Ending Female Genital Mutilation

In Burkina Faso

Through Civil Society

by

Gerti Wilson

A thesis submitted to the Faculty of the University of Delaware in partial fulfillment of the requirements for the degree of Bachelor of Arts in Political Science with Distinction

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Approved: _____
Gretchen Bauer, Ph.D.
Professor in charge of thesis on behalf of the Advisory Committee

Approved: _____
Wayne Batchis, Ph.D.
Committee member from the Department of Political Science

Approved: _____
Lindsay Hoffman, Ph.D.
Committee member from the Board of Senior Thesis Readers

Approved: _____
Hemant Kher, Ph.D.
Chair of the University Committee on Student and Faculty Honors

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ABSTRACT

The practice of female genital mutilation has become a hot button issue in recent years at both the national and international levels. One of the most highly debated issues is the role that international law should play in addressing a social practice that is based on cultural beliefs and norms. FGM is centered on a larger debate in human rights academia, which is cultural relativism versus universalism. Universalism refers to the notion that human rights are universal and should apply to every human being. Cultural Relativists disagree, and argue that human rights are culturally dependent, and that no moral principles can be made to apply to all cultures. Law alone will not create a change in social behavior, but the adoption of international and domestic law prohibiting FGM in Burkina Faso has created a positive effect in establishing a role for law in advancing the process of social change in conjunction with culture (Center for Reproductive Rights 5). FGM is a violation of the human rights of women and young girls, which is steeply rooted in gender roles formulated to subordinate women. Female Gender Mutilation affects about fifty percent of women and girls in Burkina Faso despite the practice breaching several international human rights treaties, which have been signed by states that have the most widespread use (WHO 3). Enforcement of Burkina Faso's law on genital cutting needs to be strengthened through increased legal consciousness, effective sanctions, and the collaboration of local and global organizations because international law should address social practices that are violate basic human rights.

Chapter 1

INTRODUCTION AND LITERATRURE REVIEW

Background and Terminology

The United Nations General Assembly adopted a resolution that intensified global efforts for the elimination of female genital mutilations. The resolution was passed in December 2012 and it demonstrates the political will of the international community to eliminate FGM. The resolution stressed that a number of countries are using a coordinated approach that promotes positive social change at community, national, regional and international levels. This has led to signs of progress towards eliminating the practice. It encourages "States to pursue a comprehensive, culturally sensitive, systematic approach that incorporates a social perspective and is based on human rights and gender-equality principles" (UNGA 4). In addition, the resolution calls upon "States to develop unified methods and standards for the collection of data on all forms of discrimination and violence against girls, especially forms that are under documented, such as female genital mutilations, and to develop additional indicators to effectively measure progress in eliminating the practice" (UNGA 5).

The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children adopted the term female genital mutilation, in 1990, and in 1991 the World Health Organization (WHO) recommended that the United Nations adopt it as well. There have been objections to the term because it confers judgment and condemnation of what is an age-old practice in many communitis . International

human rights advocates have pushed for the use of the term as it relates to policy ending the harmful practice. In 1999, the UN Special Rapporteur on Traditional Practices called for patience regarding this area and drew attention to the risk of demonizing cultures under cover of condemning practices harmful to women and the girl child. There are three forms of Female Genital Mutilation.

Type I is the partial or total removal of the clitoris and/or the prepuce. In medical literature this form of FGM is also referred to as clitoridectomy. A number of practicing communities also refer to it as sunna, which is Arabic for 'tradition' or 'duty'. Type II is a partial or total removal of the clitoris and labia minora, with or without excision of the labia majora. The 2007 WHO definition recognizes that although this form of cutting is more extensive than Type I, there is considerable variability in the form or degree of cutting. Type III is the narrowing of the vaginal orifice by cutting and bringing together the labia minora and or the labia majora to create a type of seal, with or without excision of the clitoris. In most instances, the cut edges of the labia are stitched together, which is referred to as infibulation. The adhesion of the labia results in near complete covering of the urethra and the vaginal orifice, which must be reopened for sexual intercourse and childbirth, a procedure known as defibulation.

Type IV is all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization. Pricking or nicking involves cutting to draw blood, but no removal of tissue and no permanent alteration of the external genitalia. This is sometimes called

symbolic circumcision, and some communities have described it as a traditional form of FGM. Although symbolic circumcision is still highly controversial, it has been proposed as an alternative to more severe forms of cutting in both African and other countries where FGM is performed.

It should be noted that each society has its own language and way of classifying types of cutting that are known to members, types of cutting that do not necessarily correspond to the WHO designations. Establishing equivalence between such locally defined types and those proposed as guidelines by the WHO is not a simple matter. Many women may be unaware of the specific procedures performed on them, and in many settings it may be culturally inappropriate to ask detailed questions about such matters or to show illustrations.

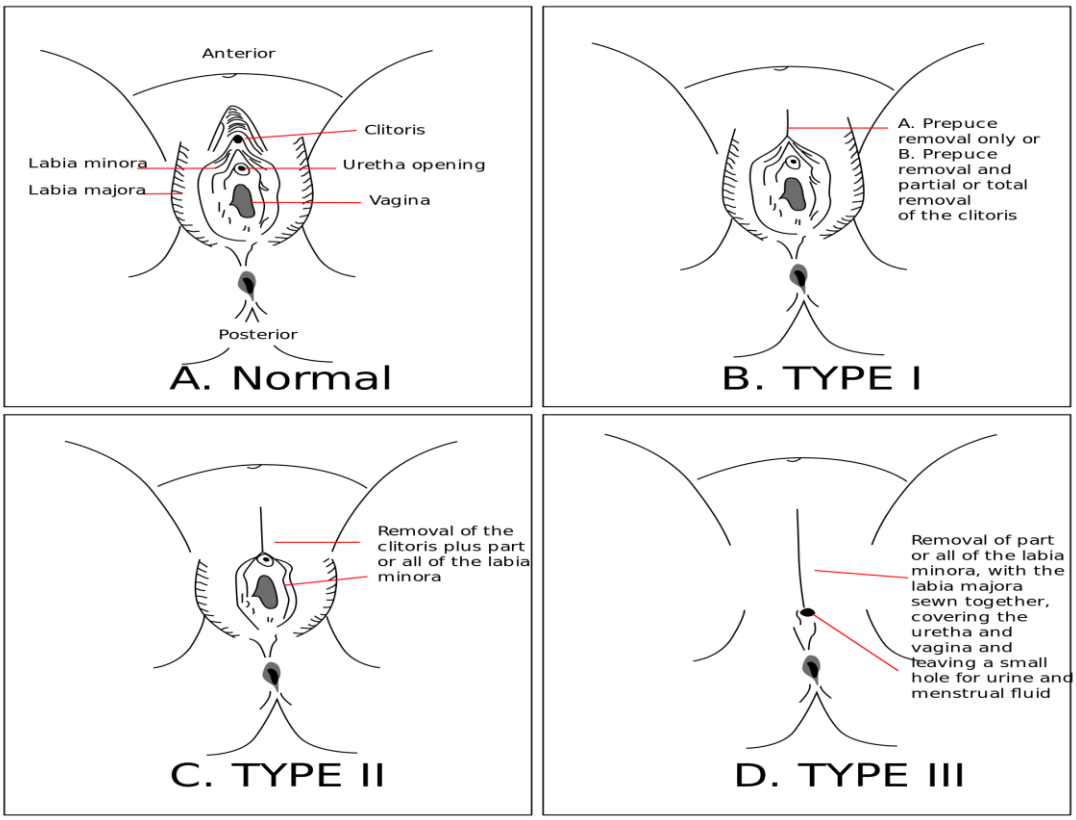

Figure 1 Types of FGM

Purpose

My thesis centers on the use of international law as a framework for social justice and the use of interpretation of address this practice in Burkina Faso. The majority of multilateral human rights treaties were signed after World War II. Treaties such as the Universal Declaration of Human Rights sought to create international norms by acknowledging fundamental rights and responsibilities of states to ensure them. Domestic law however, plays a large role in incorporating these norms into

legal principle for their states. State courts are the first step in enforcing human rights principles and international enforcement to human rights law is limited. There are systems of reporting, monitoring, and recommendations given by the UN and its bodies (Think Africa 4). Subjecting girls and women to FGM violates a number of rights protected in international and regional instruments. These rights include the right to be free from all forms of gender discrimination, the rights to life and to physical integrity, the right to health, and children's rights (Center for Reproductive Rights 12).

The right to be free from gender discrimination is guaranteed in Article 1 of CEDAW. It defines discrimination against women, as "any distinction, exclusion, or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment, or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil, or any other field (Think Africa 4)." FGM is a cultural practice aimed primarily at controlling women's sexuality and stripping them of their fundamental rights and liberties. The impact of FGM on women's human rights is recognized in the recently adopted African Protocol on Women's Rights, which requires all states parties to prohibit and condemn "all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognized international standards (Center for Reproductive Rights 27)."

Organization of Report

After the introduction, this thesis includes four chapters and an appendix. The chapters address the following issues:

- Introduction and literature review
- Cultural relativism
- FGM in Burka Faso and Civic Organizations
- Recommendations and Conclusion

The first chapter of my thesis is an overview to the topics that will be discussed throughout the paper. Background and definitions are given to provider the reader with a framework to understand the magnitude of this issue. I outline my purpose for picking such a sensitive topic for my senior thesis and the impact I hope to achieve with my work. The literature review section of this chapter describes the nature of data on FGM collected in DHS and WHO surveys. It goes into detail on how the data is analyzed and reported in DHS country reports.

The second chapter focuses on both surveys have been used to collect data on four topics over time. They are the circumcision status of the respondent herself; information about the event for those respondents who were circumcised; information about the circumcision status of one daughter and details about the event in cases where a respondent's daughter was circumcised; and women's and men's opinions of the practice. This data creates a snapshot of the practitioners of FGM, attitudes towards it, and common justifications for the continued use of FGM. The second chapter depicts the complex sources of FGM in Burkina Faso. It is a social norm deeply rooted in culture and tradition so ending the practice will need a multifaceted approach.

The third chapter on the practice of FGM reports on how FGM has been practiced and its prevalence according to respondents interviewed. There are several statistics included that depict the ages of the girl circumcised, the type of cutting done, and the type of practitioner who did the cutting. The tables of the chapter show data on these topics for the most recent DHS and WHO surveys and for all DHS surveys with the FGM module.

The final chapter briefly discusses issues that remain relevant for interpreting the significance of FGM within Burkina FGM involved. The chapter on estimating FGM in Burkina Faso focuses prevalence through household surveys conducted by USAID. Issues addressed include the relative importance of FGM nationally, the distribution of FGM within the state, trends over time in national prevalence data, trends over time in data from age cohorts, and the interpretation of daughter data for program evaluation.

Literature Review

Sally Engle Merry advocates for the commitment of local women and women's activists in translating rights in CEDAW and implementing them into the culture. This enables women to express and demand their rights in their local cultures. This works best when the practice of women's rights on the ground by joining with existing social justice movements and national women's movements and are thus, localized through various channels (Merry 22). This process of framing global human

rights claims in local terms and adapting them to existing ideas of justice may mean reframing human rights initiatives to better-fit local ideologies of gender and justice. A great example of this can be seen in India, national and state human rights commissions act as intermediaries through which global ideas of human rights are appropriated to fit the local context (Merry 12). These institutions are the location where global ideas merge with local movements and ideologies and, local definitions of human rights are institutionalized.

In her book, Sally Engle Merry explores how different actors both state and nonstate, translate global norms associated with human rights and gender violence into practices in societies gender violence is not defined in human rights terms. She identifies three cultural processes, or flows, that constitute global-local translation. First, she argues for transnational consensus building, or the making of the transnational gender antidiscrimination law. Next, Engle states that transnational institution and program transplantation and the making of national laws and regulations, as well as programs and organizations compatible with the international human rights norms. Lastly, she advocates for the localization of transnational knowledge and the emergence of human rights consciousness among local women (Merry 19).

By showing how local laws and practices are compatible with transnational requirements, they make transnational rules appear legitimate and acceptable to local actors and therefore make it easier for local actors to implement them. One of the most interesting parts of Merry's literary work is her discourse on culture. What is culture

and how does it shape human behavior? Is culture a system of norms, values and beliefs that facilitate societal integration? Is it a system of traditions? It is a world-view? It is enabling or suppressive? Is it static and rigid or dynamic and fluid?

Merry suggests that culture can be both enabling and suppressive. Its elements can be used as a resource to preserve the existing distribution of power in a society or in a community, in this case the power of men over women. Those who challenge existing power structures and propose an alternative conceptualization of gender violence can also use cultural elements as a resource. Those who have power over women on a national, community or family level often claim that practices of violence against women facilitates the integration of a given society and preserves national identity and cultural diversity. The challengers instead mobilize cultural elements that are compatible with the global ideas of gender equality, respect for women and unacceptability of discrimination and violence against women. By demonstrating this compatibility of local and global ideas they seek to redefined women's rights as compatible with national culture and identity to empower women.

Merry thus emphasizes that culture is not homogenous, integrated, consistent and fixed but contentious, accommodating conflicting elements, fluid and flexible. Culture is actively made and always changing. Culture is not independent from institutional arrangements, political structures and legal regulations. When institutional and legal arrangements change culture understood as traditions, beliefs, norms, habits, practices, meanings also changes. The lack of political involvement of women can be explained as a part of a traditional culture, but if policy-makers allocate

funds for providing childcare women are more likely to join parties, attend political meeting and participate in elections. Culture can change and people can learn new roles if institutional and legal preconditions for this are installed by policy-makers (Merry 16).

The source for institutional and legal change may come from transnational political arenas, they embedded in the culture of modernity (Meyer, Boli and Thomas 1987). In international organizations, such as UN, the representatives of nation-states and transnational activists develop global legal frameworks for human rights, for example the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Signatory states are obligated to accommodate international norms of gender equality and antidiscrimination in their national legislation and implement them. Policy-making often suggest that culture constitutes a barrier to the implementation of conventions, while feminist activists and social workers use local culture to promote human rights respect and offer women support in difficult situations. They do not build on preexisting similarities of transnational ideas and local culture but they construct similarities, embed transnational ideas into cultural frameworks and dress them in familiar costumes (p. 138).

In other words, culture for Merry is a fluid, flexible, changing and actively made resource that can either be used to preserve existing distribution of power embodied in legal and institutional, both formal and informal, arrangements, or it can be used to promote new ideas, concepts, policies and practices in the policy-making and on the ground. In this sense, it still unclear to me what is the independent role of

culture. It appears to be only an instrument in the hands of people who appeal to it to achieve their different, often contradictory political goals. There seems to be a danger in this whole debate to define culture as either a consistent and fixed set of beliefs, traditions and values or as a flexible tool-kit of cultural instruments and resources that can be used by knowledgeable strategic actors to pursue their goal. Although Merry does not provide an explicit answer to the question her book advocates for an important framework of human rights. Next, I will discuss a research study conducted by the World Health Organization in Burkina Faso.

While the practice of female genital mutilation (FGM) has been abandoned in western countries, it remains common in many African countries from Senegal to Somalia, in the Middle East, in some parts of South-East Asia and even among immigrant communities in Europe, North America and Australia. Previous studies in Burkina Faso reported a high prevalence (77%) of FGM among 15 to 49 years old women and described the commitment of the government of Burkina Faso to end this practice. Little is known about the effect of this effort on the trend of FGM in the country.

This study by the World Health Organization examined whether the prevalence of FGM changed overtime and identified the factors associated with this practice. Data from the 2010 multistage household survey of 15 to 49 years old Burkinabe women were analyzed. Of the 3,289 women who participated in the survey, 68.1% had undergone FGM. Among those who had a daughter (n = 2258), 18.7% had a circumcised daughter. Young age, ethnicity, religion, and social support from

community leaders were significantly associated with the FGM among women in Burkina Faso. Although, FGM is associated with serious health risks, its prevalence remains unacceptably high in Burkina Faso.

Social marketing interventions targeting community social norms, raising the community awareness about FGM, and empowering women to make informed decisions for their daughters are needed in order to end this deeply rooted tradition. While the prevalence of women of reproductive age who had undergone FGM in Burkina Faso (68.1%), as well as the proportion of those who had circumcised daughters (18.7%) have decreased overtime as compared to 77% in 2003 and 30.2% among their daughters (Karmaker et al., 2011), they remain unacceptably high. More efforts are needed to further reduce the practice of FGM in Burkina Faso.

The results of this study showed that the median age of girls being circumcised was eight years. This is in line with findings from previous studies. The practice of FGM at such a young age, when girls have no say whatsoever in the decision making process, underscores the need for a more aggressive involvement of the governments to protect these children. The involvement of medical personnel in the practice of FGM marks a big change in a business historically dominated by traditional practitioners. Although, this involvement commonly referred to as medicalization of FGM, will likely decrease the negative health consequences of FGM, it may, however, delay or prevent the development of effective and long-term solutions for the abandonment of this long-standing tradition (ShellDuncan, 2001).

While some policy makers may have encouraged the medicalization of FGM for short-term benefits, they should not overlook the ultimate goal of the fight against FGM, which is to ban the practice of FGM altogether. This study identified several factors associated with the practice of FGM among women of reproductive age and their daughters. Age was strongly associated with the practice of FGM in Burkina Faso. Younger women (ages 15 to 24 and 25 to 34 years) were less likely than older women (34+) to have undergone FGM. Furthermore, younger women were less likely than older women to have circumcised daughters. This difference in the prevalence of FGM or the likelihood of having a circumcised daughter between younger and older women could be a harbinger of the loss in favor of this practice. More studies are needed to confirm this change.

Contrarily, Muslim women were significantly more likely than Catholic women to have a circumcised daughter. While older women underwent FGM to fit in this patriarchal society, his does not seem to be true today. Catholic women's daughters are not likely to be circumcised. In order to bring about changes in this community, interpersonal communications should be organized with Muslim and other key leaders in the community. There was no significant difference in the prevalence of FGM by maternal educational attainment. Even the likelihood of having a circumcised daughter did not differ between women who attended or did not attend school.

The impact of maternal educational attainment on FGM remains controversial in the literature. In a study of 15 countries conducted in 2005, UNICEF (2007) found a positive relationship between maternal educational attainment and FGM in eight

countries, no relationship in six countries, and a negative relationship in one country, Nigeria, where the likelihood of having at least one circumcised daughter was greater among women with some education. FGM is practiced across all regions in Burkina Faso. However, women living in the Plateau Central as well as those from the Central East were at high risk of FGM as compared to those from the South West. The regional variations in the prevalence of FGM are probably accounted for by the ethnic group distribution and the prevailing religion in the area (Carr, 1997; Hayford and Trinitapoli, 2009).

Women who underwent FGM were less likely to have their daughters circumcised. Although, FGM is so deeply entrenched in the social, economic and political structures of the community that its abandonment is perceived as a loss of status and protection (UNICEF, 2007); the low prevalence of FGM among young mothers and their daughters is a positive sign of change over time. FGM is no longer being practiced systematically on every girl. The Government of Burkina Faso should involve women who have defied this deeply rooted ritual in its interventions aimed at reducing the practice of FGM in Burkina Faso. For example, these women could serve as spokespersons in mass media campaigns or as peer educators. The sentence should read: Maternal intention to circumcise daughters was also an important factor in the likelihood of circumcising a daughter.

Women who agreed with the statement "women should decide whether to circumcise their daughter" and those who reported receiving support from community leaders were more likely to have a circumcised daughter when compared with those

who did not. Community leaders are generally old men. They are likely to enforce the existing social norms. Even if a girl's mother or another female relative makes the decision whether to circumcise the daughter, the decision is likely to fall in line with the established patriarchal norms of ensuring that the girl remains an accepted community member (Mackie and LeJeune, 2009). While the large sample size as well as the sampling approach constitutes a major strength for this study, they also have some limitations. Information on FGM status was self-reported by women who participated in the study without any attempts to validate it through physical inspection or medical record review.

Considering that FGM is a very sensitive and stigmatizing social issue in Burkina Faso, this leaves room to question the truthfulness of a young woman when questioned by an unknown interviewer. The likelihood for women to give culturally acceptable answers to the interviewer constitutes a real concern. To conclude, the results of this study show that the practice of FGM is still high in Burkina Faso, despite the government's active involvement in the fight against it. However, the low prevalence of FGM among younger women and their daughters may be an indication of behavior change. Reports that FGM has decreased among groups in practicing countries further confirm that the fight against FGM can be won. Efforts to challenge the prevailing social norm should be reinforced, and focus on organizing young women who have abandoned the practice of FGM. Their social network should be made aware of their rejection of the FGM practice. Concomitantly, awareness-raising education and female empowerment and skill building programs should be put into

place. Only through integrated community interventions can we unravel this deeply entrenched social practice.

According to the CEDAW report, cultural patterns of high illiteracy rates and lack of education in many of the rural communities maintains traditional values that are reluctant to change. Communities in Burkina Faso that practice FGM maintain cultural norms by continuing the tradition (Center for Reproductive Rights 9). The coverage of this issue reinforces the colonialist understanding of culture that places ideas of backwardness and underdevelopment at the forefront of this debate of culture and human rights. The underdevelopment is registered through gender of depicting the submissive and suffering African woman that cannot escape traditional practices that oppress her. In this way cultural assumptions turn human rights into another tool that reinforces the victimization of women. It can often create a resistance to international human rights because traditional cultures are cited as objectifying and regulating women. By holistically disregarding culture it creates a narrative that western influence and laws are the sole method of liberating these oppressed women.

Chapter 2

PERSUASION AND CULTURE, CULTRUAL RELATIVISM

The Practice of FGM as a Social Norm

People's behavior can be influenced by a variety of factors. In the case of FGM, these factors include beliefs or knowledge about various aspects of the. A social norms perspective draws attention to the fact that the beliefs of individuals about others also condition their behavior. This perspective enriches the understanding of FGM by offering an additional lens for analyzing the mechanisms that regulate the practice. The identification of FGM as a social norm shows that the practice is connected to the behavior of an individual, family, and community

In addition to social norms, mechanisms that regulate behavior also include legal norms, which may prohibit the practice, and moral norms, such as doing what is best for one's daughter. Legislation prohibiting FGM alone will not discourage the practice. Where FGM is a social norm, the fear of social exclusion for not conforming to the norm may be stronger than the fear of fines and health issues. If individuals continue to see others cutting their daughters and continue to believe that others expect them to cut their own daughters, the law will not serve as a strong enough deterrent to stop the practice. However, FGM, legislation can serve as a tool to strengthen the legitimacy of their actions and as an argument for convincing others to do the same. Understanding the complexity of local knowledge on the custom from a woman's

standpoint is critical. Opponents of the practice must not express concerns that ignore the cultural context within which female circumcision is performed.

FGM Practitioners

Traditional practitioners almost exclusively carry out FGM procedures. These may be traditional circumcisers or traditional birth attendants; they are generally older women in the community (UNICEF, 2013a, p.42). Properly trained medical staff is rarely used (less than 1%), probably because the law in Burkina Faso states, "the maximum punishment shall be meted out if the guilty party is a member of the medical or paramedical profession

Attitudes toward FGM

Burkina Faso's prevalence of FGM is classified as moderately high (UNICEF (2013a, p.27). With 76% of 15- to 49-year-old women reported having undergone FGM (UNICEF, 2013a, p.27). The most recent DHS survey data available for 2010 shows that knowledge of FGM is almost universal throughout Burkina Faso, with over 99% of women and 98% of men having heard of the practice (DHS 2010, p.290). Attitudes towards FGM also appear fairly uniform across the age groups with 87.4% of women aged 15 to 49 who have had FGM express the view that it should be stopped, 11.7% are in favor of its continuation and 0.8% are unsure (DHS 2010, p.299). Among women who have not had FGM, 97.6% are against its continuation.

Among men the pattern is similar, with 87% aged 15 to 49 believing FGM should stop, 10% in favor of its continuation and 3% unsure (DHS 2010, p.299). While the prevalence of FGM remains high in Burkina Faso, it does appear that attitudes towards the practice have changed over the last 15 years. Statistical analysis compiled by UNICEF shows a downward trend in support does therefore suggest a shift in attitudes among women. The same report noted that among women and girls aged 15 to 49 some 52% believe that there are no benefits to undergoing FGM (UNICEF, 2013c, p.3).

	Women (%)	Men (%)
	n = 7,728	n = 2,191
Knowledge: Has heard of FGM		
Yes	91.7	82.2
Among those that know of FGM	**n = 7,158**	**n = 1,818**
What are the advantages of practicing FGM?		
Social recognition	34.8	29.6
Curbs sexual desire	31.2	25.1
Religious requirement	29.2	41.2
Better for hygiene	18.8	13.0
Better chance to get married	3.8	9.8
Sexual desire of the other sex	1.8	1.8
Other	8.5	10.6
None	21	19.9
What are the advantages of not practicing FGM?		
More sexual desire for women	19.7	12.9
Less health problems	10.6	9.7
Avoid suffering	6.9	6.1
More sexual desire for men	5.7	4.9
Less delivery problems	4.4	1.6
Accordance with religion	2.4	3.4
Other	11.9	12.9
None	52.9	58.7
Belief that FGM curbs sexual desire		
Yes	38	20.5
No	21.6	14.2
Don't know	39.1	63.4
Is the practice of FGM required by your religion?		
Yes	41.6	35.8
No	29.2	27.5
Don't know	28.0	34.0
Should FGM be retained (attitude)?		
Yes	64.4	70.9
No	22.3	17.7
It depends	7.2	4.5
Don't know	5.8	6.3
Do you think (the other sex) wants it to be retained?		
Yes	37.0	56.1
No	14.6	13.3
It depends	23.2	12.7

*For some questions the columns do not equal 100% due to missing data.
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Table 1 Knowledge of FGM

	Favorable attitude for continuing FGM		Experienced FGM
	Women (n = 6,074)[¥]	Men (n = 1,583)	Women (n = 7,048)[$]
	Odds Ratio (95% CI)	*Odds Ratio (95% CI)*	*Odds Ratio (95% CI)*
Ethnicity			
Wolof	Reference	Reference	Reference
Other ethnic groups	7.71 (3.76–15.83) **	5.22 (2.51–10.86)**	7.61 (4.56–12.68) **
Place of residence			
Urban	Reference	Reference	Reference
Rural	1.20 (0.82–1.75)	2.82 (1.09–7.31)*	1.45(.95–2.20)
Wealth			
Lowest	Reference	Reference	Reference
Second	0.98 (0.79–1.21)	0.81 (0.48–1.39)	1.08 (0.85–1.37)
Middle	1.14 (0.79–1.65)	0.84 (0.38–1.87)	0.67 (0.46–0.97)*
Fourth	0.74 (0.58–0.94)*	0.50 (0.29–0.86)*	0.63 (0.48–0.81)**
Highest	0.37 (0.28–0.50) **	0.52 (0.28–0.93)*	0.45 (0.32–0.63)**
Education			
No	Reference	Reference	Reference
Koranic	0.68 (0.52–0.88)**	1.18 (0.65–2.16)	1.36 (1.06–1.73)*
Prim. Education	0.60 (0.47–0.76)**	0.67 (0.39–1.17)	0.93 (0.75–1.14)
Second. Education	0.35 (0.27–0.46)**	0.49 (0.29–0.82)**	0.65 (0.52–0.82)**
High (University)	0.19 (0.11–0.33)**	0.29 (0.16–0.52)**	0.69 (0.39–1.23)
Age			
15–19	Reference	Reference	Reference
20–24	0.78 (0.64–0.94)**	0.77 (0.47–1.27)	1.00 (0.84–1.20)
25–29	0.67 (0.54–0.83)**	0.69 (0.41–1.15)	0.88 (0.70–1.10)
30–34	0.65 (0.52–0.82)**	0.64 (0.36–1.14)	1.14 (0.89–1.47)
35–39	0.47 (0.37–0.61)**	1.05 (0.53–2.11)	0.89 (0.66–1.20)
40–44	0.72 (0.53–0.97)*	0.57 (0.31–1.08)	1.02 (0.74–1.38)
45–49	0.54 (0.38–0.75)**	1.00 (0.46–2.18)	0.72 (0.52–1.00)
50–54	NA	0.68 (0.30–1.50)	NA
55–59	NA	0.76 (0.33–1.76)	NA
Working Status			
Not working	Reference	Reference	Reference
Working	1.10 (0.92–1.31)	0.92 (0.63–1.36)	1.80 (1.51–2.15)**
Interaction Term			
Rural*working	1.78 (1.15–2.75)*	0.94(0.41–2.18)	1.27(0.83–1.93)

**p<.001;
*p<.05.
[$]This analysis was done among those women who know (heard of) the practice of FGM; we excluded women who did not know of FGM, did not belong to one of the 4 major ethnic groups, and the missing variables.
[¥]This analysis was done among those women who either approve or disapprove the continuation of FGM; we excluded women who did not know of FGM, did not belong to one of the 4 major ethnic groups, and the missing variables.
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Table 2 Attitudes for Continuing FGM

Justification for support of the practice

Growing up in a culture where it is seen as the norm to have undergone FGM, and where FGM has only recently been deemed unlawful, women may tend to look towards the older generation for guidance. This dependence on elders, including local traditional and religious leaders, can make it difficult to break away from the practice, which is also strongly tied to social acceptance and a sense of community. In some cases all the women from previous generations will have undergone FGM. To feel a sense of community young girls may feel pressured into undergoing FGM without realizing the full consequences, or they may choose to ignore the repercussions to gain social acceptance within their community (UNFPA, 2011). UNICEF reports that 24% of women and girls (aged 15 to 49) who have heard of FGM cite social acceptance as the reason for a girl to undergo the procedure. In Burkina Faso UNICEF reports that 6% of women and girls aged 15 to 49 believe that undergoing FGM maintains cleanliness and hygiene (UNICEF, 2013) another reason often given for continuing FGM is the preservation of virginity and the prevention of promiscuity in women before marriage.

Sometimes it is expected of the potential bride to have undergone FGM before she may be considered marriageable (UNFPA, 2011). In Burkina Faso only 3% of women (aged 15 to 49) cite better marriage prospects as a benefit of FGM (UNICEF,

2013a, p.3). Additionally, the concept of social acceptance, the most commonly perceived benefit in Burkina Faso (UNICEF, 2013, p.67), may encompass better marriage prospects. On average in Burkina Faso 17% of women and 15% of men (aged 15 to 49) who have heard of FGM believe that it is a religious requirement. Among women and girls who have had FGM, the percentage of those who hold this belief is slightly higher, at 21%; only 7% of those who are uncut hold this belief (DHS 2010, p.298). There are also variations in belief depending on socioeconomic factors. For example, among the Muslim population 22% of women and 19% of men consider FGM to be a religious requirement. The figure reaches a high of 30% among men and women with traditional/animist beliefs and lows of between 2 and 5% among Catholic and Protestant men and women (p.298). In spite of the continued physical suffering that envelopes genital excision, it remains desirable in specific communities.

Chapter 3

FGM in Burkina Faso and Civic Organizations

Political Background

Burkina Faso is a landlocked country surrounded by Niger to the east, Benin to the southeast, Togo and Ghana to the south, Côte d'Ivoire to the southwest and Mali to the north. The country was previously known as the Upper Volta. Mossi tribes, originating from Ghana, immigrated into the region between the 10th and 11th centuries, forcing out the original Yonyonse inhabitants. The establishment of complex administrative systems, combined with the backing of strong armies, enabled the Mossi to create powerful states. Kings, or nabas ruled the Mossi kingdoms, with the most prominent being headed by the Mogho Naba at Ouagadougou. In the early 1890s the British and French military fought to claim parts of the country. Following the defeat of the Mossi kingdom of Ouagadougou in 1896 it became a French protectorate. In 1898 the British and French came to an agreement on the placing of borders. In 1904, as part of the reorganization of their colonial empire, the French merged the Volta basin territories with their French West Africa colony, which included Upper Senegal and Niger. In 1919 the French reversed this merger, separating the present Burkina Faso territory from Niger and Upper Senegal.

The colony of Upper Volta was further dismantled in 1932, when it was split between French Sudan, Niger and Côte d'Ivoire. Agitation in the country following World War II led the French to reverse its status again, bringing Upper Volta back into

the French Union in 1947. It eventually earned self-government status, becoming the Republic of Upper Volta in 1958, and gained full independence from France in 1960. Burkina Faso is divided into 13 administrative regions, as shown in Figure 5. The first president following independence was Maurice Yaméogo, who was deposed in 1966 after a military coup d'état. Further coups and changes in government followed until, in 1983, Thomas Sankara, a military captain, seized power. In 1984 he changed the name of the country from Upper Volta to Burkina Faso, which means 'the land of honest men'. Sankara was widely viewed as a radical leader and was assassinated during a French-backed coup in October 1987.

Estimate of FGM Prevalence

FGM has been reported in 28 countries in Africa and occurs mainly in countries along a belt stretching from Senegal in West Africa, to Egypt in North Africa, to Somalia in East Africa and the Democratic Republic of Congo in Central Africa. It also occurs in some countries in Asia and the Middle East and among certain diaspora communities in North America, Australasia and Europe. As with many ancient practices, FGM is carried out by communities as a heritage of the past, and is often associated with ethnic identity. Communities may not even question the practice or may have long forgotten the reasons for it.

As we share our research on Burkina Faso, its population is due to go to the polls and elect a new government to take forward leadership of this West-African state.1 that new government will face a number of challenges. The position of women

and girls in society and the work to abandon harmful traditional practices) such as child marriage and FGM must be kept high on the agenda. A research study by USAID, shows that while some 87% of women (who have had FGM) and men express the view that it should be stopped, overall the national prevalence of FGM in Burkina Faso remains high, at 76% of women and girls aged 15 to 49 (DHS 2010, pp.291&299). Knowledge of FGM is almost universal throughout the country (over 99% of women and 98% of men have heard of the practice [DHS 2010, p.290]) and FGM is practiced across all regions, with rates varying from 54.8% in the Centre-West to 89.5% in the Centre-East (DHS 2010, p.291). FGM is practiced across all religions and ethnic groups in Burkina Faso and analysis of available data suggests that the girls who are most at risk of FGM are those born to poorer mothers with no education living in rural areas. According to the Demographic and Health Surveys (DHS) Program (2010, p.291), Type II FGM is the most common type performed in Burkina Faso (at 77%) and it is almost exclusively carried out by traditional practitioners (in 96% of cases).

FGM is practiced across all regions, ethnic groups and religions. There is some variation in FGM prevalence by place of residence, with 68.7% of women (aged 15 to 49) in urban areas having had FGM, and 78.4% in rural (DHS 2010, p.291). The capital, Ouagadougou, contains 14% of the country's urban population and has an FGM prevalence of 64.8% for women aged 15 to 49 (DHS 2010, p.291). The regions with the highest prevalence of FGM lie in a band across the country towards the north-east of the center, and in the south-west: Centre-East (90%), Central Plateau and the North (88%), Centre North (87%), and Hauts Bassins and Cascades

(82%). Three regions in the center and towards the south have the lowest rates: Centre-West (55%), Centre (which includes Ouagadougou) (66%) and Centre-South (68%). This regional dispersal broadly corresponds to the Mossi's dominance in the central band (the FGM prevalence among the Mossi is 78%), and the Fulani's to the northeast (84%). The Gourounsi, in the south, have a lower FGM prevalence of 60% (DHS 2010 p.291; UNICEF, 2013a, p.29).

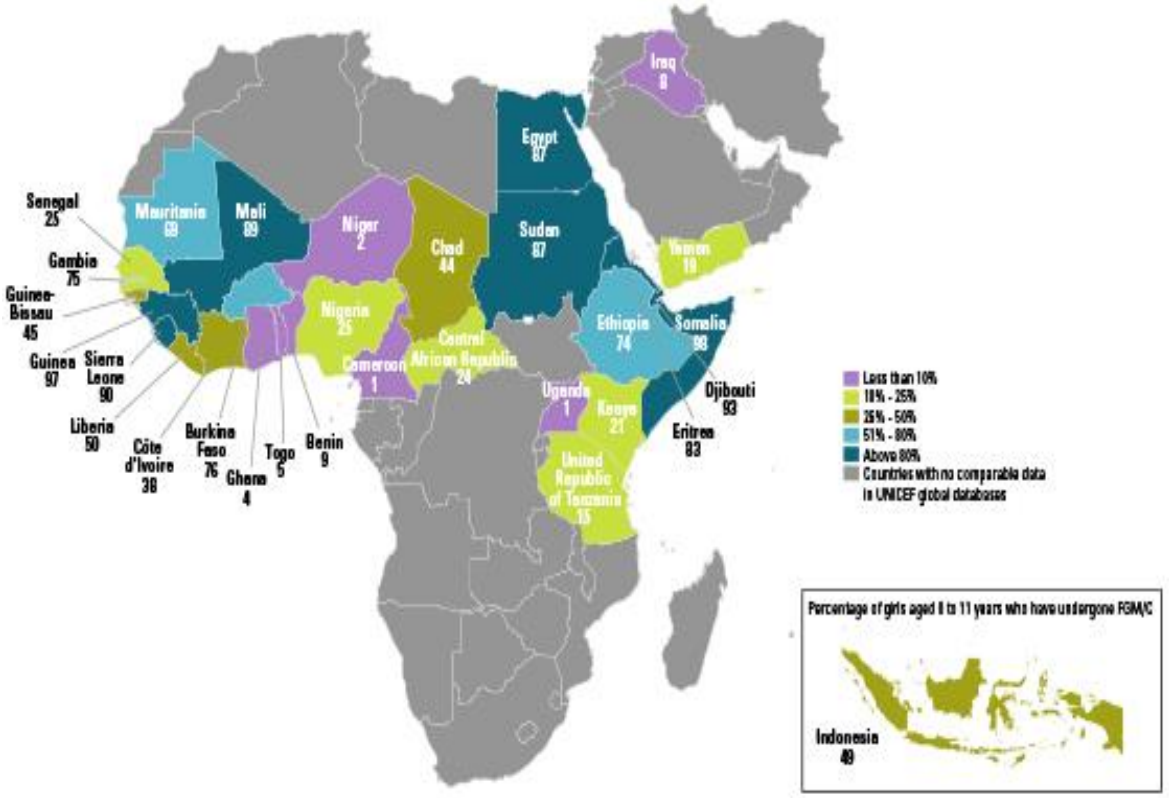

Figure 2 Prevalence of FGM in Africa

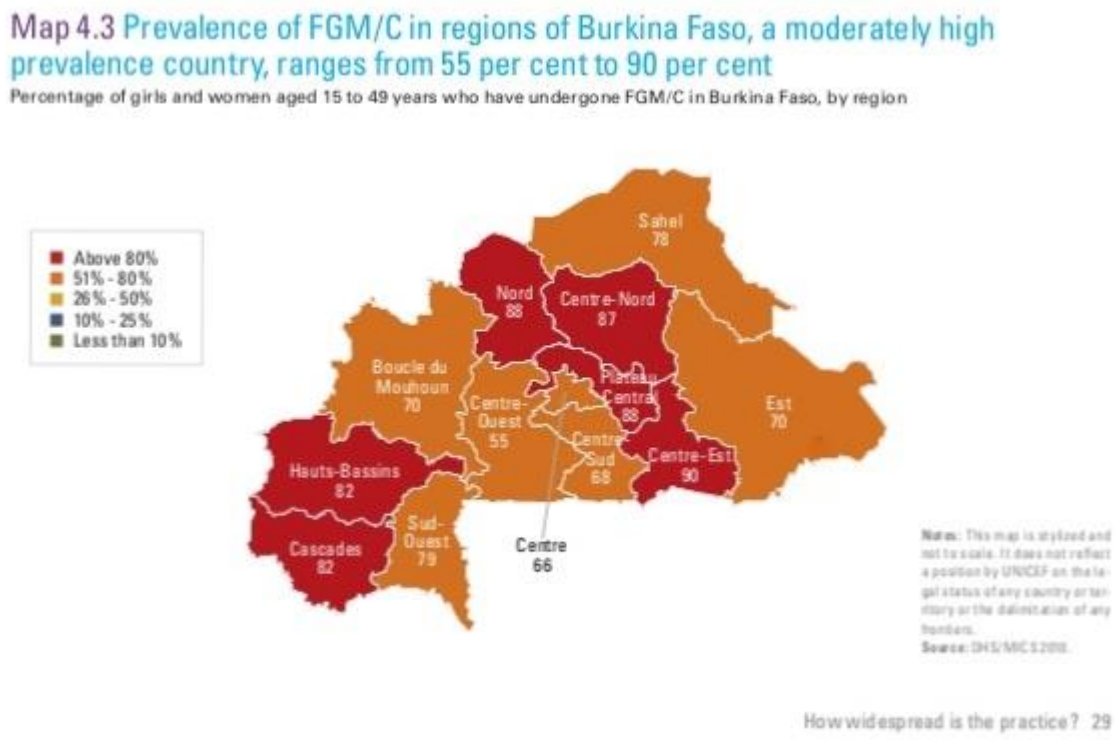

Figure 3 Prevalence of FGM in Burkina Faso

FGM and Socio-demographic characteristics

The substantial differences between Christians, Muslims, and adherents of traditional religions in education, wealth, and other sociodemographic characteristics do little to explain differences across religious groups in the practice of female circumcision. In fact, some religious differences in the transmission of female genital cutting are larger once sociodemographic differences are taken into account. Respondents' religious beliefs regarding female circumcision are more important than

sociodemographic factors in explaining circumcision behavior. Controlling for these beliefs reduced differences between Christians and practitioners of traditional religions to a statistically nonsignificant level. Aspects of religious identity specific to genital cutting largely mediate differences between Christians and traditional religionists. It is striking that controlling for specific religious beliefs does not attenuate differences between Muslim women and women who belong to traditional religions. Among the religious affiliations included in this analysis, Islam has the strongest formal doctrinal support for female circumcision, and Muslim women in this sample are the most likely to report that their religion requires circumcision. Yet differences between Muslims and other groups are the least sensitive to controlling for specific religious beliefs.

The link between religious affiliation and female circumcision is neither clearly defined nor universal. There is debate over the origins of the practice, but the consensus is that female genital cutting did not originate as an Islamic practice and in fact predates Islam. The variation we find in the strength and direction of the association between religious affiliation and female genital cutting indicates that the association between Islam and the practice of female genital cutting does not result from a universally applicable religious belief; rather, it exists and persists in part because of culturally specific interpretations of religious identity. Even in the absence of formal religious doctrine, female circumcision may be understood as a religious practice for those who practice it. Evidence suggests that some women who practice genital cutting interpret and explain it as a Muslim custom (Boddy 2007; Johnson 2000).

This research conducted by the United Nations Children's Fund (UNICEF) demonstrates the importance of individual interpretations of religious doctrine. Individual respondents' belief in the religious requirement for female genital cutting explains circumcision of daughters even in the absence of consensus in religious beliefs. At the same time, the context-dependence of religious differences in circumcision behavior highlights the collective aspects of religious identity. In communities where a high proportion of adult women are cut, Muslim women are not more likely to circumcise their daughters than women with other religious affiliations. Religion's role in circumcision decisions is most salient in communities with lower circumcision prevalence.

Local circumcision prevalence has a strong impact on both the intergenerational transmission of female genital cutting and religious differences; in fact, this impact is larger than some effects of other community characteristics, such as religious composition. Results also suggest that further development of convention theory is needed to fully account for heterogeneity in circumcision beliefs and practices. Female genital cutting appears to be more persistent among some groups than among others, and a generalized decline may not be sufficient to produce a "tipping point" among groups more attached to the practice. It is possible that female genital practices are important as a way of defining a distinct identity for Muslims in Burkina Faso, and that this role becomes more central as the prevalence of the practice declines among other groups. Institutional religious structures, such as schools and congregations, may also play a larger role in sustaining female genital cutting among Muslims than among other religious groups.

	Women (%)	Men (%)
	n = 7,728	n = 2,191
Ethnicity		
Arab	76.0	74.5
Poular	16.6	17.7
Soninke	4.0	4.0
Wolof	2.2	2.8
Others	1.0	0.8
Marital status		
Single never married	28.6	48.8
Married	58.8	48.9
Divorced and widowed	12.6	2.3
Place of residence		
Urban	46.0	56.2
Rural	54.0	43.9
Wealth		
Lowest	35.1	28.1
Second	31.2	28.8
Middle	4.0	7.9
Fourth	16.4	20.9
Highest	13.3	14.3
Education		
No	30.5	21.1
Koranic	27	19.2
Prim. Education	27.8	26.1
Second. Education	13.6	28.3
High (University)	1.1	5.3
Age		
15–19	22.0	22.5
20–24	19.0	14.6
25–29	16.9	13.6
30–34	15.4	11.8
35–39	10.8	10.4
40–44	10.1	11.4
45–49	5.9	6.4
50–54	–	6.1
55–59	–	3.2
Working Status		
Not working	70.6	33.5
Working	29.4	66.2

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Figure 4 Public Opinion of FGM

Consequences of FGM

Opposition to female genital cutting is based in both human rights concerns and the health consequences of the practice. The human rights perspective has opposed cutting on several bases: gender equity, bodily autonomy (emphasizing the practice on children too young to consent), and "physical and mental integrity" (e.g., UNICEF 2005; WHO 2008). Research on the health consequences associated with cutting demonstrates negative affects, both immediate and long term. In the short term, female circumcision can cause severe pain, hemorrhage, and infection. The long-term effects of cutting include obstetric complications that are associated with higher risk of maternal and infant mortality, including scar formation, obstruction of the vaginal opening, fistula, chronic pelvic infections, and prolonged labor (WHO Study Group 2006), bringing female genital cutting to the forefront of efforts to reach the Millennium Development Goals (UNFPA 2009; Walsh 2010).

Shock, due not only to the severe pain caused by an operation performed without anesthesia but also to the loss of blood which can continue for several days even when moderate, or to sepsis. Hemorrhage, the most common and almost inevitable consequence, given that amputation of the clitoris can also involve resection of the dorsal artery. Moreover, even amputation of the labia can cause damage to veins and arteries. Prolonged hemorrhage can cause a girl's death or lead to long-term anemia. Infections, due to unsanitary conditions, use of unsterilized instruments and the fact that urination and defecation take place over the wound in girls that are bound. In the case of infibulation, an internal explosion of the infection can occur that can affect organs such as the uterus, the fallopian tube and the ovaries, causing chronic

pelvic infections and infertility. Urinary retention can last eight to ten days. These girls find urination extremely painful due to inflammation of the wound on the vulva. This complication can cause infections of the urinary tract in lesions of adjoining tissue such as the urethra, vagina, and perineum. This is also due to the use of unsterilized instruments, the lack of proper illumination during the operation, the lack of anatomic knowledge in the practitioners and the struggling of the patient. More frequent are lesions of the anal and rectal opening with cutting of the anal sphincter and residual incontinence. Tetanus can be contracted through use of unsterilized equipment. Using the same instruments for many operations can transmit HIV/AIDS virus.

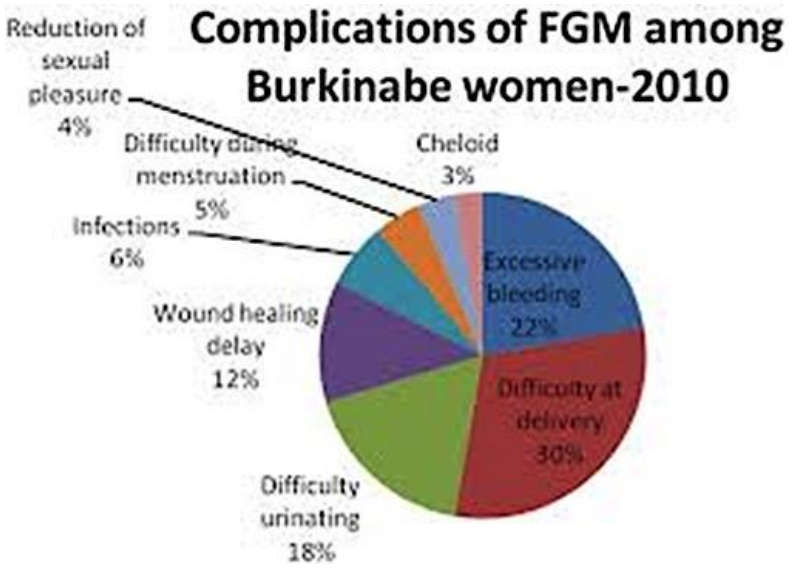

Figure 5 Complications of FGM

In 1996 Burkina Faso created a law in that specifically prohibits the practice of female genital mutilation, many of which specify the categories of people who can be charged through criminal law (UNFPA 1). The people that can be prosecuted are practitioners, parents, guardians and persons who fail to report a potential or already committed crime. The charges range, but can include imprisonment, fines and the confiscation of professional licenses. The criminal penalty varies on a case-to-case basis. The use of international human law can hold Burkina Faso more accountable for their inaction in response to FGM through global accountability. A radio campaign first raised this issue in 1975, demanding that the practice cease (UNFPA 3).

Since 1985, there has been "National Week for Women" to abolish this practice. The government began implementing dialogues on the grassroots level to discuss this formerly taboo subject. Since then there have been numerous campaigns, seminars, and other methods aimed at informing the population about the harmful effects and eradicating the practice. Much emphasis has been placed on the improvement of health care and education, participation of women in society and economic and social improvement of the position of women and children. This movement has been led by a National Committee to Fight against the Practice of Excision (CNLPE) with Burkina's First Lady as the honorary chairperson (Tarpliga 5). The First Lady actively supports the campaign.

The National Committee was set up by a Presidential decree in 1990. Included in the Committee are members of the Burkina Faso Women's Union, the Burkina Faso Midwives' Association, the Nurses' Association and the Burkina Faso Movement for

Human and People's Rights (Refworld 2). Traditional village leaders have pledged their support to the Committee. Members of the National Committee state that people are beginning to resist this practice but that traditional beliefs are so powerful that many girls and women are either obliged to or want to undergo the procedure. The National Committee operates under the administration of the Ministry for Social Action and the Family, but maintains autonomy in its activities. It is composed of three main bodies: a National Committee, a Permanent Secretary and a Provincial Committee and one subsidiary group of resource people (Refworld 3). This significant progress in the fight against FGM is a direct result of the commitment of the political authorities, and the involvement of traditional and religious leaders, NGOs and various associations, with support from other partners.

A strategic communication plan was put in place, accompanied by intense lobbying; technical capacity building and institutional support and these strategies have been quite successful. The date of May 18 is celebrated every year as the National Day to combat FGM. The visible support of opinion leaders, traditional chiefs and religious authorities has been extraordinarily influential in highlighting the problem and leading to its decrease. The government now views FGM as more than a traditional practice, but as an issue about public health, violence and individual rights (Refworld 1).

The International Covenant on Economic, Social and Cultural Rights recognizes the right of all human beings to the "highest attainable standard of physical and mental health." The right to health prohibits FGM because it can result in severe

physical and mental harm and because it constitutes an invasive procedure that is medically unnecessary (UNICEF 2). The World Health Organization includes physical, mental and social well-being in its definition of health and recognizes that health is "not merely the absence of disease or infirmity (WHO 7)." The 1994 Program of Action of the International Conference on Population and Development in Cairo, Egypt includes "sexual health, the purpose of which is the enhancement of life and personal relations" in its discussion of health (Center for Reproductive Rights 14). The Committee on the Elimination of Discrimination against Women passed a general recommendation No. 24 which specifically recommended that governments create health policies that take into account the needs of girls and adolescents who may be vulnerable to traditional practices such as FGM (Think Africa 3).

The right of the child prohibits FGM because it predominantly affects girls under the age of 18. The Convention on the Rights of the Child in article 5 acknowledges the role of parents and family in making decisions for children, but places the ultimate responsibility for protecting the rights of a child in the hands of the government (UNICEF 2). The CRC mandates governments to abolish traditional practices prejudicial to the health of children in Article 24. The international community has generally regarded FGM as a violation of children's rights because most victims of FGM are children who cannot give consent. The Children's Rights Convention requires States Parties to take "all suitable effective measures to abolish traditional practices that are prejudicial to the health of children (UNICEF 5).

The right to be free from gender discrimination is guaranteed in Article 1 of CEDAW. It defines discrimination against women, as "any distinction, exclusion, or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment, or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil, or any other field (Think Africa 4)." FGM is a cultural practice aimed primarily at controlling women's sexuality and stripping them of their fundamental rights and liberties. The impact of FGM on women's human rights is recognized in the recently adopted African Protocol on Women's Rights, which requires all states parties to prohibit and condemn "all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognized international standards (Center for Reproductive Rights 27).

The use of human rights principles to condemn the cultural practice of FGM has given rise to opposition arguments based on cultural relativism. The right to practice culture, the rights of minorities, and the right to religious freedom are used to support the belief that governments and international law should not interfere with FGM. Government action due to international or domestic law to prevent FGM is an intrusion on an individual's civil rights. In order to ensure that this egregious human rights violation comes to an end a government does have a right to suspend a citizen's rights. A state's interest in protecting and ensuring women's rights outweighs an individual's right to practice their culture.

The Banjul Charter, which has been ratified by members of the African Union, creates the African Commission of Human Rights. The Banjul Charter requires state parties to submit reports to the African Commission every two years to document compliance with human rights standards (Center for Reproductive Rights 39). The African Commission also accepts information from other sources, including nongovernmental organizations. The African Protocol on Women's Rights calls for the prohibition of harmful traditional practices such as FGM through legislative and other measures. States partied to the protocol are obligated to ensure the implementation of the protocol at the national level through monitoring. In conclusion progress has been achieved in many ways. Female genital mutilation is internationally recognized as a violation of human rights (Human Rights Watch 1). The United Nations General Assembly Special Session on Children policies and legislation to prohibit the practice have been put in place in many countries (Human Rights Watch 2). There are indications that a process of social change has been started in many countries through the framework of international law.

Process of Changing Social Norms

In Burkina Faso as in many developing countries, the wheels of justice turn slowly; enforcing laws against deeply ingrained cultural practices such as FGM/C is fraught with difficulties. When cases have come to trial, many convicted perpetrators and their accomplices (usually the child's parents) have received suspended sentences often because judges are, perhaps understandably, reluctant to

incarcerate a child's parents and thus deprive her and her siblings of their care. Moreover, because the law is not widely supported by the public, police officials, and even local political leaders, are subject to intimidation and pressure not to enforce it. In addition, some judges and their staffs still need to be convinced of the negative effects of FGM and thus, despite the statute, do not take the issue as seriously as they should.

A number of purely practical problems also hamper the rigorous application of the FGM law, which calls for six months to three years imprisonment and a fine of up to CFA francs 900,000 (US $1,724) for anyone performing, arranging or otherwise aiding FGM. Until 2008, however, the average sentence pronounced was just over three months. This is largely because many jails lack separate facilities for women, making it difficult to incarcerate them for extended periods. Furthermore, since most perpetrators are elderly, their health tends to deteriorate in jail, and their supporters often rally to demand their release–hence the large number of suspended sentences. As a result, a public perception has been created that in cases of FGM/C, pardons should be expected.

Chapter 4

Recommendations and Conclusion

Women that were born between 1990-present have the lowest odds of being circumcised. The youngest groups of women in this birth cohort were only a year old in 1996 when the FGM law was enacted in Burkina Faso whilst the oldest group should have been aged 6. The enactment of Burkina Faso's FGM law may have prevented some of the girls from undergoing FGM. The FGM law may also have had an impact amongst women of the 1980 to 1989 birth cohort. Overall there is a significant increase in the percentage of women that would like circumcision to end.

The percentage of women that have primary education or higher increased between 1999 and 2010 and the odds of being circumcised amongst women with primary education or higher were lower than in women without education in 2010. The importance of education in lowering the likelihood of FGM in Burkina Faso has been reported in the previous chapter. Considering that in most cases, circumcision takes place before girls start school, the relationship between education and FGM is expected to be indirect and its impact to be realized in the long-term. For example educated women may not subject their daughters to FGM either as a result.

In Burkina Faso, Muslim women are more likely to be circumcised and to perceive that FGM should continue compared to Christians and women of traditional or other religions. Although Islam does not recommend or promote FGM, it is suggested that Muslims may have culturally interpreted the practice as over time. It should be noted that religious connections are important, and no religion prescribes to this practice. There is already strong political opposition to the practice of FGM and consequently, it is internationally recognized as violation of human rights and an

illegal activity in many countries. Burkina Faso is one of 16 African states which have outlawed FGM. Legislation was passed in 1996 with fines of up to 900,000 CFA (US $1,800) and prison sentences of up to three years for undertaking FGM. In contrast, making it illegal may have hampered women's reporting and seeking of safe medical treatment and of remedial measures where these are needed. Due to the very personal effects of FGM and the contentious cultural mores associated with the practices of FGM, it would be valuable to review the law pertaining to FGM in Burkina Faso to identify any differences the law may be making.

As far as practical intervention is concerned, some strategies in Burkina Faso have advocated alternative rites with the aim of involving communities alongside enforcing legislation. Additionally, activities has been undertaken involving educating the women practitioners of FGM and giving them alternative skills for earning a living and spreading information to reduce public demand. In the context of Burkina Faso, the education that modernization brings may benefit women from other religions more than Muslim women. Increasing assets and increasing women's responsibility for their own healthcare decision would be important benefits to be gained from projects which encourage women to work end this harmful practice.

Although younger women with some education and those from specific groups, regions and religions are less likely to have had FGM it is still extremely common in Burkina Faso. Cultural differences and strongly personally held beliefs have an effect on the perpetuation of FGM. This is not an issue with simple policy answers. Policy initiatives should focus on education and plans that work with

religious groups and leaders. Policy should also be sensitive to the diversity and strength of women's beliefs and focus on ensuring that women are empowered to make their own decisions about FGM. Currently these decisions are made while young girls cannot make their own critical decision to participate in the practice. Perhaps the more efficient and long lasting solution to eradicating the practice of FGM in Burkina Faso might be a global effort by the government and its development partners to make significant progress in the areas of employment, poverty reduction and literacy as well as a concerted effort to encourage repudiation of FGM and support for change by religious leaders.

In conclusion local activism should be illuminated local activism. People, practices, and ideas are fluid. They are able to respond to the changing worldviews around them. Forces of change within societies where female circumcision has traditionally been carried out have ignited this process to end FGM. Additionally, their shifting attitudes of African men and women towards these practices in Africa and among those of the African diaspora should be celebrated. Understanding local context is vitally important. Although, attempts to halt these practices in Africa are not new, globalization has brought this matter to the world's attention and stimulated intense international involvement in the issue. Today, national and international nongovernmental organizations (NGOs) and development agencies play active roles supporting programs initiated by women's groups. More recently, organizations have developed and supported community based behavior change strategies. Until recently, interventions were implemented without much attention to documenting how they work and evaluating their effects on knowledge, beliefs, attitudes, and behavior. My

thesis provides insights into the struggle of African people and their allies to empower women at the grassroots level to enact social transformation. The dialogue about women's rights and human rights that has begun within these communities has reached from local to national and transnational levels. Women are becoming agents of change in areas of their lives that are extremely personal. This action should be encouraged to end the practice of FGM in Burkina Faso.

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