kusaasi, Mamprusi, Bisa and the Moshi. There are also a number of migrants from other parts of the country, especially the south (most of whom are civil servants) and from the neighbouring countries of Togo and Burkina Faso. Despite the varied tribal components of the municipality, the society is patrilineal and traditionally male dominated. Women are traditionally responsible for the bulk of household activities such as cooking and fetching water as well as for planting, weeding, harvesting and selling cereals and vegetables.

1.4: Literacy

The Bawku Municipality is ethnically heterogeneous and has one of the lowest income levels in the country (with 80% of the population living in extreme poverty). Bawku also has one of the lowest levels of literacy. Only 21.2% of adults are functionally literate against a national prevalence of 45.9%. (www.modernghana.com/.../uppereast.asp)

1.5: Research Objectives

This action research on FGM in the Bawku municipality conducted by BEWDA with support from ActionAid Ghana sought to achieve the following objectives;

1. To find out whether FGM is practiced in communities in the Bawku Municipality
2. To find out the reasons for the practice despite the existence of legislation criminalizing it
3. To find out who the actors are and where they come from;
4. To find out who are most affected

5. To find out the level of awareness of the effects of FGM on the victims as well as to map out strategies to combat the practice of FGM in the municipality.

1.6: Problem Statement

FGM is a practice that has been criminalized in Ghana with the enactment of the 1994 FGM Act, ACT 484 which states that “whoever excises, infibulates or otherwise mutilates the whole or any part of the labia minora, labia majora and or the clitoris of another person commits an offense and shall be guilty of a second degree felony and liable on conviction to imprisonment of not less than three years”. However some communities and ethnic groups in the Bawku Municipality of the Upper East Region continue to practice FGM.

1.7: Significance of the study

The findings of the research will contribute to knowledge as well as inform AAG programming and policy development. It would also campaign and advocacy work at both regional and national levels.

1.8: Methodology:

The research employed participatory techniques to collect both quantitative and qualitative data for in-depth analysis. These included probability and non-probability sampling, administration of questionnaires, key informant interviews, focus group discussions and observation. Data gathered was analyzed with the aid of SPSS.

1.9: Partner:

BEWDA, AAG's women's rights partner in Bawku, led the research with ActionAid Ghana providing support in the planning and execution of the action research.

CHAPTER TWO: OVERVIEW OF FGM

2.0: introduction

Female Genital Mutilation (FGM) is a cultural practice that dates back millennia. There are indications that FGM was practiced among Egyptians in the Pharonic era. It is now universally accepted that it is primarily a cultural and not religious practice. But some cultures use religion to justify FGM. FGM is widespread in Africa with great variations in terms of prevalence, type of FGM, age of performance and cultural explanations and rationalizations for performing it. FGM prevalence is highest in the horn of Africa countries – with Sudan, Ethiopia, Eritrea and Somalia reporting prevalence rates of 74% or higher. In nearby Kenya and Tanzania on the other hand, the prevalence is much lower, 32% and 15% respectively.

FGM is a social practice that primarily correlates with ethnic affiliation and cultural traditions and not with political boundaries. This means that in many of the countries where FGM is practiced, FGM practicing groups live in close proximity to non-practicing groups. The type of procedure may vary greatly among the different FGM practicing groups. Worldwide, the most widespread types of FGM are Types I and II. Type III FGM (infibulation) is the most severe form of mutilation in terms of its destruction of healthy tissue, physical and psychological impact. However, it is practiced in only a few countries. Infibulation is widely practiced in the horn of Africa and among Somalis in other parts of east Africa. In West Africa and therefore in Ghana, the most common type of FGM is type 11.

The age at which the procedure is performed also varies considerably, from infants of 7-10 days old to girls of 6-10 years and among 14-16 year old girls as a rite of passage. However, world-wide, pre-pubescent girls are most at risk.

2.1: Reasons for the Practice

There are various reasons given for FGM but they can be grouped under the following headings.

1. Religion: It is believed that FGM is mandated as a religious obligation by the Koran or Bible
2. Health: It prevents and cures genital diseases in women.
3. Social/moral: It ensures virginity and female modesty. Parents are able to marry their girls off 'well', to become integrated in the larger society. It is also symbolic marker of group inclusion.
4. Sexual: FGM is more pleasing to men, the clitoris interferes with intercourse, if not cut, the clitoris grows to the size of the man's penis, women are infertile if not cut.
5. Hygiene: FGM prevents bad odor and is 'cleaner'.
6. Aesthetic: A cut genitalia has a nicer appearance, and
7. Infibulation: It is also said to be a protection against rape.

In communities where FGM is a symbol of adult status, girls may want to undergo FGM so as not to be called 'children' and to be able to take part in adult conversations and adult sexual activity. In a study on FGM conducted in Kuria district in Kenya by GTZ and the Ministry of Health, FGM was said to bring honour to the family and keep the tribe, culture and identity together. It is a common practice among the Maasai, Sanburu and Pokot for whom FGM is immediately followed by highly celebrated marriage to an older man. Girls looked forward to it as rite of passage that is celebrated communally with lots of gifts given to the girls (GTZ, 2005).

2.2: Practice of FGM in Ghana

In 1996, Amnesty International Ghana, together with the Association of Church Development Projects (ACDEP) in an intervention funded by the Foundation for Women's Health, Research and Development (FORWARD), estimated that 76 percent of all women in the Upper East, Upper West and Northern regions had been excised. They cited several cities in these regions where it was widely practiced: Kassena-Nankana, Bolgatanga, Bawku East and Bawku West in the Upper East Region. In the Northern Region Bole, Mamprusi, West Walewale and Zabzugu-Tatale, Kotokoli were highlighted; Wa and Nandom in the Upper West Region; and in the northern Volta Region, Kadjebi, Worawora and Jasikan were identified.

Research has shown that through strong government commitment, extensive outreach by NGOs and a general receptivity to abandoning the practice has led to a decline of the practice among the groups that practice it. In 1998, the Gender Studies and Human Rights Documentation Center estimated that FGM had been performed on 15 percent of the Ghanaian female population. The United Nations Population Fund (UNFPA) funded a study conducted by Rural Help Integrated (1999), an NGO providing reproductive health care services in the Upper East Region and found that FGM had been performed on 36 percent of the Upper East Region's female population and thus estimated that between 9 and 12 percent of Ghanaian women nationwide had undergone the procedure.

The prevalence of FGM in Ghana ranges from 8% to 94% depending on the age group, region and or tribe. A 2005 study conducted by the Ghanaian Ministry of Health found

that approximately 15% of women aged between 12 and 19 years in the three Northern Regions of Ghana had undergone FGM. The 2007 US Department of State reports that “some observers believed that NGO – and government – sponsored awareness campaigns regarding the illegality of FGM had driven the practice underground and that the real rate in these regions was as high as 30 percent” (US Department of State 2007, Country Reports on Human Rights Practices 2006, 6 March, Section 5 Women).

2.3: Attitudes and Beliefs:

The practice among some groups in Ghana appears to have no spiritual roots. It is not perpetuated by religion, but rather by traditional tribal beliefs. Some ethnic groups such as the “Bisa” tribe in the Pusiga District in the Upper East Region of Ghana, believe that FGM leads to cleanliness, reduces the sexual sensitivity of girls and women and promotes fidelity among women. Others believe it increases fertility and prevent the death of first-born babies.. Other common beliefs are that children born to uncircumcised women are ‘stubborn and troublesome’ and more likely to go blind if the mother’s clitoris touches the eyes during birth. In some areas the presence of a clitoris in women suggests she is a “man” where the describing the clitoris is described as vestigial penis.

Uncircumcised women are regarded by some as unclean, less attractive and less desirable for marriage. Social or peer pressure is also cited as a primary reason that compels some women to undergo this procedure (Touray, 2011) womensbantabaa.blogspot.com/.../women-speak-against-fema).

2.4: International declarations on violence against women

The Declaration on the Elimination of Violence against Women (DEVAW) declares violence against women as an obstacle to the achievement of equality, development and peace, as also recognized in the Nairobi Forward-looking Strategies for the Advancement of Women, in which a set of measures to combat violence against women was recommended.

DEVAW affirms that violence against women constitutes a violation of the rights and fundamental freedoms of women and impairs or nullifies the enjoyment of those rights and freedoms. DEVAW is also concerned about the long-standing failure to protect and promote those rights and freedoms in the case of violence against women. The Declaration recognized that violence against women is a manifestation of historically unequal power relations between men and women, which has led to domination over and discrimination against women by men and to the prevention of the full advancement of women. DEVAW notes that violence against women is one of the crucial social mechanisms by which women are forced into subordinate position compared to men.

DEVAW called on states to refrain from engaging in violence against women to exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by the State or by private persons.

The Commission on the Status of Women (CSW) acknowledges that female genital mutilation violates, and impairs or nullifies the enjoyment of the human rights of women and girls, It also recognised that female genital mutilation is an irreparable, irreversible

abuse. CSW agrees that harmful traditional or customary practices, including female genital mutilation, constitute a serious threat to the health of women and girls, including their psychological, sexual and reproductive health, which can increase their vulnerability to HIV and may have adverse obstetric and prenatal outcomes as well as fatal consequences, and that the abandonment of this harmful practice can be achieved only as a result of a comprehensive movement that involves all public and private stakeholders in society (General Assembly Resolution 55/2; General Assembly Resolution 60/1).

The Inter-African Committee (IAC) on traditional practices affecting the health of women initiated the adoption of 'zero tolerance to FGM day' in February 2003, in Addis Ababa, Ethiopia. The efforts of the IAC were augmented by the Cairo Declaration of June 2003, which supported the zero tolerance to FGM call, appealing to Heads of State, governments, parliaments and responsible authorities in concerned countries, as well as international organizations and non-governmental organizations, to endorse recommendations in their legislation, social and health policies, aid programmes, bilateral and multilateral cooperation initiatives.

2.5: FGM Legal Framework in Ghana

Article 15 of the 1992 constitution of the republic of Ghana states emphatically in sub section 1 and 2 that;

(1)The dignity of all persons shall be inviolable. (2) No person shall, whether or not he is arrested, restricted or retained, be Subjected to -

(a) torture or other cruel, inhuman or degrading treatment or punishment;

(b) any other condition that detracts or is likely to detract from his dignity and worth as a human being

Article 26, subsection 2 of the 1992 Constitution of the Republic of Ghana gives backing to the aforementioned as it states that “all customary practices which dehumanise or are injurious to the physical and mental wellbeing of a person are prohibited”. The constitution is the supreme law of the land, hence when tradition or custom contravene the constitution, the constitution automatically reigns. Customs and traditions must therefore be professed within the remit of the 1992 Constitution.

In 1994, Parliament amended the Criminal Code of 1960 to include the offense of FGM/FGC. This Act (Act 484) inserted Section 69A that states that “whoever excises, infibulates or otherwise mutilates the whole or any part of the labia minora, labia majora and the clitoris of another person commits an offense and shall be guilty of a second degree felony and liable on conviction to imprisonment of not less than three years”. Following from this, it’s indicative that the practice of FGM causes both physical and psychological pain to an individual such as causing pain, causing harm or injury and detracting a person from dignity and so therefore can be tortious. Legislation prohibiting FGM notwithstanding, some tribes in northern Ghana, particularly in the Upper East Region, still practice FGM in their communities with impunity.

CHAPTER THREE: METHODOLOGY

3:0 introduction

Chapter three focuses on the methodology, techniques and instruments used to collect data to arrive at the research findings.

3.1: Methodology

The research employed participatory techniques to collect both quantitative and qualitative data for in-depth analysis. This involved enumerators having direct contact with respondents in the selected communities for the completion of questionnaire as well as conducting key informant interviews.

3.2: Sampling:

A combination of probability and non-probability sampling techniques were employed in the selection of five communities, as well as the 100 respondents. Selected communities were Mognori, Mandago, Waanre, Bardo and Widana. Twenty respondents were interviewed in each community resulting in a total 100 respondents.

3.2.1: Sampling techniques

A combination of random sampling, purposive sampling and snow balling were used to identify key respondents in the five selected communities. For the purpose of validity, all 100 respondents were women and girls while key informant interviews were conducted with heads of health facilities and state agencies and decentralized departments in the Bawku municipality.

3.2.2 Sample frame: respondents were made of women, girls, opinion leaders, assembly members, traditional leaders, nurses and teachers and heads of departments from the Ghana Health Service, Departments of Social Welfare and Community Development and the gender desk office.

3.3: Data collection:

Data was collected through the administration of questionnaires, interviews and focus group discussions by enumerators in the five communities. 100 questionnaires were administered, 10 key informant interviews conducted and 5 focus group discussions held comprising two male and three female groups. Two groups were met in Mognori, one in Bardo, and two in Widana.

3.4: Data Analysis

Data was analyzed with the aid of SPSS for quantitative data while qualitative data was analyzed through manual comparison, determination of logic, trends, similarities and differences.

3.5: Time Frame

Data collection, entry and analysis were executed within two weeks of commencement of the research, with another two weeks used for data cleaning, analysis and report writing.

CHAPTER FOUR: RESEARCH KEY FINDINGS

4:0: Introduction

Chapter four presents the key findings of the research based on analyzed data from the respondents, focus group discussions, and key informant interviews. There were also observations.

4.1: Characteristic of respondents

4.1.1: Age

Women and girls during the research were clustered into six age groups 5-15 years, 16-24 years, 25-34 years, 35-44 years, 45-54 years and 55 years and above. Sixteen respondents came from the 5-15 year cohort, fifteen from 16-24 years and seventeen from 25-34 year groups, while twenty-four respondents were between 35-44 years, seventeen from the 45-54 year group and eleven respondents were above 55 years.

Fig 1.: Age distribution of respondents

Age range of respondents	Frequency	Percent
5-15yr	16	16.0
16-24yrs	15	15.0
25-34yrs	17	17.0
35-44yrs	24	24.0
45-54yrs	17	17.0
55yr +	11	11.0
Total	100	100.0

(Source: field survey 2012)

4.1.2: Tribe of respondents

Five tribes were covered in the five communities during the research namely; Kusaasi, Bisa, Moshie, Yanga and Fulani. Bisa were 59 and represented 59% of the respondents, Kusaasi 18, Moshie 13, Yanga were 3 and 2 were Fulani. Even though Kusaasi is the most dominant tribe in the Bawku Municipal, the research concentrated mostly on Bisa communities, where information obtained through community interactions and from the local health centres indicated a high prevalence of FGM practice. This was attributed to the practice where young women and girls are taken across either the Ghana-Togo Border or Ghana–Burkina Faso Borders to the excised.

Fig 2: Tribe of respondents

TRIBE	Frequency	Percent
Bisa	59	59.0
Kusaasi	18	18.0
Moshi	13	13.0
Yanga	3	3.0
Fulani	2	2.0
Total	95	95.0
Missing System	5	5.0
Total	100	100.0

(Source: field survey 2012)

4.1.3: Main Occupation of respondent

50 of women respondents were farmers, 20 were traders while 21 were either still in school or had no occupation. Below is a tabular illustration of the main occupation of respondents.

Fig 3: Main Occupation of respondent

OCCUPATION	Frequency	Percent
farmer	50	50.0
no occupation/student	21	21.0
trader	20	20.0
health worker	5	5.0
teacher	3	3.0
seamstress	1	1.0
Total	100	100.0

(Source: field survey 2012)

4.1.4: Level of education of respondent

The research revealed a very high level of illiteracy amongst women and girls in the selected communities. Out of a total of one hundred women interviewed, 63 had had no form of formal education at all. 20 had received primary education, 6 had got tertiary education, 4 had JHS/Middle school education and only 2 attained SHS/technical school education.

Fig 4: level of education of respondents

EDUCATION LEVEL	frequency	percent
no education	63	63
primary education	20	20
college/ tertiary	6	6
JHS/middle school	4	4
SHS/technical education	2	2
total	95	95
missing system	5	5
total	100	100

(Source: field survey 2012)

4.1.5: Marital status of respondents'

The study revealed that 57% of respondents were married, 30% were single with 13% were widows.

Marital Status	Frequency	Percent
Valid married	57	57.0
single	30	30.0
widowed	13	13.0
Total	100	100.0

(Source: field survey 2012)

4.1.6: Religion of respondents

The dominant religion in the five selected communities is Islam, hence 77 of the respondents were Muslim, and 21 were Christian. Only 1 respondent was a practitioner of African traditional religion.

4.1.7 Proportion of respondents who support the practice of FGM

Although many members of the public and medical practitioners view FGM as having very adverse short and long term effects on the victims, the table below indicates that 61 of respondents interviewed are in support of FGM, with only 39 who strongly argue that it should be outlawed and perpetrators punished.

4.2: Prevalence of FGM in communities

The research revealed that FGM continues to happen in all the 5 respondent communities. 56% of respondents acknowledged that the practice of FGM still happens in their communities. This was confirmed through focus group discussions in the communities where both men and women groups confirmed the practice. This fact was also confirmed through analysis of data from key informants and health facilities. However there are indications that the trend has been on the decline. The Municipal Health Director¹ and officers in charge of Mognori, Pusiga and Widana health centers² confirmed the existence of the practice. However, they noted that cases were not reported at the health facilities, instead nurses made observations of the mutilation during the weighing of girls in the health facilities.

¹ Dr. T. Mensah Afful

² Margaret Akudago, Beatrice Mbokode and Felicia Aneateba

Fig 5: Prevalence of FGM in communities

	Frequency	Percent
Valid yes	56	56.0
no	44	44.0
Total	100	100.0

(Source: field survey 2012)

More evidence of the continuing practice of FGM in communities showed in the report of 6 of the respondents who said the last time they heard of the incidence of FGM in the community was one month prior to the study. 15 of the respondents reported that the last time they heard of girls undergoing FGM in their communities was five months before the study. While 21 respondents said that they had last heard of FGM being carried out one year ago, 25 thought it was between 2-5 years and 22 respondents reporting that they had heard of cases of FGM over the last six years. The results show that FGM still prevails in the communities, as a total of 75 of respondents reported hearing of the practice occurring in their communities within the last 5 years.

4.3: Prevalence of FGM among respondents

The research revealed that 69 out of the 100 respondents had undergone FGM, 22 had not undergone FGM while 9 did not respond to the question. The youngest respondent who had undergone FGM was a girl of 14 years from Waanre community near Pusiga.

Fig 6: prevalence of FGM among respondents

	Frequency	Percent
yes	69	69.0
no	22	22.0
Total	91	91.0
Missing System	9	9.0
Total	100	100.0

(Source: field survey 2012)

4.4: Age of FGM

In focus group discussions carried out in Mognori, Mandago, Waanre, Bardo and Widana 88% of the respondents indicated that girls below the age of 15 years are the most at risk of undergoing FGM. However Community Health centres, studied in this research indicated baby girls less than a year old, who were brought to the centres for ante-natal services were found to have undergone the practice.

Fig 7: Age of FGM

	Frequency	Percent
girls below 15 yrs	88	88.0
girls 16-25 yrs	3	3.0
girls 25-34	3	3.0
35yrs +	3	3.0
Total	97	97.0
Missing System	3	3.0
Total	100	100.0

(Source: field survey 2012)

4.5: Who influenced girls to undergo FGM

The research revealed that it was mostly mothers and grandmothers who prepared girls for FGM. The preparation included educating them on the social benefits of FGM, and how to conduct themselves upon marriage.

Rewards for going through FGM included the presentation with new clothes, 'outdooring' in the community, merry making and of gifts by relatives and friends. 60 of respondents said mothers mostly initiated the process and took the decision for FGM to take place. Fourteen (14) respondents also revealed that grandmothers are very instrumental in the preparation for FGM. Interestingly, 7 other respondents reported that peers influence some of their colleagues to undergo the practice. All the respondents could not indicate the role of the father in the FGM practice.

Fig 8: Who influences girls to undergo FGM

WHO INFLUENCES	frequency	percent
Mothers	60	60
grandmother	14	14
peers	3	3
not applicable	9	9
total	93	93
missing	7	7
TOTAL	100	100

(Source: field survey 2012)

4.6: Where FGM takes place

The research further revealed that 44 of respondents underwent FGM in their home communities while 16 were taken to neighbouring communities for the purpose of FGM. 34 respondents stated that they preferred to go to neighbouring Burkina Faso or Togo to have their daughters undergo FGM. They indicated that they might be arrested by the police or social welfare if found out.

Fig 9: Where FGM takes place

Places where FGM takes place	Frequency	Percent
in the home community	44	44.0
in a neighbouring community in Ghana	16	16.0
in a community in a neighbouring country	34	34.0
Total	94	94.0
Missing System	6	6.0
Total	100	100.0

(Source: field survey 2012)

4.7: When FGM is carried out in communities

The research established that most FGM takes place between October and December with a few cases happening between January and March. The reason given for the choice of period is the cold weather at that time. This was confirmed at the focus group discussions by both the men's and women's groups who said the cold period was necessary to facilitate the healing process of the wound created as a result of the mutilation.

4.8 Effects of FGM on Women and Girls

32% of respondents believe that FGM affects the rights and dignity of girls because it is done without their consultation or involvement in the decision making process. During a focus group discussion, a woman from the Bardo community indicated that women who have undergone FGM do not have 'normal' levels of sexual desire when compared to other women. 25% believe that FGM can lead to death during child birth when complications develop and or during prolonged delivery. 22% also believe that a woman/girl can bleed to death during and after FGM while 12% believe it causes pain. 5% believe it can lead to HIV infection among women and girls when unsterilized instruments are used for the procedure.

Fig 10: Effects of FGM on Women and Girls

Effects of FGM on Women and Girls	Frequency	Percent
can lead to death	25	25.0
woman can over bleed and die	22	22.0
pain	12	12.0
can be infected with HIV	5	5.0
affects the rights and dignity of a woman	32	32.0
Total	96	96.0
Missing System	4	4.0
Total	100	100.0

(Source: field survey 2012)

Focus group discussions conducted in 3 communities (Mognori, Waanre and Bardo) reported the effects associated with FGM are linked to women's reproductive function.

These include death during childbirth, excessive bleeding during the process, and

prolonged labour as well as extreme pains. The effects mentioned from the focus group discussions therefore tally closely with the responses given in the interviews.

4.9: Level of awareness of FGM law

Interaction with respondents and key informants revealed that the details of FGM legislation are not well known by many women in the communities. That notwithstanding they were aware that FGM was illegal and that when caught in the act the culprit will be sanctioned. This may explain why perpetrators conceal the practice and why community members do not want to expose fellow members engaged in the act. 77 respondents as indicated in the table below said they were aware of the FGM law while 17 expressed ignorance of the existence of such a law.

Fig: 11: level of awareness of FGM law

	Frequency	Percent
Valid yes	77	77.0
no	17	17.0
Total	94	94.0
Missing System	6	6.0
Total	100	100.0

4.10: Strategies to eliminate FGM in communities

To find a sustainable and lasting solution to the practice of FGM, participants were asked to suggest strategies leading to the abandonment of FGM.

Respondents suggested the following:

- Intensify health education in communities, schools as well as in ante-natal sessions.
- Establish peer educator groups in schools in the communities.
- Perpetrators should be arrested and punished by the police.
- Communities should report suspected cases to the police.
- Families involved in the practice of FGM should be identified and reported to traditional leaders and subsequently to the security agencies for prosecution.
- IEC materials should be developed to educate communities.
- Community bye-laws should be enacted by traditional leaders and assembly members.
- An incentive system to be established by government for people who detect and report cases of FGM to the police.
- Establish community FGM monitoring committees.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.0. Conclusions

The research revealed that FGM still occurs in the Bawku Municipality in the following communities: Mognori, Mandago, Waanre, Bardo and Widana.

56% of respondents stated that FGM still happens in their communities as confirmed by male and female groups and representatives of health, social welfare and community services departments of Bawku. However, the statutory agencies could not provide any statistics as they had not received direct reports from victims in their facilities even though many of the excised babies are taken to the health centres for ant-natal health care.

The reasons given by community members for the practice of FGM included the likelihood that women who have been cut will stay faithful to their partners, and will not be promiscuous, thus increasing girls' chances of getting married. Uncut married women are ridiculed by co-wives. It is a perception in the communities that FGM prevents the death of first babies and disease of the clitoris.

The key actors involved in FGM practice in the communities are the affected girls, mothers, grandmothers and the FGM practitioners from within the communities or from neighbouring communities or from Burkina Faso and Togo. The women who conduct the operation are popularly referred to locally as 'wanzams'. It was reported by the communities that many of the FGM practitioners in the communities have died, resulting in mothers taking girls to neighbouring Burkina Faso and Togo.

Girls below 15 years are the most at risk of FGM in the communities. The research revealed that 88% of the respondents confirmed this age.

Though some public education has previously been carried out by government and civil society organisations, the suspicion is that there is low awareness of the law. FGM in the communities is carried out under cover and even though the people may not know the letter of the law, they are aware of the consequences when apprehended and are therefore not prepared to disclose identities of perpetrators in the communities. Throughout the research, there was confirmation that FGM continues in the communities as well as in neighbouring communities. However, not a single perpetrator was identified or mentioned. This shows that awareness of the FGM legislation is not low as earlier suspected.

The FGM Act 484 is intended as a deterrent to perpetrators of the practice. Sanctions should be severe and disincentive enough to scare perpetrators from the practice. However, the legislation merely being deterrent and not sanctioning perpetrators severely is not adequate to stop the practice. Hence, stiffer punishment in the class of first degree felony, where a person can serve up to twenty five years or more should be instituted to ensure total eradication of the practice.

5.1: Recommendations

Based on the findings of the research, the following recommendations are being proposed:

The effective function of law such as the FGM law in any society depends upon certain factors. These include adequate publicity, appropriate structure of the law enforcement agencies in terms of training, equipment and conditions of service to enforce the law. Hence structures set up by the state such as the NCCE, CHRAJ and the police to

educate the public on their civic responsibility, their human rights and responsibilities should be adequately resourced to ensure that every citizen respects and recognizes the rights of others. BEWDA and AAG should network with organisations like the Gender Center and ACDEP who have conducted similar studies in northern Ghana to advocate for zero tolerance to FGM at the national and regional levels by ensuring that the systems work and that the law is enforced.

Communities should be supported in the very short term to form and facilitate the operations of Community Based Anti-violence Teams (COMBATs). These structures will serve as community watch dogs and inform appropriate agencies of any attempts by any individual or group of persons to facilitate or undertake FGM in the community or in neighbouring communities.

Child protection networks, girls' clubs or child rights clubs should be formed in schools and in the communities, where FGM is known to be practiced, in collaboration with the Ghana Education Service (GES) and the Commission of Human Rights and Administrative Justice (CHRAJ), to empower girls as well as educate boys on the harmful effects of negative traditional practices such as FGM.

The Ghana Health Directorate, especially the community health centres, should include FGM education in their regular health outreach programmes, touching on the health implications of the practice which far outweighs any perceived benefits.

TESTIMONIES

4.4.1: Testimony by Salifu Rahinatu

My name is Rahinatu Salifu; I come from Kolanaba, a section of Waanre near Pusiga and a Bisa by tribe. I am sixteen years of age and in class five in the Kultamise Presby Primary School some five kilometers away from my community.

I was a little child when my mother sent me to be circumcised and as I grew up I was made to understand that when a girl is circumcised she becomes faithful to her husband and on top of that the girl becomes fertile and attractive to potential husbands. As time went on, I realized that FGM has some effects on the girl. I heard that my uncle's daughter died due to over bleeding after the circumcision.



PIC: [Rahinatu Salifu](#)

(Courtesy: Peter Asaal –BEWDA, 2012)

FGM is still practiced in Waanre because some people still believe that it is a good practice but for me I don't feel comfortable amongst my friends and don't know what will happen to me one day if I decide to give birth'.

FGM normally takes place during the cold season. Children are prepared by their mothers and then the practitioners come from neighbouring communities like Mandago or from a community in Togo or Burkina Faso to circumcise the girls.

Rahinatu continues, "I want to advise all young girls, especially my colleagues to say no to FGM and report any mother or parent who wants to force them to undergo the practice.

4.4.2: Testimony by Sulimana Shirifa

My name is Shirifa Sulimana. I come from Kultamise near Pusiga. I am 18 years of age and Bisa by tribe. FGM is an old practice that we came to meet. According to history, it is a practice that every girl must go through to be recognized in the community. As I speak, FGM is still practiced in Kultamise. I was circumcised when I



Pic: Sulimana Shirifa
(courtesy Peter Asaal, 2012)

was 15 years of old and have no regrets for going through it. It is a practice in Kultamise that men will return women who have not gone through FGM, because as the saying goes, 'their store is full'. I had to join my colleagues and we were taken to Sugurnuoma in Togo where the practitioner is based.

I experienced some pains from the operation but all the same I don't regret and would encourage my colleagues to do same.

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