DHS Analytical Studies 5

Female Genital Cutting in Guinea: Qualitative and Quantitative Research Strategies

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Female Genital Cutting in Guinea: Qualitative and Quantitative Research Strategies

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Preface

One of the most significant contributions of the MEASURE *DHS*+ program is the creation of an internationally comparable body of data on the demographic and health characteristics of populations in developing countries. The *DHS Analytical Studies* series and the *DHS Comparative Reports* series examine these data, focusing on specific topics. The principal objectives of both series are: to provide information for policy formulation at the international level, and to examine individual country results in an international context. Whereas *Comparative Reports* are primarily descriptive, *Analytical Studies* take a more analytical approach.

The *Analytical Studies* series comprises in-depth, focused studies on a variety of substantive topics. The studies are based on a variable number of data sets, depending on the topic under study. A range of methodologies is used, including multivariate statistical techniques.

It is anticipated that the *Analytical Studies* will enhance the understanding of significant issues in the fields of international population and health for analysts and policymakers.

Martin Vaessen
Project Director

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Executive Summary

This report presents the results of two studies of female genital cutting (FGC) carried out in Guinea in 1998 and 1999. Both studies collected data through individual interviews with women and men. The smaller, formative study used open-ended questions; the larger, descriptive study used a standard survey questionnaire. The formative research obtained the vocabulary and descriptive phrases commonly used to discuss FGC, individual accounts of the experience of female circumcision, and information about the social context of the practice. The DHS survey interviewed a nationally representative sample of women of reproductive age using a questionnaire with pre-coded answers to identify how certain variables are distributed among women in Guinea. Data from both studies were examined for evidence of how FGC is currently practiced in Guinea and for how the practice may be changing.

A comparison of the results showed many examples of corroboration and complementarity in the two studies. Areas of corroboration include the prevalence of FGC, the trend toward circumcising girls at younger ages, the increasing medicalization of FGC, and the overall social importance of the practice. Areas of complementarity include the use of women's descriptive phrases to formulate answers to questions in the DHS survey questionnaire, approaches to the social context, and consideration of the validity of certain variables in the survey data.

The results of both studies indicate that FGC is nearly universal in Guinea. The DHS survey showed that nearly all girls (99 percent) go through female circumcision. The formative study found that among Sosso, Fulani, and Maninka, all girls were expected to be circumcised. The only significant opposition to FGC was found among Guerze Christians in Forest Guinea.

Girls are being circumcised at younger ages than in the past, and they are spending less time in the period of seclusion and instruction that follows circumcision. The formative research found that many Sosso and Maninka women talked about how girls are being cut at younger ages and complained that this provides less opportunity for seclusion and instruction. A comparison of the data for mothers and daughters from the DHS survey also showed that girls are being cut at an earlier age. Among those who have been circumcised, 80 percent of daughters were cut by the age of nine, while only 52 percent of their mothers had been cut by that age.

There is a clear tendency toward medicalization of FGC in the data from both studies. Medicalization in this case means that FGC is done at home or in a health facility by health care personnel rather than by a traditional practitioner. Generally, it also means having a milder form of FGC performed. The DHS survey showed that for mothers who had at least one daughter circumcised, the daughter was three times as likely to have been cut by a nurse as the mother was. The survey also found that older women tended to have more radical cutting performed. In the formative research, women talked about how some mothers now take their daughters to a health facility so the operation can be performed under sanitary conditions.

Both approaches found that the practice of FGC forms part of the expectations of most individuals. In the open-ended discussions of the formative

research, women talked about circumcision as important for being pure, clean, and properly educated about behavior appropriate to a wife. Many women as well as some men mentioned the importance of circumcision in terms of parental responsibility: parents must educate a daughter, have her circumcised, and find her a husband. In the DHS survey, women and men were asked if they thought the practice should be continued. Two-thirds of the women and one-half of the men said that it should be continued.

Organizations and agencies planning campaigns against FGC in Guinea and elsewhere face several critical choices. First, they can seek to eradicate the practice, no matter what form it takes, or they can sanction the milder forms of FGC. Second, they can encourage changes in the practice, or look for ways to promote the changes that are already occurring or not consider them. Third, they can seek to create a dialogue with the population about past experience with FGC, or rely on public health messages about the dangers of the practice. Fourth, they can target specific subgroups of the population, or try to reach everyone. Programs concerned with FGC have to come to terms with these issues in planning their activities.

1 Introduction

Female genital cutting (FGC) is a common practice in many societies located north of the equator in sub-Saharan Africa. Nearly universal in a small number of countries, it is practiced by various ethnic groups in at least 25 African countries. In some societies, the procedure is routinely carried out when a girl is a few weeks or a few months old, while in others, it occurs later in childhood. In the case of the latter, FGC is typically part of a ritual initiation into womanhood that includes a period of seclusion and education about the rights and duties of a wife. It is often assumed that FGC "is an 'ancient' and deeply entrenched practice, that it is associated with initiation, with Islam, and with patriarchy" (Shell-Duncan and Hernlund, 2000:3). The same authors point out, however, that FGC is a recent practice in some societies; it is not always part of an initiation ritual; and much of the Islamic world does not observe the practice.

1.1 FGC Terminology

A number of terms have been used to refer to the practice of *female genital cutting,* among them *female circumcision, female genital mutilation,* and occasionally *female genital surgery*. Many people object to the use of the term *female circumcision*, which, they argue, mistakenly suggests that the practice is analogous to male circumcision. In the mid-1990s, the World Health Organization (WHO) and many other groups adopted the term *female genital mutilation*, which emphasizes the permanent physical damage done to the female genitalia. This is the term used by the majority of English speakers. Recently, researchers and interested parties have express concern that the term female genital mutilation "stigmatizes the practice to the detriment of the programs trying to change it" (USAID, 2000). The more neutral term, *female genital cutting*, is used in this report. French speakers generally use the term *excision*[1] for all types of FGC.

1.2 Objectives

Publications about FGC have generally focused on the prevalence of the practice, the types of FGC practiced, the possible medical consequences, and ways to discourage the practice. This report has a different focus: it uses two research approaches to examine FGC in a the context of a single country. The authors wanted to determine what could be learned about FGC by comparing results obtained with two different methods of data collection. The question was posed, would the results corroborate, complement, or contradict each other? One study drew mainly on open-ended interviews with individuals, a method referred to as "formative (or qualitative) research." The other study was a standard Demographic and Health Survey (DHS) that used questionnaires with precoded answers, a method referred to as "quantitative research." Both studies were carried out in the Republic of Guinea in West Africa from 1998 to 1999. Funding was provided by USAID while technical assistance was provided by ORC Macro.

1.3 Sources of Data

In this report the focus of investigation is the occurrence of FGC as an event in the lives of girls and women in Guinea. The two sources of data are

1) **Interviews with women from the four main ethnic groups.** More than 400 women responded to open-ended questions about FGC and coming of age in Guinea.

2) **Interviews with a nationally representative sample of women age 15-49.** A total of 6,753 women

[1] This report translates *excision* as female genital cutting except in cases of direct translation from the interviews, when the French nomenclature has been kept, or when the term *circumcision* appeared more appropriate.

responded to a structured questionnaire with precoded answers.

In the first case, women were invited to talk about the process of growing up in their family and community, the kinds of instruction (training, schooling) they had received, skills they had learned, their personal experience with initiation and FGC, and what they thought of the practice. In the latter case, women responded to questions in the FGC module included in the Women's Questionnaire that was used in the 1999 Guinea Demographic and Health Survey (DNS and MI, 2000).

Women's responses to open-ended questions provide accounts of past events from their own perspective. In the process of answering the questions, women can choose the terms and concepts that best describe their particular experience. The information obtained is the result of a dialogue between the interviewer and the respondent that varies from person to person. By asking open-ended questions and allowing respondents to rephrase or reject questions as they are asked, it is possible to identify the important elements in the social context surrounding FGC. The who, what, where, and when, of the event is recalled by women in their own words, thereby giving the researcher an insider's view of the phenomenon.

The Women's Questionnaire used in the Guinea DHS survey, is a standardized survey instrument designed for use in comparing survey results across countries. The structure of the questionnaire, the content of the questions, the manner in which the questions are asked, and the precoded answers are all standardized and formulated from the outside. The view presented by the findings, then, is necessarily an outside view. This approach provides national and regional data on the prevalence and distribution of FGC in the population, and differentials in selected variables associated with FGC.

Both approaches provide fundamental information about FGC in Guinea, and both approaches are used in this inquiry. By examining the two kinds of data collected on FGC, the authors believe it is possible to more accurately describe and/or explain: 1) the context in which FGC occurs, 2) the distribution of different types of FGC in the population, and 3) trends in the practice of FGC over time.

1.4 Inside and Outside Perspectives

Anthropologists commonly use the terms *emic* and *etic* to distinguish between the local perspective (a view from the inside) and the nonlocal perspective (a view from the outside). Thus, an emic view of an FGC initiation ritual would involve description and interpretation using local terms, concepts, and meanings. An etic view would use concepts from outside the society in the description and interpretation of data. In this report we use the terms *inside* and *outside* (within and without) to call attention to how the meaning of events is established and whether the terms and concepts invoked are locally relevant or are relevant mainly for researchers.

The inside/outside contrast is a relative concept that forms a continuum, with the accounts of events by participants situated at one end, and the accounts by outside researchers at the other end. Accounts of past events, like liquids, tend to take the shape of their container. Whether we use inside (local) or outside (social science) concepts to structure accounts is important, because our chosen concepts give events their particular form.

The responses produced by the questions in the formative research and those produced by the questionnaires in the DHS survey differ in two important respects that go beyond the simple dichotomy of inside and outside. First, the two approaches differ in the way the respondent's answers are recorded: formative research uses open-ended questions that produce responses in the form of sentences that are analyzed for content and meaning; a survey produces sentences that are turned into precoded answers to questions. Second, open-ended questions allow the respondent to reformulate questions that may be unclear or inappropriate to local knowledge. This allows respondents to correct the interviewer's questions and make

them more meaningful (more appropriate to local knowledge). While this flexibility is useful, it sacrifices the uniformity of how questions are asked and how answers are coded, thus making comparisons across populations more difficult.

1.5 Key Questions

Both inside and outside views of FGC are useful in exploring the two key questions in this analysis:

1) How is female genital cutting currently practiced in Guinea?

This question examines the social role of FGC in Guinean society today (in the context of the various types of FGC practiced) and the distribution of FGC in the population.

2) How have these practices changed over the past 20 to 30 years?

This question examines changes in the practice of FGC over time. It also examines how women and men perceive these changes and the social context in which families might choose not to have their daughters undergo the operation.

The authors also compare the formative research findings and the survey research findings. It was expected that there would be many similarities in the results obtained by the two approaches, but this was not certain at the outset. The authors wanted to determine to what extent the results corroborate, complement, or contradict each other. In fact, the comparison found many examples of corroboration and complementarity.

Given the controversial nature of FGC and the lack of documented information about FGC prevalence in Africa, this report begins with a summary of recent studies and commentary on FGC in African countries. It then outlines the background and assumptions associated with the two research strategies (formative research and survey research) used to provide the data for this study of FGC in Guinea.

The third section describes how FGC is currently being practiced in Guinea by the four main ethnic groups: the Sosso (Soussou); the Fulani (Peulh); the Maninka (Malinké); and the Kpèllè, or Guerze (Guerzé). It is based on women's accounts of events and their answers to questions about the various types of FGC practiced. Differences between age groups and ethnic groups are examined and there is a discussion of certain anomalies that were observed in the data.

The fourth section examines changes in the practice of FGC over time: changes in the age at which girls are circumcised, changes in the type of cutting involved, changes in the place where the operation is carried out, and changes in the instruments used for the operation. The authors consider possible explanations for these changes. The final section discusses ways in which the research results obtained by the two approaches are related.

2 Background

2.1 Studies of Female Genital Cutting

While descriptions and discussions of the practice of FGC have appeared in the literature for decades, research and policy interest in the practice did not develop until the publication of reports on the medical consequences of FGC. In a comprehensive review of FGC studies, Frances Althaus (1997) describes the awakening of interest in the practice of FGC in the 1970s and early 1980s in Africa, Europe, and North America and the changes in terminology reflecting that interest. As early as 1984, during a meeting of African women's groups in Dakar, the Inter-African Committee Against Harmful Traditional Practices (IAC) was formed to work against FGC in African countries. The Platform of the Fourth World Conference on Women in Beijing in 1995 declared that female genital mutilation was both a threat to women's reproductive health and a violation of their human rights.

The practice of female genital cutting is most common in a band of African countries from Mauritania and Guinea in the west to Somalia and Egypt in the east. It does not occur in or is extremely rare in the Arabic-speaking countries of North Africa—Algeria, Morocco, Libya, and Tunisia—although the practice does exist in Yemen and in some Muslim populations of Indonesia and Malaysia. While FGC is often associated with Islam, it is also practiced by a small number of Christian and Jewish groups.

The research questions that have guided studies of FGC have varied depending to the stance taken on FGC. That is, does the researcher regard the practice primarily as an affront to human dignity, or does the researcher see it as a social institution that has a function in the society? Studies that examine the various types of FGC typically focus on the negative medical consequences of the practice (Toubia, 1994). Ethnographic studies on the other hand describe how FGC is practiced in specific societies (Ahmadu, 2000; Droz, 2000; Leonard, 2000; Shell-Duncan et al., 2000). Efforts to obtain national-level figures for FGC prevalence derive from a need to determine the over all number of women affected (WHO, 1998). However, since the practice of FGC tends to follow ethnic rather than political lines, national boundaries are not particularly useful in understanding the distribution of FGC.

Few sources of national-level prevalence are available besides the DHS surveys, which include questions about FGC in the women's questionnaire. The FGC results from the first seven of these survey have been summarized by Dara Carr (1997).

Carla Obermeyer (1999) conducted an extensive study of the literature on FGC by reviewing 435 published sources from 1966 to 1996. Obermeyer evaluates the evidence for prevalence rates and for medical consequences and discusses the evidence for diminished sexual pleasure after the surgery. She found that "studies that systematically investigate the sexual feelings of women and men in societies where genital surgeries are found are rare, and the scant information that is available calls into question the assertion that female genital surgeries are fundamentally antithetical to women's sexuality and incompatible with sexual enjoyment" (1999:95). Obermeyer stresses the need for studies that combine objective measures of the practice with subjective judgments from participants in the practice to better understand the complex forces that account for the persistence or decline of FGC.

The most comprehensive and insightful publication on FGC to date is a collection of studies edited by Shell-Duncan and Hernlund (2000), *Female circumcision in Africa: Culture, controversy, and change.* The introduction to the book reviews the history of FGC, summarizes the current debates, provides critiques of the literature, and reflects on efforts to end the practice in African countries. Several of the chapters call into question widely held assumptions about FGC in Africa.

2.2 Prevalence of FGC by Country

Although the practice of FGC has been known to researchers for a long time, reliable national-level data on the practice have been hard to obtain. Most reports in English or French are limited in scope and take the form of personal narratives, anecdotes, or research limited to a small region of a country. Until the 1990s, reliable survey data on the prevalence of FGC was available only for Sudan (Carr, 1997; Toubia, 1994). Writers seeking to determine the total number of women circumcised had to rely on national estimates based on uncertain sources.

In 1998, the Family and Reproductive Health Division of WHO published its official position on FGC in *Female genital mutilation: An overview.* The document was written for WHO by N. Toubia and S. Izett of Research, Action, and Information Network for Bodily Integrity of Women (RAINBOW). The book provides a brief overview of efforts to obtain accurate figures for FGC prevalence in African countries, and a summary of the health consequences and national and international policies and agreements related to FGC. Included in the chapter on prevalence is a table with national prevalence rates for 28 countries along with the population estimate for the female population; from this the total number of women affected by FGC in each country can be calculated (1998:11). The text explains how FGC prevalence rates were obtained for each country; the sources include a few large-scale national surveys, regional studies, statements by activist groups, anecdotal evidence, and figures from the first country-specific estimates of prevalence published (Hosken, 1982).

Little reliable information on the prevalence of FGC at the national level was available before 1990. That picture has shifted as DHS surveys have been carried out in an increasing number of African countries. Toward the end of the 1980s, the Demographic and Health Surveys included a module on4 "female circumcision" in the questionnaire for the DHS survey in northern Sudan. As part of a series of questions about women's health, women were asked whether they had ever been circumcised. This series of questions evolved into an FGC module that has been used in 11 African countries[2] including the Republic of Guinea.

The FGC results from DHS surveys conducted from 1991 through 1996 were summarized and placed in the wider context of FGC studies by Dara Carr (1997). The report included data from the Central African Republic (CAR), Côte d'Ivoire, Egypt, Eritrea, Mali, northern Sudan, and Yemen. This plus data from subsequent DHS surveys, has provided support for two critical points: 1) FGC varies from 90 percent to 99 percent in a small number of countries in northern Africa, and 2) the prevalence of FGC in other African countries varies with ethnicity. For example, in CAR the overall prevalence rate is 43 percent; however, the rate varies from 3 percent to 84 percent according to ethnicity. Among the Banda the rate is 84 percent; among the Gbaya it is 32 percent; and among four other groups the rate is less than 6 percent. As Ellen Gruenbaum (2001) has pointed out, female circumcision often serves as a marker for ethnic identity.

Recognition of the association between ethnicity and FGC prevalence has implications for data collection, data analysis, and program planning in women's health. Table 1 shows the DHS surveys that have incorporated some form of the FGC module in their questionnaire.

[2] Burkina Faso, the Central African Republic, Côte d'Ivoire, Egypt, Eritrea, Guinea, Kenya, Mali, Niger, northern Sudan, and Tanzania.

Table 1 National-level prevalence of FGC in DHS survey countries, 1989-1999

Country	Year of survey	Sample size	Prevalence of FGC (%)
Guinea	1999	6,753	99
Egypt	1996	14,779	97
Mali	1995-96	9,704	94
Eritrea	1995	5,054	90
Northern Sudan	1989-90	5,860	89
Burkina Faso	1998-99	6,445	72
Cote d'Ivoire	1998	3,040	45
Central African Republic	1994-95	5,884	43
Kenya	1998	7,881	38
Nigeria	1999	8,206	25
Tanzania	1996	8,120	18
Niger	1998	7,577	5

The high prevalence rates of the top five countries indicate that most people live in social contexts in which almost every girl is circumcised. Prevalence is not 100 percent, however, because of differentials between ethnic groups. It is possible to describe three distinct social contexts that can apply to girls in these African countries:

FGC context—Nearly every girl undergoes genital cutting at a very young age or as part of an initiation process later in childhood.

Non-FGC context—Girls are prepared for marriage without any genital cutting.

Mixed FGC/Non-FGC context—Different ethnic groups are mixed together, and some girls undergo genital cutting while others do not. Interaction of this type typically occurs in cities.

Efforts to promote the discussion of FGC in particular regions will need to take into consideration which of the three social contexts applies. Guinea, the subject of this study, falls in the first category.

In her review of FGC prevalence statistics in Africa and a survey conducted in Togo, Thérèse Locoh (1998) stresses the importance of ethnicity in determining the FGC prevalence. Although the national rate for FGC in Togo is 12 percent, according to the national survey conducted in 1996, prevalence varies by ethnicity from just over 0 percent to 98 percent.

2.3 The Context of FGC in Guinea

The Republic of Guinea is located on the west coast of Africa, north of Sierra Leone and south of Senegal and Guinea-Bissau; its borders also touch Côte d'Ivoire, Liberia, and Mali. The history and geography of the country have combined to create a complex mosaic of diverse ethnic groups (Devey, 1997). However, there are three large, relatively homogeneous groups: the Sosso (speaking Sosso), the Fulani (speaking Fulfulde), and the Malinké, or Maninka (speaking Maninka). The Sosso predominate in Lower Guinea, the Fulani in Middle Guinea, and the Maninka in Upper Guinea. Forest Guinea is populated by more than ten ethnic groups, including many Maninka and Fulani. The largest groups in the Forest Guinea are the Guerze (or Kpèllè), the Kissi, and the Toma. These four regions of Guinea are known as "natural regions," each being characterized by a distinct ecology and specific ethnolinguistic groups.

FGC has been common in the Republic of Guinea for several generations at least and perhaps much longer. Both Muslim and Christian populations practice genital cutting in Guinea, although some Christian groups in Forest Guinea oppose the practice. It is not known when the various ethnic groups adopted the practice. Simon Ottenberg—an anthropologist specializing in the art and religion of the Limba people in northern Sierra Leone on the Guinean border—reports that the Limba in the far north of Sierra Leone did not begin practicing FGC until the reign of Chief Alymamy Fana in Bafodea at the beginning of the 20th century (1994:364). For the Limba, FGC began as part of the formation of secret societies for women. Since we know

that southern Guinea and northern Sierra Leone were settled by peoples arriving from the north, it seems likely that the practice of FGC reached Guinea before the beginning of the 20th century.

Relatively few accounts of female genital cutting in Guinea are available in the ethnographic literature. Monique and Robert Gessain spent time in Guinea between 1946 and 1955 conducting research in Coniagui and Bassari villages in the northwestern corner of Guinea. Monique Gessain (1960) reports that in the 1950s, the Coniagui occupied about 80 villages, and they circumcised girls at about 18 years of age. Although she does not provide details about how the circumcision was done, Gessain does say that the period of seclusion lasted several weeks. She says further that the time between circumcision and marriage is a happy time for Coniagui women because they are freer to travel to other villages and have amorous adventures.

Michael Jackson, who did extensive ethnographic fieldwork in the 1970s among the Kuranko of Sierra Leone, describes what he observed as villages prepared for the annual circumcision of girls (1977). Kuranko and Kissi live in both Sierra Leone and Guinea, and are similar in ritual practice to the Maninka.

Therefore, what happened in the 1970s just across the border will likely resemble what occurred during that time among many of the populations of the Forest area of Guinea (Kuranko, Kissi, Toma).

At that time, circumcision was done in January, after the rice was harvested and work in the fields was minimal. Jackson does not describe what kind of excision was done. Rather, he writes at length about the preparatory dances, the formal announcements of the date, the tension of the day just before the cutting, the measures taken to protect the girls against sorcery, the period of three weeks or so of seclusion, and the day of coming out when the girls receive gifts from their fiancé. They then travel around visiting relatives for some months before joining their husband.

In her book on Kissi society (Forest region) based on fieldwork in the late 1940s, Denise Paulme states that the Kissi circumcise their girls at 12 to 18 years of age and that the seclusion period varies from several weeks to several months. She describes the period of weeks or months just before the initiation as a time of romantic adventures for these girls already promised to a man. She reports that everyone told her that "Before the initiation, if a girl is very talkative, lies around a lot, or even refuses to pound rice (grain) for her mother, we don't think too much of it. Once she is married, however (marriage usually follows circumcision initiation very closely), she has to respond quickly if her husband or her mother-in-law calls"[3] (1954:169).

All three of these authors (Gessain, Jackson, and Paulme) describe the activities surrounding FGC as imbued with meaning and cultural importance, with rites that prepare a girl for marriage taking place soon after the event. Writing from observations made 30 to 50 years ago, they describe the time just before or just after seclusion as a period of adventure for young girls.

In his 1971 study of political and social change in Guinea, Claude Rivière, who taught sociology in Conakry from 1964 to 1968, devotes a chapter to the status of women in Guinea (Rivière, 1971). He describes FGC as a rite of passage that establishes femininity, gives girls the rights that women hold, and marks them as ready for marriage. Rivière includes a brief description of how the Kissi circumcise their daughters, noting that the Toma and Maninka proceed in much the same manner. In the 1960s the Kissi would circumcise girls in groups, with the girls remaining in seclusion for two weeks. The actual cutting was done by a specialist assisted by several nurses. Whereas during the first week the girls rested and recovered, the second week was devoted to learning songs and dances and to instruction about how to be a good wife and mother. The songs and dances were performed when the girls emerged from seclusion and the villages began several days of celebration with food, music, and dance.

Rivière does not provide information about the age of circumcision or exactly what kind of cutting occurred for the Kissi. He simply states that throughout the country, nearly everyone is circumcised, that the age varies from 6 to 14 years, and that the clitoris is removed with or without the labia minora. He also mentions that about 15 years earlier, in the 1950s, there was a movement in parts of Guinea, especially among the Kissi and the Sosso, against radical cutting. Those doing the cutting were accused of mutilating and sterilizing girls. There is no indication who directed this campaign or how it affected the practice of FGC.

The government of Guinea condemned the practice of FGC indirectly more than 30 years ago. In 1969, Article 265 of the penal code was adopted. It explicitly forbade mutilation of the genital organs of both men (*la castration*) and women (*excision*), making the crime punishable by imprisonment for life. However, no one has ever been indicted for this crime. In 1984, a group of volunteers founded an organization called *Cellule de coordination sur les pratiques traditionelles affectant la santé des femmes et des enfants* (CPTAFE) to combat FGC. CPTAFE is the Guinean branch of the Inter-African Committee on Traditional

[3] Translation by Yoder, from the text "Avant l'initiation, que la fille traîne, bavarde, refuse d'écraser le grain pour sa mère, on n'y attache pas d'importance; une fois mariée, (et le mariage suit normalement l'initiation de très près), elle devra se dépêcher si son mari ou sa belle-mère l'appelle."

Practices Affecting the Health of Women and Children, a nongovernmental organization founded in Dakar in 1984. CPTAFE has produced several videos and a play for the public and continues to develop messages for broadcast on Guinean radio and television. CPTAFE sought an official and direct condemnation of FGC from the government; the government followed their recommendation in 1989. In 1999, there were further discussions in Parliament about the need to strengthen laws against FGC.

Until recently, the only sources of information about FGC in Guinea were ethnographic accounts and reports from CPTAFE based on anecdotal information. The 1998 WHO report gave a prevalence rate of 60 percent for Guinea. The findings from the two studies presented here provide a more accurate picture of current FGC practices in Guinea.

2.4 DHS Formative Research

Goals and Objectives

The formative study of female genital cutting in Guinea was undertaken for two main reasons: 1) to help formulate the FGC questions included in the questionnaire for the 1999 DHS survey in Guinea; and 2) to refine the strategy and methodology used to investigate the subject of FGC. Information was needed on the social context of FGC in Guinea, on the events associated with coming of age among girls, and on the practice of FGC itself. The researchers sought to find out how FGC is situated in the social context of young girls, to what extent women are able to recall and relate their personal experience with FGC, how women and men perceive FGC, and how FGC is practiced today.

Although the overall objective was improving the quality of data obtained from DHS surveys, the most immediate objective was to obtain precise information on women's experience with FGC in Guinea. The study set out to explore the events that mark the preparation for marriage and adulthood among young girls in Guinea. Although it was assumed that FGC would often be included in these events, the researchers sought to find out how the respondents themselves viewed FGC in the context of the coming-of-age process and preparation for marriage. The study sought to understand women's experience with FGC through their own words.

Training and Fieldwork

As preparation for the study, 11 interviewers and 2 supervisors participated in a 10-day workshop on the principles of qualitative research, the logic underlying this study, and the best way to ask questions in the four main languages of Guinea. Since it was assumed that there would be differences between the major ethnic groups in the practice of FGC and that language served as a marker for ethnicity, research was done in the four languages. Guides for the individual interviews with women and with men were developed in each of the languages during the training and printed for use in the interviews. The interview questions were general, such as the following: "What kind of household tasks did you learn to do at home? What kind of initiation did you go through? What kinds of instruction (schooling) were you given?"

After completing the training, two research teams were formed composed of a supervisor and four interviewers (three females and one male) to conduct interviews in the four languages: one team for Sosso and Fulfulde, the other for Maninka and Guerze. Each team spent two weeks collecting data at each of the regional field sites. In each of the four regions (Lower, Middle, Upper, and Forest Guinea), one week was spent in an urban center, and a second week was spent in a rural village. Sites were selected that were readily accessible by vehicle, had relatively homogeneous populations, and had demographic characteristics common to the ethnic group in question. The Sosso and Maninka interviews were conducted at the end of November and the beginning of December 1998; the Fulfulde and Guerze interviews were conducted in January 1999.

The methods used to collect data on FGC included the following: individual interviews with married and unmarried women and married men; facilitated group discussions with women and men; and interviews with traditional and clinical practitioners of FGC. The individual interviews with women were the main focus of the study because the researchers were seeking firsthand accounts of experience with FGC in the context of growing up. The individual interviews with men discussed education, the process of finding a wife, the image of an ideal spouse, and opinions on female circumcision. The group discussions focused on opinions about the practice of FGC in general. All of the interviews and discussions were recorded and then analyzed by the researchers in Guinea.

A total of 422 women and 76 men were interviewed, as well as 22 women considered specialists in FGC—traditional circumcisers (*exciseuses*), traditional birth attendants (*matrones*), and nurses and midwives. Group discussions were held with 16 groups of men and women. The interviewers and the supervisors carried out the first part of the analysis when they returned from the field.

2.5 DHS Survey

From May through July 1999, the National Statistics Office (Direction Nationale de la Statistique) directed a national survey of a representative sample of households in Guinea, with technical assistance provided by Macro International Inc. The sample was chosen using the enumeration areas (EAs) from the 1996 census with the country divided into five geographic regions: the capital city Conakry, Lower Guinea, Middle Guinea, Upper Guinea, and Forest Guinea. The sample was stratified, weighted, and representative at the national and regional levels. Households were chosen in two stages: first, 293 enumeration areas (clusters) were systematically chosen with a probability proportional to the number of households in each EA, and second, from 10 to 40 households were randomly chosen from the list of households in each EA. A sample of 6,753 women age 15 to 49 and 1,980 men age 15 to 59 were interviewed individually using a questionnaire with precoded answers (DNS and MI, 2000).

The women's questionnaire was the DHS Model B questionnaire designed for use in countries with low contraceptive prevalence. Three weeks of training for interviewers were devoted to the use of the questionnaire in French augmented by discussions in the languages spoken by most of the population: Sosso, Fulfulde, Maninka, and Guerze. The interviewers participated in exercises to learn how to ask questions in these languages, although the actual questions and answers to be coded remained in French. Other languages used in interviewing were French, Kissi, and Toma.

Included in the questionnaire was the DHS module for FGC, a series of questions about female genital cutting. Women were asked whether they had heard of *excision,* then they were asked if they had been circumcised, at what age, what do they call the circumcision done to them, and who performed the operation. For women who had at least one living daughter, parallel questions were asked about the experience with FGC of the daughter most recently circumcised. Men were asked whether their wife had been circumcised and several questions about the benefits and drawbacks of the practice for girls. The complete report on the findings of the 1999 DHS survey in Guinea was published in May 2000 (DNS and MI, 2000).

It has been difficult to use survey questions to identify the types of operations carried out during female circumcision. The types of FGC vary from a simple pricking of the clitoris to removal of all the external female genitalia and almost complete closure of the vaginal area (infibulation). The World Health Organization describes FGC as comprising "all procedures that involve partial or total removal of female external genitalia and/or injury to the female genital organs for cultural or any other nontherapeutic reason" (WHO, 1998:6). Based on the recommendations of Dr. Nahid Toubia (1994), WHO has classified the practice into the following four types:

- Total or partial removal of the clitoris (clitoridectomy)

- Removal of the clitoris and part of the labia minora (excision)
- Removal of the clitoris, the labia minora, and the labia majora, with stitches closing the vaginal opening (infibulation)
- Any variant of the above.

Before the DHS formative research began, it was not known if the WHO typology would be relevant or useful in the Guinean context. The formative study found that women use descriptive phrases in all the major languages to identify four kinds of genital cutting carried out during circumcision. The descriptive phrases were printed in each of the languages as possible answers to the question about what had been done during circumcision. The four types of genital cutting defined by the formative study are actually more precise than the WHO types, and thus provide more detailed information.

With the exception of the question and answers noted above, the French-language questionnaire used for the DHS survey in Guinea drew on concepts and concerns stemming from the efforts of researchers to understand why the practice of FGC continues to exist. Whereas the formative research focused on understanding FGC from the inside, as a social event or cultural practice, the DHS survey sought to sample the opinions of the entire population as to how and why they thought the practice continued to exist. The FGC module in the survey questionnaire included questions about the advantages and disadvantages of the practice of FGC and whether the respondent's religion supported the practice. Unfortunately, the problem with such questions is that they may ask respondents to reflect on FGC in ways entirely new to them.

The authors have always assumed that both formative (qualitative) and survey (quantitative) approaches are essential for a better understanding of many phenomena. The two approaches answer different questions but often complement each other. After a presentation of the findings from the two studies in the next section, we will return to the issues of corroboration, complementarity, and contradiction.

3 Current Practices in Guinea

3.1 Social Context of Female Genital Cutting

The ethnographic accounts noted earlier paint a picture of circumcision as a ritual initiation through which all girls pass in order to become a woman ready for marriage. Both the Coniagui and Kuranko/Kissi examples of FGC indicate that girls in the 1950s and 1960s were being cut when they were 15 to 18 years of age, and went to join their husband soon thereafter. The observers also noted that girls enjoyed a period of relative freedom just before or just after circumcision.

The accounts women gave of their own circumcision in the formative research did not present such a rich image of social activities. Most of the women were much younger when they were cut, too young for adventures of that kind. They spoke, rather, of the cutting followed by a period of seclusion of several weeks during which they learned about their duties and responsibilities to their future husband and family members. The person in charge of the cutting, who cared for their wounds—holder of the title of *sema*, or *seema,* in Maninka, Fulfulde, and Sosso—was in charge of their teaching.

In the minds of the women interviewed in Guinea, circumcision is an obligatory rite of passage for becoming an adult. The event of genital cutting, followed by a period of seclusion, still establishes a liminal (transitional) space and time for the initiated, who have new rights and privileges when they emerge from that space. In the open-ended interviews, the women used the terms for uninitiated and the initiated when explaining the passage from one status to another. In Maninka, for example, this constitutes a passage from being *solima* (uninitiated) to being *sunkudun* (initiated).

The questionnaire used in the DHS survey asked women what the benefits or advantages of FGC were for girls. The majority of women (65 percent) said it was to obtain social approval. This is not surprising since nearly all girls live in a social context where they go through the procedure as part of growing up. The percentages giving that answer varied by ethnicity: Guerze (85 percent), Fulani (69 percent), Sosso (67 percent), and Maninka (53 percent).

Women's accounts, as well as the ethnographic descriptions, show the circumcision rituals as organized and directed by female relatives of the girls involved, generally mothers, aunts, or grandmothers. A small number of women spoke of family pressure to have their daughters circumcised. Men interviewed in the formative study said that FGC was the business of women, but that they would provide money to pay expenses incurred during the event.

In both individual and group interviews of the formative study, women stressed the importance of the period of seclusion after the actual operation as critical to a girl's education. A young married Maninka woman said

> *A girl never forgets what she has learned on the mat[4] her whole life long; she learns to be a wife and run a household.*

A facilitator for a group discussion with older Guerze women summarized their opinions in this way:

[4] "On the mat" refers to the period of time girls remain in seclusion. Girls spend time sitting on a woven mat on the ground.

For most women, excision is an event through which girls are educated, where they learn to respect others in their society. A circumcised woman is respected by the whole society. For these reasons we cannot abandon the practice. The circumcision camp is a learning and moral training center.

The women commenting on FGC as a social event implied that FGC is a normal event in a young girl's life. They rarely mentioned the possible dangers associated with the practice. Benefits for the girls were stated in terms of achievement of social status and assurance of eligibility for marriage. The anthropologist Melissa Parker, after seeing her first circumcision in northern Sudan, noted that everyone appeared calm and fairly relaxed, suggesting it was just a normal event (1995).

In a setting where it is considered clean (and correct) to circumcise a daughter, there is little scope for alternative behavior. Many Sosso and Fulani women talked about the importance of rendering their daughters clean and pure through circumcision (Yoder et al., 1999). In fact, in most social contexts in Guinea, all women are circumcised, so the question of whether or not to circumcise a daughter is rarely considered.

3.2 Women's Accounts of Genital Cutting

Individual interviews with more than 400 women (using the formative questioning guide) suggested that most women in Guinea are circumcised. All the Sosso and Fulani women interviewed had been circumcised, only three of the Maninka were not circumcised, and 77 of 100 Guerze had been circumcised. The DHS survey found that 99 percent of the sample had been circumcised, with very little variation by region, ethnic group, or urban-rural residence. Thus, FGC in Guinea is nearly universal.

The authors expected to find differences in how FGC is performed according to ethnicity since FGC often serves as a marker for ethnicity. Comparison of ethnic groups in Guinea can present some problems, however, because ethnicity, while usually ascribed by birth, may in some cases be chosen. Currently in Guinea, Fulani identity may offer social or political advantages in some contexts, making it more likely that children of mixed marriages choose a Fulani identity.

Although female circumcision is nearly universal in Guinea, a small proportion of women of the Guerze population from Forest Guinea are not circumcised. Our interviews with women from N'Zérékoré and Guékédou suggested that these may be members of Christian churches. Data from the DHS survey show that 89 percent of Guerze women in Forest Guinea have undergone genital cutting. Of the uncircumcised Guerze women, more than half were Christian.

In the formative research, female interviewers used questioning guides to encourage women to talk about their experiences growing up: what they learned at home, what they learned at school or other centers outside the home, from whom they learned, and what experiences had particularly marked them before they reached their teens. They were also asked to describe the initiation rites in which they had participated. For most women, that included some form of FGC. They talked about the types of FGC with which they were familiar, and many could recall exactly how the procedure was performed on them.

The researchers found that in each of the major languages, at least six or seven terms or expressions for FGC were common knowledge. These terms were euphemisms or descriptions of genital cutting. Some terms were actually slang used by young people; other terms were used by everyone.

From these descriptions, the team of interviewers identified four types of genital cutting known to the women interviewed in the main regions of the country. In Forest Guinea, where the prevalence of FGC is lowest, women could name only one form of FGC in the Guerze language: *gëlëè tëghaa,* which involves

the total removal of the clitoris and the labia minora. Some women, however, described having a less radical form of FGC performed on them in a clinic. Maninka women (Upper Guinea) spoke of total removal of the clitoris and the labia minora, which they call *sunna,* and of partial removal of the clitoris. The types of genital cutting familiar to women in Guinea are described as follows in the major language groups:

Sosso

The total removal of the clitoris and labia minora is called *akaba iya fikhè,* which means "to remove or render clean." The older women were unanimous in claiming that this was the most common practice in former times and that its perpetuation was due to the spread of Islam, some principles of which had contributed to reinforcing the practice. These women considered this form of FGC to be *sunna*, that is, a parental obligation. As an old Sosso woman stated,

> *Excision is done sunna fashion; that is, the clitoris and the labia minora are removed so that the girl is clean; otherwise, she would be the laughing stock of her friends. If you hear it's sunna, that means it's done right.*

Sometimes only a part of the clitoris is excised, a procedure called *n'dekhabara* which means "to remove a part."

The Sosso women identified a third type of FGC called *ama khono,* which means "to wound." Interview data do not provide information on the frequency of this procedure, which consists of grasping the clitoris or foreskin with forceps and making a small incision to allow a little blood flow. Several women talked about the importance of seeing blood flow. This type is usually performed in clinics by midwives or matrones. The principal of a high school described her daughters' FGC as follows:

> *I had excision done for my two daughters so their friends wouldn't make fun of them. In fact, I told the matrone to just pretend to do the excision, but to prick the tip of the clitoris so that my aunt, who absolutely wanted them circumcised, could see a little bleeding, and that's how it was done. My girls spent only ten days on the excision mat.*

Fulfulde

There are two Fulfulde expressions to indicate total removal of the clitoris and labia minora: *itta haa laabha poye* (to remove everything cleanly) and *itta fow haa laabha* (to remove everything, including the labia minora). The term *itta seedha* (remove a bit) indicates partial excision of the clitoris. Pinching and nicking is called *barmina fi nyinbintingol,* meaning "to wound without removing, to symbolically excise."

Maninka

To describe the total removal of the clitoris and the labia minora, the women interviewed simply used the word *sunna,* which has religious implications. They said this is the way to make the girl clean and pure. As one older woman from Bökörö said, "*Sunna* makes the girl pure and proud. If she does not go through *sunna,* she cannot hold her head high in front of her friends." These women said it was the most common type of FGC in their region.

However, partial removal of the clitoris is also sometimes performed, a procedure the women called *landala télen* or *ka donin té ala,* which means to cut a bit. Most of the women recognized this form but said it was not common in their region. They also thought this was the type of FGC performed in health clinics.

Guerze

Although the Guerze-speaking women cited only *gëlëè tëghaa* (total removal of the clitoris and the labia minora) in their language, when speaking of their personal experience with FGC, a few said they take their daughters to clinics and request partial rather than total excision.

Overview of Women's Accounts of Genital Cutting

Overall, it was possible to gather from the interviews what women commonly recognize as the types of FGC performed in their region: the Guerze speakers cited one type, the Maninka speakers cited two types, and the Fulfulde and Sosso speakers cited four types. In each language, one of the forms of FGC was described as *sunna*, meaning that that form is part of the parental obligation toward a daughter.

These descriptions of FGC obtained from the formative study were used in the precoded answers to the question in the DHS survey about what had been done to the women (and their daughters). The results defined the distribution of the types of FGC recognized by women in Guinea, types that are slightly different from the WHO terminology.

Infibulation was cited only once in the interviews. A Fulani woman talked of *notugol,* which the interviewer translated into French as *accoler* and defined as the joining of the labia. Without knowing to what extent this practice exists in Guinea, the fact that it was mentioned only once suggests it is not common. In the survey, infibulation was not precoded as an answer. Those who might have given that answer were placed in the "other" category, which included only 6 of the 6,656 women (see Table 2)

3.3 Types of FGC and their Distribution

The Sosso and Fulfulde women spoke of four ways that genital cutting is done, while Maninka and Guerze women spoke of only one or two ways. FGC in Guinea thus takes the following forms:

- Pinching and nicking
- Partial removal of the clitoris
- Total removal of the clitoris
- Total removal of the clitoris and the labia minora

The four types of circumcision known to women in Guinea can be ranked according to the severity of the cutting, from the superficial cutting (pinching and nicking) to the most severe type (removal of the clitoris and labia minor). Drawing on the DHS survey data, Table 2 shows the distribution of these types and the percentage of women who were not circumcised. Very few women had the superficial (symbolic) cutting, and only 1 percent had never been circumcised. Half of the women had what in the context of Guinea is the radical (most severe) form of circumcision.

Table 2 Percent distribution of women by type of circumcision, Guinea DHS survey 1999

Type of circumcision	Number	Percent
Not circumcised	91	1
Superficial cutting	113	2
Partial removal of clitoris	1,222	18
Complete removal of clitoris	1,883	28
Removal of clitoris and labia minora	3,388	50
Other	6	0
Missing	51	1
Total	6,753	100

The large proportion of women with complete removal of the clitoris and labia minora (50 percent) raises the question of whether women who had the most severe form of cutting are different from those who had a less severe form (48 percent) and whether the 91 women who were not circumcised are different from the other women. Almost two-thirds of those who were not circumcised belonged to the Guerze ethnic group, which makes up only 7 percent of the total population.

3.4 Factors Associated with Type of FGC

Research on circumcision often compares women's circumcision status with their background characteristics. A woman's ethnicity, age, level of education, and residence (urban-rural) have been presented as determinants of her circumcision status (Carr, 1997; Locoh, 1998). This correlation needs to be examined carefully to determine whether specific background variables are relevant to a woman's situation at the time her circumcision status is being established. Cohort and ethnicity do not change over a woman's lifetime, so associations can be tested between the type of circumcision and the circumcised girl's characteristics. Level of education and residence, however, may change after a woman has been circumcised and are thus less likely to affect circumcision.

In the following analysis, the respondent's type of circumcision is compared with variables that are either consistent over her lifetime or are her mother's background characteristics. Currently, 80 percent of circumcisions in Guinea take place when girls are age 9 and younger. Therefore, the sociodemographic data collected in the DHS survey for women age 15 to 49 are not directly applicable to the woman's situation at the time she was circumcised. The women and men interviewed in the formative study reported that a girl's mother and female relatives usually decide on the type of circumcision for the daughter. Thus, the characteristics of the mother and female relatives, as well as the characteristics of the girl, are potentially associated with the decision.

The authors have hypothesized that different types of circumcision are related to differences in ethnicity. Table 3 shows the distribution of circumcision types according to ethnicity, based on data from the DHS survey. The distribution supports the argument that the practice of circumcision varies by ethnicity. Although the numbers are small for the Guerze, it appears that they were more likely to have superficial nicking or pinching than the other groups. Almost 40 percent of the Maninka had partial removal of the clitoris, whereas less than 13 percent of women in the other ethnic groups had this type of circumcision.

The Sosso were more likely to have complete removal of the clitoris (55 percent), while the other ethnic groups were more likely to have the radical type of circumcision—complete removal of the clitoris and the labia minora. More than 70 percent of the Kissi, Toma, and Guerze respondents had both the clitoris and labia minora removed, compared with less than 51 percent among the Sosso, Fulani, and Maninka.

Table 3 Percent distribution of women by circumcision type, according to ethnicity, Guinea DHS survey 1999

Ethnic group	Not circumcised	Superficial cutting	Partial removal of clitoris	Complete removal of clitoris	Removal of clitoris and labia minora	Other/ missing	Total	Number
Sosso	0	1	10	55	33	0	100.0	1,336
Fulani	0	1	12	35	50	15	100.0	2,427
Maninka	1	2	39	11	47	1	100.0	1,875
Guerze	11	6	6	4	72	3	100.0	492
Toma	1	0	6	3	88	1	100.0	174
Kissi	0	1	5	8	85	20	100.0	340
Other	12	2	9	29	48	1	100.0	109
Total	1	2	18	28	50	4	100.0	6,753

Ethnicity and religion are correlated in Guinea. Ninety-nine percent of the Sosso, Fulani, and Maninka in the DHS survey reported they were Muslim, while 80 percent of the Kissi were Christian, and the Guerze and Toma were Christian, animist, or reported no religion. Thus, for the three major ethnic groups (Sosso, Fulani, and Maninka), religion cannot be used as a determinant of circumcision type. The DHS data do indicate, however, that among circumcised women, 45 percent of Muslims have had a radical circumcision compared with 86 percent of Christians and 83 percent of women with other religions.

When examining the relationship between education and FGC, researchers have argued that a girl's education is a proxy for the wealth of the family, which might affect the decisions surrounding a circumcision (Carr, 1997). In families of higher socioeconomic status, women might be more exposed to Western ideas through mass media. Also, these women might be more educated, which again might result in more exposure to Western ideas and less to traditional practices. Since the mother and close relatives of the girl being circumcised usually make the decision about the type of genital cutting the girl receives, the mothers' characteristics may be a better indicator of the type of FGC chosen than the girl's characteristics.

In the DHS survey, women who had circumcised daughters were asked about the circumstances surrounding the event. Information was only collected on the daughter who was most recently circumcised. If we assume that the mother's education acts as a proxy for whether the mother has control over the decision to have her daughter circumcised, we can test the association between mother's education and daughter's circumcision type. The association assumes that women who are more educated will be more likely to have heard of the negative effects of radical circumcisions and might therefore be more likely to choose less radical forms of FGC for their daughters.

The data show that the daughters of educated women are slightly more likely to have received the less severe forms of circumcision (superficial cutting or partial removal of the clitoris) compared with the daughters of uneducated women (see Table 4). Women with no education were more likely to choose the radical type of circumcision for their daughter (removal of the clitoris and the labia minora). This finding suggests that more educated women may have a better understanding of the potential health hazards of circumcision and are less likely to select it for their daughter.

Table 4 Percent distribution of respondents' daughters by circumcision type, according to respondent's education and exposure to radio, Guinea DHS survey 1999

Background characteristic	Superficial cutting	Partial removal of clitoris	Complete removal of clitoris	Removal of clitoris and labia minora	Other/ missing	Total	Number
No education	4	27	28	40	1	100.0	1,995
Some education	9	40	23	27	1	100.0	310
Total	5	29	27	38	1	100.0	2,305
Infrequent radio	4	27	28	41	1	100.0	1,732
Daily radio exposure	7	36	27	29	1	100.0	555
Total	5	29	27	38	1	100.0	2,287

Note: A total of 18 respondents were missing data on exposure to radio.

Similar to the effect of education, regular exposure to mass media (which potentially includes public health announcements against FGC) may influence a woman's decision regarding her daughter's circumcision. Table 4 shows that the daughters of women who had daily exposure to radio were more likely to have received a less severe type of circumcision while daughters of women who had infrequent exposure to radio were more likely to have received a radical circumcision.

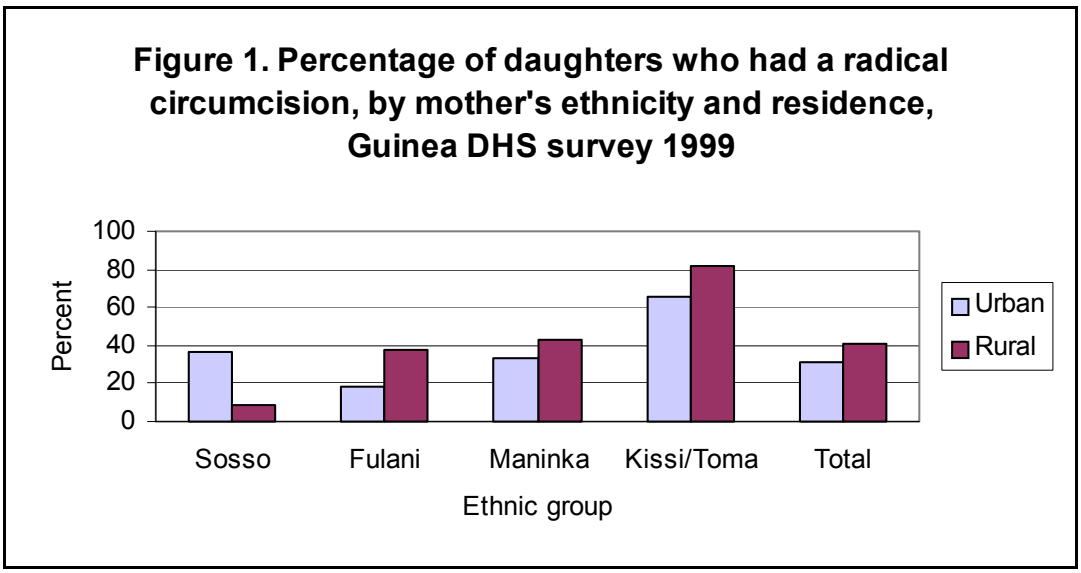
A woman's place residence appears to be associated with her daughter's type of circumcision (see Table 5). Urban women were more likely to have a daughter with a moderate (less severe) type of circumcision, while rural women were more likely to have a daughter with a radical circumcision. This trend is similar to the trend seen for mother's education in Table 4. Women in urban areas are also more likely to have some education than women in rural areas.

Among urban women, there is a notable difference in the type of circumcision a daughter receives based on whether her family lives in Conakry or in some other urban area. Women in Conakry were less likely to have complete removal of the clitoris and were more likely to have partial removal of the clitoris or superficial cutting. Conakry receives more outside influences than other urban areas in Guinea. Also, women in Conakry tend to have fewer ties to their extended families than women in rural areas do.

Table 5 Percent distribution of respondents' daughters by daughter's circumcision type, according to respondent's residence (urban-rural), Guinea DHS survey 1999

Residence	Superficial cutting	Partial removal of clitoris	Complete removal of clitoris	Removal of clitoris and labia minora	Other/ missing	Total	Number
Rural	3	25	30	41	1	100.0	1,696
Urban	9	40	20	30	1	100.0	609
Conakry	14	43	14	29	0	100.0	314
Other urban	5	36	26	32	2	100.0	295

The association between residence and type of circumcision varies with ethnicity. Among the Sosso, the daughters of urban women were much more likely to have had a radical circumcision than their rural counterparts. This was not the case for the other ethnic groups, in which a larger proportion of the daughters of rural women had had a radical circumcision (see Figure 1).



A common argument seen in FGC literature suggests that the tradition of female genital cutting is a continuation of the circumcisions experienced by older female family members (Carr, 1997). The older women tend to perpetuate particular types of FGC because they expect that younger female relatives should have the same life experiences they had. The data from Guinea tend to support this conclusion. Most daughters in Guinea have the same type of circumcision as their mother (see Table 6). For example, 91 percent of daughters who had a partial circumcision (partial removal of the clitoris) had mothers who had a partial circumcision.

Table 6 Percent distribution of respondents' daughters by daughter's circumcision type, according to respondent's circumcision type, Guinea DHS survey 1999

	Daughter's circumcision						
Mother's circumcision	Superficial cutting	Partial removal of clitoris	Complete removal of clitoris	Removal of clitoris and labia minora	Other/ missing	Total	Number
Superficial cutting	(75)	(11)	(15)	(0)	(0)	100.0	17
Partial removal of clitoris	3	91	2	1	0	100.0	333
Complete removal of clitoris	4	25	67	3	3	100.0	704
Removal of clitoris and labia minora	5	15	11	68	1	100.0	1,232
Total	5	29	27	38	1	100.0	2,305

( ) Numbers are too small to be representative; however, the values for superficial cut have been included to show the potential for correlation. The numbers are not presented for others, missing and not circumcised because they have no bearing on the daughter's circumcision type.

The data from both the formative study and the DHS survey have shown that the practice of FGC is nearly universal in Guinea, that only among the Guerze of Forest Guinea are some girls not circumcised, and that the type of circumcision varies with ethnicity. Variables such as education, exposure to radio, and place of residence are not seen as potential determinants of a woman's own circumcision because the circumcision occurred some time previous to the current situation. However, the survey data do suggest associations

between the daughter's type of FGC and the mother's education, exposure to radio, and place of residence. A mother's type of circumcision also appears to be correlated with her daughter's type of circumcision.

3.5 Multivariate Analysis Results

The variables used to describe women who have a daughter who received a radical circumcision can be considered simultaneously in a multivariate setting. The multivariate analysis allows us to test the significance of associations while controlling for the potential confounding variables noted earlier: ethnicity, education, exposure to radio, residence, and religion. The odds ratios are calculated using a logistic regression of the dichotomous outcome variable (whether or not a daughter had a radical circumcision) on the independent variables. A mother's type of circumcision is not included in the model because the variables that affect the daughter's circumcision are likely to also affect the women's type of circumcision, making the mother's type endogenous to the model.

Table 7 shows the odds ratios of having a daughter with a radical circumcision for women with different characteristics. The ratios marked with an asterisk were statistically significant at the 0.05 level, indicating that there was less than a 5 percent probability that the results were due to chance alone. Because the sample of daughters considers only girls that have been circumcised, there is a chance of getting a larger number of girls in the selection that were circumcised at young ages. To avoid selection bias toward girls circumcised at young ages, the multivariate analysis is restricted to daughters age 8 or older.

Table 7 Odds ratios of respondents' daughter having a radical circumcision (removal of clitoris and labia minora), Guinea DHS survey 1999

Covariate	Odds ratio
Christian (reference: Muslim)	1.58
Other religion (reference: Muslim)	2.46*
Primary education (reference: none)	0.73
Secondary education (reference: none)	0.45*
Listens to radio daily (reference: less frequently)	0.76*
Urban households excluding Conakry (reference: rural)	0.70*
Urban households in Conakry (reference: rural)	1.25
Sosso (reference: Maninka)	0.40*
Fulani (reference: Maninka)	0.71*
Other ethnic groups (reference: Maninka)	3.13*
Number of women	1,908

* Significant at the 0.05 level

There was not a statistically significant difference in the risk of a Christian versus a Muslim daughter having a radical circumcision. However, daughters of women from other religions (primarily animists and those with no religion) were 2.5 times more likely to have had a radical circumcision. The model is controlling for ethnicity so the majority of this difference is occurring in the Kissi, Toma, Guerze, and other ethnic groups. This supports the finding noted earlier that a woman's religious beliefs have little influence on her daughter's experience with circumcision.

Secondary education is significantly associated with a daughter's type of circumcision while primary education is in the expected direction but is not statistically significant. Women with secondary education were 55 percent less likely to have a daughter with a radical circumcision than women with no education.

Listening to the radio daily is significantly associated with a daughter's type of circumcision. Women who listened to the radio every day were 24 percent less likely to have a daughter with a radical circumcision. This finding and the education finding support the argument that women with more exposure to outside ideas are less likely to want a radical circumcision for their daughter.

Women from urban households excluding Conakry were 30 percent less likely to have a daughter with a radical circumcision compared with rural women. This finding supports the idea that even controlling for education, women in urban areas may have fewer traditional norms placed on them. There was no significant difference between women in rural areas and women in Conakry.

The type of circumcision a woman chooses for her daughter appears to vary by ethnicity. Compared with Maninka women, Sosso and Fulani women were less likely (60 percent and 29 percent, respectively) to have a daughter with a radical circumcision. In contrast, women in the other ethnic groups (Kissi, Toma, Guerze, and others) were 3 times more likely to have a daughter who received a radical circumcision.

The multivariate analysis suggests that there are significant differences in the type of circumcision a daughter receives based on her mother's socioeconomic characteristics. The results indicate that mainstream religion (Christianity and Islam) is not a determinant of a daughter's circumcision experience, that ethnicity is the important factor. Exposure to outside ideas (through education, radio, and urban residence) also influences the likelihood of a woman having a daughter with a radical circumcision.

4 Changes Over Time in the Practice of FGC

Although female genital cutting is considered a part of local tradition in Guinea, this analysis assumes that the practice has been changing over time as social relations and control over resources have evolved. Although the concept of "tradition" suggests an image of consistency and permanence, the image is at odds with the historical record. It is not known when the Sosso, the Fulani, and the Maninka of Guinea adopted the practice of FGC, though it is believed that the practice arrived in Guinea from the north. If, as Ottenberg suggests (1994), FGC reached the Guinea-Sierra Leone border near the end of the nineteenth century as a result of the southward movement of the Sosso, Fulani, and Maninka populations, the practice must have entered Guinea well before the end of the century.

Writing in the late 1960s about the status of women and FGC in Guinea, Claude Rivière (1971) mentions three ways the practice has changed over time: 1) girls are being cut earlier than before, at age 6 to 14 years rather than age 10 to 25 years; 2) girls spend only two weeks in seclusion instead of the several months to a year they once did; and 3) in urban centers where girls attend school, the circumcision now takes place during the rainy season when the girls are out of school. Formerly, the normal period for performing FGC in Guinea was during the dry season after harvest time when the heavy work in the fields was finished and people had more leisure time.

Rivière does not identify the sources from which he drew these conclusions, although he cites early ethnographic studies of female circumcision. It is also likely that he had many discussions of the topic with friends and colleagues in the capital, Conakry. If the age of circumcision has decreased in Guinea, as it has in many other countries, it implies that less attention is being given to the initiation aspects of female circumcision, and people are devoting less time and resources to the celebration at the end of seclusion. In other words, the ritual or symbolic aspects of FGC are receiving less attention now than in the past.

A comparison of the mother/daughter data from the DHS survey indicates that there has been a decrease in the age at which girls are circumcised. The median age dropped almost two years between mothers and daughters, from 9.3 years to 7.4 years (Table 8). While 48 percent of mothers were cut between the ages of 5 and 9 and 4 percent were cut before age 5, 66 percent of daughters were cut between the ages of 5 and 9, and 14 percent were cut before age 5. In other words, whereas 80 percent of daughters had undergone FGC by the age of 9, only 52 percent of their mothers had been circumcised by that age (DNS and MI, 2000). If we assume that younger girls get less ritual attention than older girls, the downward shift in age at circumcision suggests that rituals associated with FGC may be becoming less important.

The formative research included interviews with more than 20 specialists in genital cutting (traditional circumcisers). These women were asked about their practice and what had happened the preceding year. One of the women, a traditional birth attendant from Upper Guinea (Maninka), explained what had happened to the girls of that region last year. She said they had been cut at the hospital, and the procedure had been a partial circumcision (partial removal of the clitoris). A midwife at the hospital treated all of the girls afterward. She added,

> *We found female circumcision in our society; it's part of our customs. However, it seems to be losing its instructional value more and more in the way that it is now being practiced. The girls spend only two weeks in seclusion and come out without having learned much of anything about how to be a woman as they once did.*

Table 8 Percent distribution of circumcised women by median age at circumcision and current age, and percent distribution of circumcised daughters of these women, by median age at circumcision and mother's current age, and the change in median age at circumcision between mothers and daughters, Guinea DHS survey 1999

	Median age at circumcision				
Current age	Median age of woman	Number	Median age of daughter	Number	Change in median age (woman-daughter)
15-19	8.9	1,277	*	5	*
20-24	8.7	1,070	5.1	53	-3.6
25-29	9.1	1,237	6.6	270	-2.5
30-34	9.3	959	7.3	446	-2.0
35-39	9.5	935	7.4	594	-2.1
40-45	10.0	615	7.8	472	-2.2
45-49	10.1	562	8.2	465	-1.9
Total	9.3	6,656	7.4	2,305	-1.9

Note: Only the most recently circumcised daughter is included.
* Less than 25 cases; estimate was suppressed.

4.1 Circumstances of Genital Cutting

During the formative research, a number of women commented on changes in the practice of FGC. Members of a group of young married women from Gouécké (Guerze) said,

> *Excision used to be very important for women because it educated their children. But these days, the old women don't have the time to instruct them as needed. The learning of certain tasks that used to be standard isn't followed. For most women, excision does not have the value it used to. Some people say the scarring after excision hinders the baby's birth. So excision is of no benefit to the woman; we should give it up, or we'll make our children suffer for nothing because they learn nothing from circumcision anymore.*

A specialist in circumcision in Lower Guinea (Sosso) said,

> *The way we used to practice circumcision is not good for the woman. I have found that what I heard on the radio is true; it's the same thing that is found in the Koran: You should not circumcise a girl in a way that causes her trouble or complications. We specialists in circumcision, we pay for what our elders did who practiced the sunna form, for they frightened a lot of women with the tragedies they caused.*

The research team that interviewed Sosso and Fulfulde women collected detailed information about women's experiences with FGC. In the Sosso group, 72 of 108 provided information on the type of cutting they had experienced: 54 percent reported radical circumcision (removal of the clitoris and labia minora) and 33 percent reported complete removal of the clitoris. Among the Fulani, 81 of 108 provided information, 20 percent reported radical circumcision and 64 percent reported complete removal of the clitoris. These findings suggest that the Sosso favor the radical form of circumcision more than the Fulani. (In contrast, the DHS survey findings indicate that the Fulani favor the radical form of circumcision more than the Sosso.)

Tables 9 and 10 show how experience with FGC varies among Sosso and Fulani women. The women were divided into broad categories—unmarried girls (<=20 years), young married women (<=20 years), and older women (35+ years). Comparison of the categories shows trends in the place of circumcision, the circumcision practitioner, and the instrument used for circumcision.

Table 9 Distribution of Sosso women who experienced FGC by FGC circumstances and age group, Guinea Formative Study 1998

	Place			Practitioner			Instrument used	
Age group	Bush	Home	Hospital	Circumciser	Nurse	Midwife	Knife	Scissors
Unmarried girls	9	9	6	13	3	8	9	4
Young married women	13	7	4	23	2	5	20	5
Older women	23	7	0	26	1	0	30	0

Although the numbers are small, almost all of the older women were cut with a knife by a traditional circumciser in the bush, while many of the unmarried (young) girls were cut with scissors by a midwife at home or at a hospital. The same trends were seen for the Fulani women (Table 10).

Table 10 Distribution of Fulani women who experienced FGC by FGC circumstances and age group, Guinea Formative Study 1998

	Place			Practitioner			Instrument used	
Age group	Bush	Home	Hospital	Circumciser	Nurse	Midwife	Knife	Scissors
Unmarried girls	2	9	13	6	5	8	5	15
Young married women	13	0	10	17	3	4	20	7
Older women	16	1	1	25	0	1	29	1

Although the age categories and the manner in which the interviews were carried out differed in the DHS survey and the formative study, the DHS survey data showed the same trends as the formative study. While 87 percent of mothers were cut by a traditional circumciser, only 69 percent of their daughters were. Conversely, while only 8 percent of mothers had been cut by a nurse, the figure was 24 percent for their daughters. These data all point to increasing medicalization of FGC in Guinea (Table 11). The trend is strongest among the Fulani, where the percentage of genital cuttings done by nurses increased from 11 percent among mothers to 31 percent among daughters.

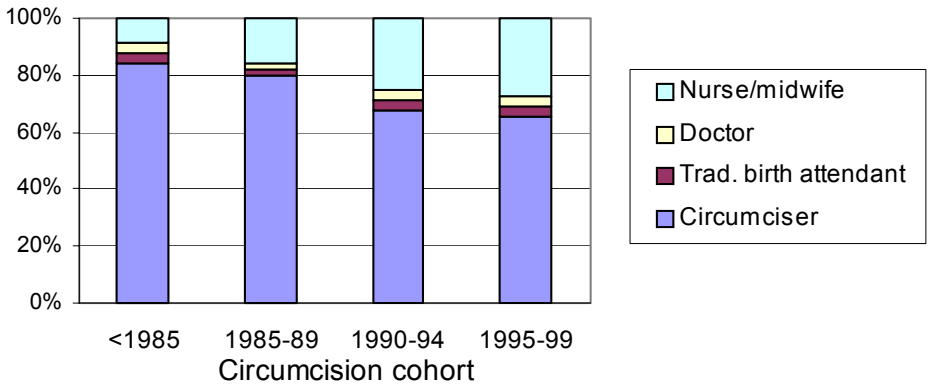
Table 11 Percent distribution of mothers and daughters by type of FGC practitioner, according to ethnicity, Guinea DHS survey 1999

Ethnic group	Circumciser	Nurse/ midwife	Trad. birth attendant	Other	Total
Sosso					
Mothers	86	9	3	2	100
Daughters	69	25	3	4	100
Fulani					
Mothers	85	11	2	2	100
Daughters	62	31	3	3	100
Maninka					
Mothers	86	8	4	2	100
Daughters	72	17	6	5	100
Others					
Mothers	97	2	0	1	100
Daughters	89	9	1	2	100
Total					
Mothers	87	8	3	2	100
Daughters	69	24	4	4	100

One way to draw information out of the DHS survey data is to look at differentials in FGC variables according to "circumcision cohort" rather than "birth cohort." The authors used *year of circumcision* to aggregate the daughters into calendar-based, circumcision cohorts (< 1985, 1985-89, 1990-94, and 1995-99). Age at circumcision was then compared by type of FGC practitioner. Daughter data was used in this analysis because the recall time since the event was shorter for daughters than for mothers. Since women were only asked their daughter's age at circumcised, year of circumcision was obtained by adding the daughter's age at circumcision to her year of birth.

Figure 2 shows the use of circumcision cohorts to highlight changes in the type of FGC practitioner used for circumcisions. Like the formative study, the DHS survey indicates that nurses and midwives are increasingly called on to perform the genital cutting operation, while traditional circumcisers are used less often. No DHS survey data were collected on place of circumcision or instrument used, so it was not possible to carry out circumcision cohort analysis on these variables.

Figure 2. Percent distribution of circumcised daughters by year of circumcision and FGC practitioner, Guinea DHS survey 1999



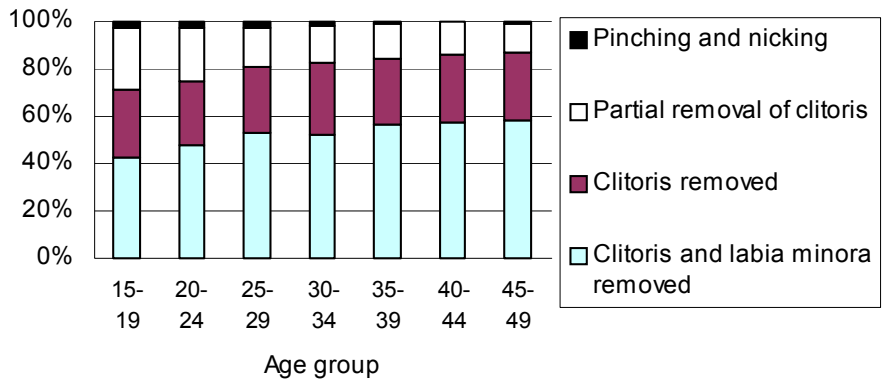
4.2 Changes in Type of Genital Cutting

The results of both the DHS survey and the formative study point to ongoing changes in the types of genital cutting practiced in Guinea. In this section the authors use birth cohort data from the DHS survey and text data from the formative study to analyze these changes. Seven birth cohorts (women 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49) were used in the analysis of FGC in women. The youngest cohort (women age 15-19) was excluded in the analysis of FGC in daughters because there were too few cases.

Prevalence of different types of FGC varies among birth cohorts, and patterns can be seen in the preference for more severe or less severe forms of the practice (see Figure 3). Radical circumcision (removal of the clitoris and the labia minora) is more common among older women (58 percent) than younger women (42 percent). Conversely, a less severe form of circumcision that involves partial removal of the clitoris is more common among younger women (26 percent) than older women (12 percent). Likewise, the practice of superficial pinching and nicking has increased from 1 to 3 percent between the oldest and the youngest age cohorts. Thus it appears there has been a trend toward less severe forms of FGC in recent years.

We can find further indication of changes in the prevalence of types of circumcision by looking at

Figure 3. Percent distribution of circumcised women by type of circumcision and age group, Guinea DHS survey 1999



the proportion of daughters who had a radical circumcision by circumcision cohorts. Circumcisions were aggregated into calendar-based periods and the proportion of radical circumcisions in each period was compared. Between 1970 and 1984, approximately 45 percent of the daughters who were circumcised had radical circumcisions; between 1985 and 1989 this figure increased slightly to 47 percent (data not shown). The periods 1990 to 1994 and 1995 to 1999, however, were marked by decreases in the proportion of daughter's having radical circumcisions (39 percent and 34 percent, respectively).

Data from the ethnographic literature, the open-ended interviews with individuals and groups, and the DHS survey all point to a pattern of change in the way female genital cutting is carried out in Guinea. Compared with earlier generations, girls now get cut at a younger age, spend less time in seclusion, have less radical operations, and are more likely to be cut by a medical practitioner.

4.3 Female and Male Perspectives

The DHS survey asked women and men about the negative consequences of FGC. The women's responses indicated that they were well aware of the painfulness of the experience. For women, the main negative factors associated with FGC were pain (59 percent) and medical complications (11 percent); 32 percent of the women reported no negative factors. For men, the main negative factors were also pain (29 percent) and medical complications (26 percent); however, 44 percent of men said that there were no negative factors associated with FGC.

Although twice as many women as men thought that pain was the main negative effect of FGC, less than half as many women as men cited medical complications as a negative effect. This differential may be because men follow media broadcasts more than women. A group of young Sosso men commented as follows:

> *Excision was practiced by our ancestors for reasons they know and that we will not criticize. Today we have enough information on the rural and national radio, on television, and even from foreign radio to know about the dangers of excision . . . Besides, whatever is generally believed, excision is not an Islamic practice; the Koran does not ever recommend it. That's why the authorities have to abolish this practice in Guinea, so the women can find joy again with their husband in their home.*

Researchers, policymakers, and activists have long been interested in what people say about the reasons for female genital cutting. Their assumption is that some motivation can be identified that, if properly dealt with, can bring an end to the practice. Yet the issue of why female circumcision continues is complex. Researchers do not ask how or why the practice might be abandoned. Most of the women and men interviewed in Guinea are in agreement that female genital cutting is necessary for proper education and preparation for adult life. A substantial proportion of women and men also believe that FGC reduces sexual desire and may have negative health effects. Most men and women regard FGC as the business of women.

Overall, men spoke out more critically against FGC than women did. The formative research produced far more objections to FGC from men (and given in more detail) than from women. These findings may reflect a real difference in how women and men talk about this issue; however, other explanations should be considered. First, men have more power in public affairs and are accustomed to speaking in public, while women are often forbidden to speak publicly. Second, the male interviewers were more adept at eliciting critical comments than the female interviewers.

The DHS survey asked women and men the question, "Do you think this type of practice should be continued or should be stopped?" A higher proportion of women (68 percent) than men (52 percent) said the practice should be continued. The authors believe it would be difficult to link the answers to this question

with the practice of FGC in Guinea, because FGC is virtually universal in Guinea. More likely, the answers reflect relative exposure to media messages about the dangers of genital cutting. Among women who listen to the radio daily, 59 percent said the practice should be continued, while among those who did not listen to the radio daily, 72 percent said the practice should continue. Among men who listen to the radio daily 45 percent said the practice should be continued while 58 percent of men who did not listen to the radio regularly said it should be continued (data not shown).

Listening to how women and men talk about genital cutting in the abstract is useful, particularly for tracking trends over time. More important in the long run is expanded research on FGC including detailed descriptions of how the practice occurs, how the events surrounding female circumcision are organized, and what vested interests FGC serves. Finding answers to these and other questions means examining the social interactions that surround the activities and events associated with female circumcision. Who takes part, in what way, at what time, and for what purpose? It means listening to the women who participate in the practice, the practitioners who carry out the operation, and other key personnel assigned roles in the event. Only in this way will we gain an understanding of what the practice of FGC looks like from the inside.

5 Conclusions

This report has examined the results of two contrasting research approaches—the formative study and the national sample survey—to gain a better understand of how female genital cutting is practiced in Guinea and how it may have changed over the past few decades. The 1998 formative research study in Guinea obtained the vocabulary and descriptive phrases commonly used to discuss FGC, individual accounts of the experience of female circumcision, and information about the social context of the practice. For want of a better term, this approach to data collection is generally known as "qualitative research." The 1999 DHS survey in Guinea, which was conducted using a nationally representative sample of women and a questionnaire with precoded answers, sought to identify how certain variables are distributed among women in Guinea. This approach to data collection is known as "quantitative research" because the results are presented numerically and the analyses feature statistical tests of the association of variables. The terms qualitative and quantitative highlight differences in the formulation of research questions, in the form of the data produced during fieldwork, in the analytical tools used to collect the data, and in the way the data are presented and interpreted.

Despite contrasting methodological approaches, the authors expected to find many similarities in the results obtained from the two research projects carried out in Guinea. It seemed important to determine the extent to which the two research approaches corroborate, complement, or contradict each other. As it turned out, comparison of the results showed many examples of corroboration and complementarity. Areas of corroboration included the prevalence of FGC, the tendency for girls to be circumcised at younger ages, the increasing medicalization of FGC, and the overall social importance of the practice. Areas of complementarity included the use of women's descriptive phrases of FGC to formulate the precoded answers to DHS survey questions, provision of descriptive information about the social context in which FGC exists, and consideration of the validity of certain variables in the DHS survey data.

5.1 What the Findings Show

The findings of both approaches regarding the prevalence of FGC indicate that the practice is almost universal in Guinea. The DHS survey showed that nearly all girls (99 percent) go through female circumcision. The formative study found that among the Sosso, Fulani, and Maninka, all girls are expected to be circumcised and that among the Guerze of Forest Guinea, some Christian groups oppose FGC. According to the survey findings, Christians in Forest Guinea are the only identifiable group with a prevalence of FGC below the norm.

Regarding age at circumcision, the formative research found that many Sosso and Maninka women talked about how girls are undergoing FGC at younger ages. The women complained that this situation provides less opportunity for the seclusion and instruction that accompanies female circumcision. A comparison of the data for mothers and daughters from the DHS survey also showed that girls are being cut at an earlier age. While only 52 percent of mothers had been cut by the age of nine, 80 percent of daughters had been cut by that age.

Evidence for increasing medicalization of FGC and reduction of the severity of the operation comes from both the formative study and the DHS survey. Medicalization of FGC implies that girls are being cut by trained medical personnel, and only a minor form of FGC is performed (e.g., pinching, nicking, or partial removal of the clitoris). Compared with their mothers, daughters are three times as likely to be cut by a nurse. Not surprisingly, the survey found that older women are more likely to have had the radical form of FGC (removal of the clitoris and the labia minora) than younger women. In the formative research, women talked about how mothers now take their daughters to a health facility so that the operation can be performed under sanitary conditions, by health care personnel, and with less severe genital cutting.

The results of both research approaches found that the practice of FGC forms part of the expectations of most people in Guinea. In the open-ended discussions carried out in the formative research, women talked

about the importance of being pure, clean, and properly educated about behavior appropriate to a wife. Both women and men mentioned FGC as part of parental responsibility toward girls: parents must educate a girl, have her circumcised, and find her a husband. While merits of the various types of FGC were debated in these discussions, the importance of doing some sort of FGC was rarely questioned. In the DHS survey, women and men were asked whether they thought the practice should be continued or should be stopped. The results indicated stronger support for the practice among women than among men: two-thirds of the women said the practice should be continued compared with just half of the men.

The complementary nature of the findings from Guinea demonstrates the benefits of coordinating formative and survey research approaches. First, by conducting the qualitative study before the DHS survey, researchers were able to suggest possible answers to the survey question that asked women specifically how they were cut. The precoded answers used in the survey questionnaire were taken directly from women's responses to this question in the formative study. Thus, rather than using answers derived from concepts familiar to researchers, the survey used women's own phrases (in four languages) to structure the answers to the question. This culturally and linguistically specific typology yielded richer data on the types of FGC practiced in Guinea than would have been obtained using the standard WHO typology.

Second, open-ended discussions with groups or individuals can provide information about the social context and details about events reported in the survey. The survey questionnaire was used to establish the distribution of women (circumcised and uncircumcised) and the identity of the persons who carried out the cutting. The questionnaire did not provide any other information about the event. In the formative research discussions, women were able to describe details of the time, place, instruments used, the period of seclusion, and any subsequent health problems. Women's descriptions of their experiences with FGC allowed us to reconstruct the social context of the circumcision events enumerated in the survey.

Third, it has proved productive to consider the usefulness of certain variables in the light of discussions with individual respondents. As mentioned earlier, it is customary to aggregate survey data by urban-rural residence and level of education. However, women's accounts of their own or their daughter's experience with FGC indicate that when girls are cut in Guinea (usually between the age of 7 and 10), their education has not yet been completed. Thus, level of education has no impact on whether a girl will be cut or what type of cutting is done. It may be useful, however, to examine the relationship between mother's level of education and how and whether their daughters will be cut. A similar case can be made for use of the background variable urban-rural residence, since some women may be recent migrants to urban areas.

Fourth, the survey results can be used to decide which results from the formative research can be generalized to the entire population and which cannot. For example, the formative research showed differences in the way FGC was performed by ethnic group. The DHS survey showed how type of FGC varies with ethnicity at the national level.

Comparison of the results revealed conflicting or confusing findings for only a few variables. In the formative research, most of the Guerze women from Forest Guinea spoke about only one type of circumcision: removal of both the clitoris and the labia minora. A few said that some women took their daughters to health facilities for a partial excision (partial removal of the clitoris). The survey data, however, showed that 6 percent of Guerze women had undergone superficial cutting (nicking and pinching), the highest percentage of any ethnic group. A possible explanation for this discrepancy is that the formative research took place in areas where the less severe form of FGC was rare. It should also be noted that 6 percent is a rather small proportion even though it is higher than for the other ethnic groups.

In instances where there is a significant conflict between information obtained through qualitative research and information obtained through quantitative research, researchers should look for explanations in the process used to produce the findings. It is an axiom of qualitative research that the production of data (sometimes called the construction of knowledge) has an impact on the nature of the results. In formative

research this is seen in the in-depth interview process, which directly affects the quality of the research data. In survey research the effect of the interview process on the results is assumed to be random. Either way, the interview process may be a source of error and thus of conflicting information.

5.2 Implementing Change

Female genital cutting is a controversial subject among women's empowerment and development organizations as well as programs to improve maternal health. The *outside* perspective of these groups sees FGC as an entrenched cultural practice that needs to be outlawed as a hurtful custom from which girls should be protected. In Guinea, the contrasting *inside* perspective sees FGC as an important social event that recognizes a girl's status in the community and prepares her for her role as wife and mother.

Documented sources indicate that FGC is a recent phenomenon in some societies, that it is not necessarily linked to Islam, and that sometimes it is not part of an initiation into adulthood. In short, many of the assumptions made about FGC are now being questioned (Shell-Duncan and Hernlund, 2000). The studies of FGC in Guinea have shown that the practice is tied to ethnicity and that it forms part of the common-sense knowledge of how girls achieve maturity.

The findings presented in this analysis indicate that while the practice of FGC is nearly universal in Guinea, the age of circumcision has been decreasing, and the practice of FGC is gradually being medicalized. The formative research has shown that while FGC is part of the coming-of-age process for most girls, the ritual importance of the event has lessened as girls are circumcised at younger ages.

Assuming that government agencies, NGOs, and other interested parties in Guinea are seeking to discourage the practice of FGC, the question can be raised, how best to go about implementing change? Should efforts be made to accelerate the changes already taking place? Should the focus be simply on ending the practice as soon as possible? Are there certain groups in the population that should be targeted first?

As researchers from the *outside*, the authors are reluctant to put forward specific suggestions about what type of anti-FGC campaign might work in Guinea. This practice is part of the commonsense understandings of how a girl becomes a woman, part of what people take for granted about girls' maturation. How does one change such understandings? We can suggest a decisionmaking process that seems promising. Any campaign against FGC must make certain strategic decisions and must enter into a dialogue with the population.

Agencies and organizations planning campaigns against FGC in Guinea are faced with fundamental choices.

- Do they seek to eradicate FGC, no matter what form it takes, or do they sanction the milder forms of genital cutting performed in health centers?

- Do they look for ways to promote the changes in FGC that have been taking place over the past few decades (girls cut at younger ages, preference for less severe forms of FGC, more operations performed in health centers, de-emphasis of the ceremonial aspects of female circumcision), or do they ignore them?

- Do they seek to create a dialogue with the population about FGC, or do they broadcast information about the medical dangers of FGC and tell people to stop practicing female circumcision?

- Do they target some sectors of the population more than others?

The examples of development programs that have succeeded through community participation, and the community mobilization against FGC in Senegal (TOSTAN 1999) point to the critical importance of dialogue with the population. Ideally, stakeholders should open a dialogue with local leaders about knowledge and experience with female circumcision. They would engage them in discussions about the importance of the practice and the benefits and drawbacks of current FGC practices. This dialogue should include discussion of how the practice has been changing over time.

Such a dialogue could be opened with a view toward mobilizing communities to directly discuss ways to change the practice of female circumcision. This approach would replace prescriptive communication methods with participatory and interactive methods that favor an open and constructive dialogue in the national languages. It would allow the debate to expand and include the domain of social development as well as the health domain. Although the negative medical effects of FGC are significant and cannot be discounted, the practice of female circumcision has implications that are broader than the health of young women, and these must be addressed.

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