

**Africa Division**

Regional Division Sahel/Central Africa, Madagascar

**Sector project**

Promotion of initiatives to end Female Genital Mutilation

**Baseline data collection for  
FGM programmes:**

**a review of selective approaches and methods**

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## **Baseline data collection for FGM programmes:**

**a review of selective approaches and methods**

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# Table of Contents

<b>List of abbreviations</b>	<b>ii</b>
<b>List of boxes</b>	<b>iv</b>
<b>Preface</b>	<b>iv</b>
<b>Introduction</b>	<b>1</b>
<b>1. The Role of Baseline Data in FGM Projects and Initiatives</b>	<b>3</b>
1.1 Questions Arising in FGM Projects and Initiatives	3
1.2 Choice of a Strategic Programme Approach	3
<b>2. Structured Approach of Baseline Data Collection for FGM Programmes</b>	<b>5</b>
2.1 Quantitative and Qualitative Methods	5
2.2 Research Process	6
2.3 Indicators	9
<b>3. Selective Baseline Studies on FGM</b>	<b>12</b>
3.1 Qualitative Data Collection	13
3.2 Quantitative Data	17
3.3 Method Mix	22
3.3.1 FGM Baseline Survey	22
3.3.2 Community Survey with Experimental Design	25
3.4 Action Research	27
3.5 Operational Research	28
<b>4. Recommendations and Conclusion</b>	<b>31</b>
4.1 Recommendations	31
4.2 Conclusion	33
<b>Annex 1: Steps in baseline data collection</b>	<b>34</b>
<b>Annex 2: List of baseline studies discussed</b>	<b>35</b>
<b>References</b>	<b>37</b>



## List of abbreviations

DHS	Demographic and Health Survey
FC	Female circumcision
FGC	Female genital cutting
FGD	Focus group discussion
FGM	Female genital mutilation
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit GmbH (German Technical Cooperation)
IEC	Information, education and communication
MOH	Ministry of Health
NGO	Non-governmental organisation
PRA	Participatory rural appraisal
RH	Reproductive health
STD	Sexually transmitted diseases
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
WHO	World Health Organisation

## **List of boxes**

Box 1: Range of select approaches

Box 2: Indicators to monitor and evaluate FGM projects

Box 3: Examples of variables and indicators in FGM projects

Box 4: Categories of baseline data collection according to research method

Box 5: Example from FGD guidelines

Box 6: FGM Module DHS Kenya 1998

Box 7: Examples of questions from an open-question interview

## Preface

The baseline studies presented in this document give technical cooperation projects and NGOs an overview of the international efforts to improve evidence-based decision-making for strategies of FGM interventions and to use research-based tools for monitoring and evaluation in order to determine the success or failure of these programmes.

The review starts with an introduction to methodological issues which can assist the reader to choose an appropriate method or a combination of different methods for designing and monitoring FGM projects. Furthermore, the planning of quantitative and qualitative methods, which have proven their usefulness in various countries, is described in detail.

Given that FGM elimination programmes have to deal with a sensitive and culturally embedded practice, it is crucial that programmes develop strategies based on a deep understanding of community values, beliefs, practices, and rules of interaction. This kind of information can be derived from research or community assessment methodologies. The findings of the research can guide the design and implementation of new approaches to addressing FGM, or the expansion of existing approaches.

More recently, projects working at community level have developed and supported a range of interventions that utilise community-based behaviour change strategies. Assessing actual behaviour has become imperative for designing potentially successful projects for and with them and for measuring change over time. At international level the current discussions concerning intervention research design and measurement issues focus on the monitoring of behaviour change as the “state of the art”. They also consider the numerous influential mechanisms that exist in one’s environment which act as determinants of behaviour and deterrents or persuaders with respect to the desired behaviour change.

It is hoped that the approaches and experiences in this document will stimulate interest both in undertaking baseline research more routinely when programming anti-FGM activities and in furthering the development and application of research methods appropriate for this subject.



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## Introduction

The central task of the GTZ sector project “Promotion of Initiatives to end Female Genital Mutilation” is to support initiatives in their endeavour to stop the practice of female genital mutilation (FGM) also known as female circumcision or female genital cutting (FGC). While working hand-in-hand with government institutions as well as non-governmental organisations, the sector project seeks to contribute to the development of project indicators and tools for monitoring and evaluation, which are adequate and scientific but at the same time practical and easy to implement.

Baseline data and indicators are of paramount importance to design effective programmes based on facts and evidence. Project planning should be based on the results and findings of the baseline survey. The programme manager finds support for the intervention not only by sharing the data with the target group and collaborators but also by designing and planning the research in a participatory manner. The achievements of an intervention to ban FGM can be demonstrated and presented based on evidence at the end of the project phase. Project planning based on evidence provided through baseline and follow-up data also facilitates fund-raising.

The experiences of data collection on FGM are documented in this review. They stem primarily from the health sector and display a diversity of methodological approaches. Not much is known of the specific role of baseline data collection for monitoring the process and impact of an intervention concerning FGM. Technical advice is needed on research approaches for baseline studies on FGM that are recommendable, feasible and at the same time cost-efficient.

This document provides technical co-operation projects, NGOs and institutions with an overview of the existing experience on baseline studies in the field of FGM interventions and programmes. In Chapter 1 the role of baseline data collection for FGM programmes is outlined. Chapter 2 presents an insight in quantitative and qualitative data collection, a possible research design and indicators appropriate for data collection in FGM programmes. In Chapter 3 select baseline studies of FGM programmes are presented, discussed and analysed. The studies are categorised according to their research methodology into qualitative, quantitative, mixed approaches, action and operational research. Several sub-categories have been chosen to cover the range of different research designs. The studies are presented in a summarised manner and are followed by an analysis and a critical assessment.

Examples of research questions and variables are mentioned. The analysis focuses on specific areas of interest and major elements of the study. Chapter 4 provides the reader with a summary of the document’s major findings and recommendations on how to include FGM baseline data collection in their ongoing activities and some conclusions. In the Annex the reader will find two checklists, one showing “steps in baseline data collection”, the second giving FGM specific examples of indicators and tools. The baseline studies are listed according to countries and their methodological category. Other literature references can be found in the annex as well.

This document presents a selection from the wide range of diverse methodological research designs and studies in FGM baseline data collection. The measurement of

baseline information for an FGM intervention does not need to be extremely complicated. Of importance is rather the right choice of the research questions, variables and indicators and of the appropriate methodological approach. Technical Cooperation can act effectively with the methods and instruments it already has at its disposal. Within this context, we hope to encourage all those involved to use data collection as a means to design a project, extend existing project approaches and monitor the process of change with the aim to ultimately put an end to female genital mutilation.

# **1. The Role of Baseline Data in FGM Projects and Initiatives**

## **1.1 Questions Arising in FGM Projects and Initiatives**

FGM is a practice deeply rooted in the cultural and social values of a community. A number of programme approaches exist to overcome this harmful traditional practice. For the programme addressing FGM, several questions arise and need to be answered like:

- Why are projects or initiatives to overcome FGM so special and exist in such variety?
- What is the appropriate strategy?
- Why are certain approaches working?
- Which target groups need to be addressed?
- Which is the interest of the donor?
- How can the intervention be monitored and evaluated?
- Which strategies have shown not to be successful?
- Which approaches have really made a tangible difference for the communities?

Thus, the programme manager has to take into account a number of possible interventions targeting different parts of the community and applying different methodologies.

## **1.2 Choice of a Strategic Programme Approach**

To support decision-making in this field, the brochure *Addressing Female Genital Mutation: Challenges and Perspectives for Health Programmes* is available from the FGM sector project or can be downloaded at [www.gtz.de/fgm/publications](http://www.gtz.de/fgm/publications).

It introduces a range of select approaches:

- The human-rights approach
- The legal approach
- The health approach
- The religious approach
- Training health workers as change agents
- Training and reconversion of traditional circumcisers
- Establishing alternative rituals
- IEC and behaviour change campaigns
- Comprehensive social development
- The research-based approach

**Box 1: Range of select approaches**

Then which strategic programme approach should one choose? Decision-making is usually based on the available information about the socio-cultural context of FGM. National Reproductive Health surveys like the DHS provide information about FGM prevalence. If this information is sufficient to design a FGM intervention, then how can the specific programme be monitored or evaluated?

To choose the “right” strategic approach or a mix of approaches for the planned intervention and to monitor and evaluate the process of programme implementation, tools like baseline data collection can provide valuable information at different times of the project implementation. Baseline data can also explore the role of certain target groups, attitudes, behaviour and practices prevailing in the community, the FGM status of women and girls and possible intervention strategies from the viewpoint of the community. Baseline data collection can provide the information to create indicators for programme monitoring and evaluation. In times of scarce resources, it is inevitable to design an appropriate intervention only after baseline data have been collected. A possible donor will be easier to convince if one can deliver the evidence that the project strategy chosen is based on prior research. Baseline data collection concerning FGM can be a difficult task due to the personal and secretive of this practice. Taboos, the fear of legal implications or the existence of secret societies may often hinder the interviewee from revealing important information. However, there are many advantages to having baseline information at hand to choose a strategic programme approach, as will be demonstrated in the following chapters.

## 2. Structured Approach of Baseline Data Collection for FGM Programmes

### 2.1 Quantitative and Qualitative Methods

In general data collection methods are either quantitative or qualitative. The distinction derives from the viewpoint of the observer and has an impact on the form of data analysis and its results. The environment in which FGM exists is part of a complex socio-cultural system and the related mind-set and feelings of individuals living in this society. To understand this environment is the main focus of research on FGM.

FGM is looked at in a so-called “objective” manner with a *quantitative approach* to research. From the data generated, the researcher attempts to identify and measure important variables. These variables are information about FGM that is supposed to be representative for the population included in the study. Data analysis systematically explains how these variables are interrelated. This is usually achieved with a standardised questionnaire, which based on the sample size calculation and means of randomisation, is supposed to be representative of a certain population. Typical information gained through quantitative data collection is FGM prevalence, average age of circumcision, percentage of parents who want to continue to circumcise their daughters, and percentage of circumcisions performed by health workers.

An appropriate tool for quantitative data collection for FGM programmes is:

*Interview of individuals using a standardised questionnaire*

with closed questions (meaning all answers are ticked either yes or no or other pre-formulated answers, see also the example of DHS questions chapter 3.2.3). Questionnaires are usually developed in a target specific manner, that means there are different ones for mothers, fathers, girls, etc. Sometimes standardised questionnaires with closed questions also ask some open questions, which are later classified in the process of data analysis. Of paramount importance is the way in which questions are formulated. They should be neither leading nor misleading. Pre-formulated answers should be exclusive and should cover the whole range of possible pre-formulated answers; therefore, it is advisable to pre-test and field-test the questionnaire before use to check the quality of the questions.

The second view forms a *qualitative or interpretive approach* to research and knowledge. Individuals are interviewed or observed during discussions in order to gain insights into their subjective experiences and the reasons for their actions (Polgar, Thomas 1995). This is usually achieved by observation, open-questioned interviews and focus group discussion. Using the qualitative approach, the researcher seeks information about the attitudes of the community concerning FGM, personal experiences of girls during the process of circumcision, historical information, personal views of certain key people in the community and their opinions on interventions concerning FGM in the community.

The relevant tools for qualitative data collection of FGM programmes are:

*In-depth interviews with individuals*

Interviews are held with the help of an interview guide, featuring mainly open questions. The individual is encouraged to present personal attitudes, experiences, and observations. In FGM programmes this method is used to obtain information from key people in the community such as religious or tribal leaders or to get an insight into the personal experiences of circumcised girls or the attitude of parents about the continuation of the traditional practice.

*Focus group discussions*

In a FGD usually eight to ten persons representing a target group with similar characteristics (age group, gender, profession), discuss given questions. Two to three specially trained facilitators steer and record the discussion based on a pre-formulated set of open questions. The group dynamic and the often vivid exchange of opinions provide certain advantages over individual interviews. The FGDs represent the opinion of these specific local target groups. For FGM programmes different social sub-groups like women, elderly men, young adults and health workers can provide the information needed for baseline data and programme design.

*Participatory rural appraisal*

A participatory rural appraisal is a concept of data collection based on community involvement using mainly qualitative methods such as focus group discussions and interviews of key informants. Tools such as problem analysis and preference ranking are applied to develop a community strategy and an action plan to be carried out by community-based associations with full participation of the community in order to solve the identified problems. The community defines to what extent they see FGM as a problem and decides if this issue is taken up in the community action plans. The concept of PRA has been mainly employed in agricultural and community development interventions.

Baseline data collection for FGM programmes is not complete without applying quantitative and qualitative methods. FGM is a complex cultural issue that cannot be generalised from one geographical area to another as each ethnic setting has created a different constellation of factors contributing to the continuation of FGM. The planned research to develop an appropriate intervention should therefore use a quantitative and qualitative method mix in order to gain cultural insight while at the same time gathering numeric data to develop quantitative indicators for monitoring and evaluation.

## **2.2 Research Process**

Baseline data collection for FGM programmes follows a research process quite similar to that of other programmes; nevertheless, it requires considering certain points, which will be mentioned under the following topics:

1. Planning
2. Hypothesis, aims and objectives
3. Research design
4. Data collection
5. Data entry and analysis
6. Interpretations and conclusions
7. Report writing
8. Discussion/restitution with community/target groups
9. Dissemination of research results.

*Planning* involves selecting the appropriate research strategies and tools to answer questions or to test hypotheses concerning FGM. Previous research evidence and routine data should be taken into account as well as ethical and economical factors. Then the methodological approach is determined. The quantitative tools like standardised questionnaires are designed. The qualitative approach and its tools like the interview guide and the focus group discussion guides are developed. Determining the human resources needed, the logistics, a time frame and a provisional budget are also part of planning. Before the final planning the geographical area of the planned intervention should be visited by the research team. Important points to cover are: visits to future collaborators to collect information about the ethnic groups and the culture, dates of school holidays or circumcision events, official documents concerning the area, seasonal aspects and logistics. Based on the gathered information, study areas and the appropriate time of the year for the study can be determined.

The *hypothesis or the aims* are the ground stones of the research. The key questions are formulated as *objectives*. They can lead to indicators used for programme monitoring and evaluation, i.e., “What is the attitude of parents concerning circumcising future daughters?”

During the *research design*, sampling methods are applied to ensure the generalisability of the results and controlled observation is conducted to demonstrate causal relationships. If a quantitative approach is chosen, the number of interviewees to answer the standardised questionnaire is determined through the process of sampling. If a qualitative approach is chosen, interview guides for key persons in the community and FGD guidelines are created.

*Data collection* concerning FGM needs specific approaches in order to avoid bias, which might come with a cultural sensitive issue like FGM. Also ethical issues need clarification. Local research assistants, chosen after a selection process based on their education and an aptitude test, are usually employed to carry out the collection of data for a quantitative FGM survey. Focus group discussion should be held by trained persons with the help of a tape recorder, which is also useful for documentation in open interviews.

Some examples concerning possible bias in data collection for FGM programmes are:

- In-/Exclusion of an important target group: A survey addressing youth in Kenya, which is not completed during school holidays, can miss the target group due to their absence from home while being in boarding school. This will exclude major parts of the target group.
- Appropriate choice of research assistants: Research assistants, who belong to a different ethnic group, might receive different information than locally recruited research assistants due to ethnic resentments or language barriers.
- Interviewees under legal age: Parents might refuse their underage children to be interviewed because some questions might not be appropriate according to them.

Some of these issues can come out only during pre- and field-testing of the developed tools. If strong biases are only noticed after data collection, they have to be taken into account during the data interpretation.

For *data entry* computer skills are needed. Quantitative data are entered in a database or directly in data analysis software like EPI Info or SPSS. To ensure the quality of the data, the data analyst uses methods to detect false or double entries. Qualitative data, like extracting important information from FGDs, has to be treated in a specific manner to summarize the outcome. One possibility is the use of keywords, which are counted and weighted according to their occurring frequency. Another option is a summary illustrated with quotes.

*Data analysis* can use descriptive statistics like the generation of frequencies and graphs in order to summarize and describe quantitative data. Qualitative data is analysed by comparing interviews of key people or FGD of different groups and is presented in a summarized manner under certain sub-categories like the circumcision procedure or male attitudes towards FGM. *Further analysis* of quantitative data uses the principles of probability to calculate confidence intervals and to test hypotheses. Comparison and regression of certain variables can indicate deeper relationships between certain variables like age group, gender, education and religion. This way the age-specific FGM prevalence can be calculated as well as the average age of circumcision in relationship to the ethnic background. Other calculations of multivariable relationships can include the connection between age, economic background or education and attitude towards the continuation of the traditional practice.

The next step in any research project involves *interpreting* the results. Findings may support or contradict existing theories or practices. They can also suggest that new techniques/strategies may be more effective or new theoretical notions may explain certain phenomena. The interpretation of data for FGM programmes focuses on programme relevant aspects like attitudes and possibilities for behaviour change. The interpretation includes the specification of indicators or benchmarks in order to evaluate and monitor the intervention. The *conclusions* propose programme design or additional research.

In order to document the research, some effort should be put into *report writing*. All interested parties will then have a chance to use this valuable information in order to plan their own project, compare it to their own research and add other necessary research.

The *dissemination of research results* is bound to influence the future intervention. Several options are available. Of paramount importance is the *restitution to target group* as the information fed back lays a ground stone of trust and willingness of the community to engage in a FGM programme. Stakeholders on national, provincial, district or community levels will appreciate the information and will probably be more willing to engage in future activities.

As the aim of the collection of baseline data in the area of FGM is to design an adequate programme intervention, the way the research is conducted and implemented can be of paramount importance for the success of the programme. *Participatory planning of the research process* with all stakeholders, their involvement in the analysis and the interpretation make baseline data collection become a part of the necessary process of change and empowerment.

### 2.3 Indicators

The WHO supports the monitoring and evaluation of FGM projects (Bathija, 2001). An indicator measures change and is used to assess whether an intervention or activity has achieved the intended result. The development of indicators is part of a frame of objectives (measurable statements), results, activities (work plan to be implemented) and data to be collected to produce those indicators. Types of indicators that are used to monitor and evaluate FGM projects are:

- Process indicators
- Activity targets
- Output indicators
- Result indicators
- Trend monitoring
- Impact monitoring

#### Box 2: Indicators to monitor and evaluate FGM projects

- *Health professionals and their relation to the community*

Those health workers that are part of the community themselves, such as fathers and mothers, uncles and aunts, play an important role in the decision as to whether or not to circumcise the female members of their family.

- *Process indicators and activity targets*

Process indicators measure the accomplishment of a process, an activity, a task or a delivery of goods. In FGM projects these can be, for example, workshop held, baseline study carried out, and IEC material distributed; however, they are not real indicators as such as they do not measure change. They are rather used to tick off the list of tasks; consequently, it is better to call these process indicators “*activity targets*” to clearly distinguish them from

“real” indicators. Nevertheless, they are important to monitor and follow which activities were completed and which goods delivered.

- *Output indicators*

Output indicators measure the outcome from the activities that took place. For example, an output indicator describes if the participants learned the taught skills during training. This can be measured by employing a pre-test and a post-test during a workshop on FGM for health workers. In the case of a meeting with tribal leaders, the change of participants’ attitudes after the workshop could be measured with a small questionnaire in order to assess the workshop’s outcome.

- *Result indicators*

This indicator measures if change occurs beyond the project itself. An example could be the use of skills by the trainees after the workshop is over. The actual use of moderation skills acquired during the workshop can be, for example, measured by assessing the successful application of these skills during local meetings of a community mobiliser with her church group.

- *Trend monitoring*

What changes are taking place in the society to which the project might be contributing? An example is the monitoring of the prevalence of FGM among young girls over time. The causal relationship, i.e., “is the change due to the project’s efforts?”, cannot be proven as many other factors beyond one intervention could cause this change. The contribution of the project to a decreasing trend of age specific prevalence of FGM can only be estimated.

- *Impact monitoring*

To what extent can the change be attributed to the intervention? As many factors in a society can contribute to a change in the FGM prevalence, it is extremely difficult to measure impact. In this case only sophisticated modeling or experimental designs can come close to delivering evidence of direct project related impact.

A *good mix* of output or result indicators to evaluate the process of change and several activity targets or process indicators to monitor the ongoing implementation is needed. A major part of the necessary information to create indicators can derive from a baseline data collection. Quantitative data can lead to numeric indicators; qualitative information to qualitative indicators. Both kinds will in combination be useful for the design of an appropriate set of indicators. As indicators need time frames, it might be advisable to create some short-, medium- or long-term ones, whereby the longest should not exceed the project life span. An intervention will need one or two indicators per result and for the project goal.

In the presentation of the baseline studies in the next chapter the advantage of having gathered baseline information for indicator creation will be clearly stated.

Variables in baseline data collection often lead to the development of indicators. Some examples are:

- Question: Are you circumcised?
- Variable: state of circumcision
- *Indicator: FGM prevalence decreases by xx % over xx time*
  
- Question: Do you intend to circumcise your junior/future daughters?
- Variable: Intention to continue FGM
- *Indicator: Intention to continue FGM decreases by xx % over xx time*
  
- Question: Which health consequences of FGM are you aware of?
- Variable: Knowledge of health consequences
- *Indicator: The population is more aware of health consequences by xx % in xx time*

**Box 3: Examples of variables and indicators in FGM projects**

WHO has developed criteria for the selection of RH health indicators (see website <http://www.who.org>). These criteria are valid for FGM projects as well:

- Ethical
- Useful
- Scientifically robust
- Representative
- Understandable
- Accessible

To the following questions concerning quantitative and qualitative methods, research process and indicators, answers can be found in the presentation of select baseline studies and the recommendations.

- Through which appropriate tool will an indicator be measured?
- How can the project team determine which indicators reflect a process of change?
- Which indicators can be chosen as part of a participative monitoring system?
- How can cost-effective evaluation take place?
- Which is the best mix of indicators for this specific intervention?

### 3. Selective Baseline Studies on FGM

A range of baseline studies on FGM is available in the international literature or as project documents. The material presented here consists of a selection of documents available to the GTZ FGM sector project. The selection covers 14 examples from ten African countries (Benin, Burkina Faso, Chad, Egypt, Ethiopia, Guinea-Conakry, Kenya, Mali, Senegal and Sudan). The majority of them has been realised in collaboration with or stem from collaborating projects with GTZ. Some are examples of international research and interventions on FGM (see annex 3 for a complete list).

These studies have been chosen to illustrate different methodological approaches: qualitative, quantitative, mixed methods, action research and operational research. The research methods used in each study are described under each sub-category:

Qualitative data collection:

- Focus group discussions
- Mixed qualitative approach
- Participatory rural appraisal

Quantitative data collection:

- FGM prevalence measured during a reproductive health survey
- FGM prevalence survey
- DHS - FGM module

Method mix:

- FGM baseline survey
- Community survey with experimental design

Action research

Operational research

**Box 4: Categories of baseline data collection according to research method**

Due to the voluminous amount of material available, not all the interesting information from each study can be described here in full. The studies also differ widely from each other in ways of presentation and length; nevertheless, an effort is made to convey the main ideas and variations in the field of baseline data collection in FGM programmes.

Each study is summarized in order to describe the background and context of the programme, the research methods and to give an overall picture of the results achieved. Some characteristics, interesting details and highlights of each study are also presented.

Unfortunately, not all studies come with a complete overview of the research design or the tools used. Some lack a clear presentation of results, others lack conclusions or recommendations. Cost-efficiency can only be estimated and is therefore not de-

scribed. Each summarized presentation is followed by an analysis and critical assessment of the research methods used and of the results.

To make the studies comparable, the presentation of each baseline study follows this pattern:

1. Local and project background
2. Objectives
3. Research methods
4. Results, including interesting details and highlights
5. Analysis

### **3.1 Qualitative Data Collection**

During qualitative data collection on FGM, individuals are asked or observed in order to gain insights into their personal experiences and the reasons for their actions. Qualitative data can provide in-depth information of the cultural background, historical developments, attitudes and practices concerning FGM, target group specific information, personal views and experiences, and the view of the community concerning possible interventions. The appropriate methods for qualitative baseline studies of FGM projects are described in Chapter 2.1:

- In-depth interviews with individuals/key people
- Focus group discussions
- Participatory rural appraisal

#### **3.1.1 Focus Group Discussions**

The GTZ family health project in **Senegal** pursues the improvement of reproductive health in the framework of technical cooperation. The project objectives cover the areas of family planning, HIV/AIDS, safe motherhood and FGM. FGM is practiced in Senegal among some ethnic groups. The project, which is based in Dakar and Kolda (local FGM prevalence is 85%), decided to gather specific information about perceptions, attitudes and practices on FGM in the region of Kolda in rural and urban communities (Kessler-Bodiang, Eppel, Guèye, 2000).

The main aim of this study was to develop an effective strategy in the fight against FGM based on knowledge, perceptions, attitudes and beliefs of the population of Kolda. Special attention was given to the social value of FGM, how it is performed, the perceived advantages, risks and motives for the practice. Knowledge on Islam and the law concerning FGM was measured and propositions for possible strategies collected.

To grasp the cultural variation of FGM in different settings, the project team chose the method of focus group discussion. To cover geographical, ethnic, gender and age group differences, a total number of 57 focus group discussions of 8-10 persons each were held. The study tried to cover a large number of different locations and six dif-

ferent target groups: young women, middle-aged women, elderly women, young men, elderly men and religious leaders.

Extensive descriptive results contain quotes and describe notable differences among the statements of different social and ethnic groups. Conclusions and recommendations point at the necessity of sensitising the community on reproductive health, legal issues, women's rights and the importance of religion. Even the process of change towards the abandonment of FGM should be lead by the people themselves. The contribution of health workers is of importance and demands their professional input to support the process of change.

Subject 1: *Prevalence and trends of FGM*

- Does the traditional practice of FGM exist in your area?
- How has it changed over the last few years?
- What do you think about FGM?

Subject 2: *Knowledge of FGM and perceptions of intervention strategies*

- What are the advantages and disadvantages of FGM?
- Have you participated in a community meeting concerning FGM?
- What do you think about those meetings?
- What do you think of the law that forbids FGM?
- Do you think that FGM will be abolished because it is illegal now?
- Do you know the legal consequences of performing FGM?

Subject 3: *Rituals, religion and practice concerning FGM*

- What do you know about the FGM ceremonies?
- What do you think about them?

Subject 4: *Improvement of intervention strategies concerning FGM*

- Who are the important personalities to include in the fight against FGM?
- Do you have preferences on how information on FGM should be presented?
- Which approaches do you suggest to improve intervention strategies?

**Box 5: Example from FGD (guidelines)<sup>1</sup>**

**Comment:** – hier sollte eigentlich das Senegal bsp stehen!

*Analysis:*

The study is very detailed and provides many quotes to illustrate the rich in-depth information collected. The document is available as a well-designed booklet (see annex 3). The perceptions and attitudes of the ethnically diverse people of the region of Kolda concerning FGM are well documented. Discussion results are grouped according to research questions. The focus group discussions have generated a detailed picture of the local and ethnic differences. The data collected enabled the project to plan appropriate future interventions.

<sup>1</sup> Translated from the study to investigate FGM in five provinces of Burkina Faso (Ouedraogo, Kaboré, Sanon, 2001)

The total number of FGDs might seem too high regarding the input of human resources and logistics, but this was necessary according to the research team to cover a wide range of variations and target groups. The extensive use of FGDs can also be seen as a starting point for a planned intervention in the future, as the public discussion of this practice can enhance the future participatory process of change. After this qualitative study was carried out, an additional quantitative RH survey was planned by the project team with questions about FGM prevalence in order to formulate quantitative indicators for project monitoring and evaluation.

### 3.1.2 Mixed Qualitative Approach

The GTZ project to improve the health of the rural population in **Guinea-Conakry** decided to employ several qualitative methods to explore the perceptions and attitudes of the population of the region of Faranah concerning the FGM and search for alternative strategies to abolish the traditional practice (Keita, 1999). To gather relevant information of the cultural setting, the chosen mix of qualitative methods included 22 focus group discussions with key informants of respected men and women in the community and almost 500 in-depth interviews with health workers, circumcisers, husbands and wives in the reproductive age group, elderly women and leaders.

Information was sought regarding the practice, FGM as part of the cultural heritage, FGM as a tradition of Islamic origin, and myths concerning delivery problems in un-circumcised women. Decision-making, reasons for the continuation of the practice and health consequences were described. Perceptions, opinions and attitudes of the different groups in the community were collected. The following information regarding FGM was gathered: its social and political context, circumcision season, age of circumcision, place of circumcision, instruments used, types performed and health care. All respondents defined the FGM prevalence as common as 100%.

The study presents answers to the key research question “Why does the population continue the practice?” The results include information about the health consequences of the practice. In general the population is misinformed about any negative consequences of FGM. Main discussion points are summarised and recommendations given on how to apply an effective strategy by integrating the youth and by including local administrative structures using a frank dialogue amongst the parties concerned. According to the author, the fight against FGM should be mainly done by workers from the social sector and not by health workers as this often leads to the medicalisation of FGM. The involved agents should be trained in techniques for community sensitisation.

#### *Analysis:*

The study is detailed and provides the project team with insights into the practice and its social context. The methods used have definitely painted an in-depth picture of the community members’ attitudes, perception and their reported behaviour concerning FGM. Gender-specific reasons for continuing and for abolishing the practice were gathered. Strategies are discussed in what way the population can abolish the traditional practice that paces the way for the intervention design. The report concludes with a well-defined set of strategies.

The youth as a target group was not questioned in the study, even though the development of strategies concerning the youth is amongst the research objectives. Some additional FGDs with youth could be performed to gain specific information on this target group.

Also the Cellule Régionale Cona-Ciaf de Sarh in **Chad** used a mixed qualitative approach of FGDs and interviews. In collaboration with the GTZ health project in Chad and other stakeholders, they conducted a study regarding possibilities to improve the female initiation in the region of Moyen-Chari (Kolmagne, Jadjobaye, 1997). Over 1,300 persons of different sub-regions were included, composed of circumcisers, circumcised girls and women, non-circumcised girls and women, traditional and religious leaders, men and some specific key informants.

The study provides detailed information about the background and the environment of the practice. Interesting information is provided about the professional and economic situation of the circumcisers and of the possibility of introducing the alternative rite of passage.

*Analysis:*

Much detailed information about FGM was gathered during this study, especially interesting details concerning the circumcisers. The results and the summary of the gathered information are presented in the report, but the research design and analysis of the data are not included. A research of this magnitude deserves to be presented with its research design and tangible results. In the case of a follow-up study or a similar baseline data collection in another region of Chad, future researchers and programme managers may have a problem in comparing their research design and outcomes with this study. The authors have mixed in their presentation results with recommendations. The conclusion and the strategies for the future intervention are not included in the report, but can be found in the report of the workshop following the presentation of the results.

### **3.1.3 Participatory Rural Appraisal**

The Oromia Regional Health Bureau in collaboration with the GTZ reproductive health project in **Ethiopia** conducted a reproductive health survey in the West Shoa Zone, Oromia. The reproductive health issues, that were covered, are family planning, STD/AIDS, harmful traditional practices, antenatal care, community action plan and others (WIBD Consult 1999). The objective of the survey was to identify and prioritise health problems in the community and to develop participatory community action plans.

In order to start the process of change in the community with the collection of information, the researchers used a participatory rural appraisal approach (see chapter 2 for explanation).

FGM is described as being only one of a range of harmful traditional practices like uvula cutting, milk teeth extraction, witch craft, throat irritation of children and abortion. Specific information about FGM was retrieved concerning decision-making, age of circumcision, practitioners, reasons, rumours and myths for continuing the prac-

tice, change of severity/type of the cut in the recent past, the attitude of the women towards FGM as a good practice.

*Analysis:*

In the context of the wealth of information about reproductive health in the report of this PRA, FGM features only as being of minor importance, especially as the community considers FGM as a valuable and good tradition, which should be continued. No urge for major changes is expressed in the community action plan. FGM was not considered as a practice worth changing. The willingness for change concerned rather other RH issues. The study demonstrates therefore that some communities do not perceive FGM as a problem at all.

Nevertheless, the health education requested by the community might be an entry point for further discussion concerning the discontinuation of FGM, even though an interest to abandon the practice was not declared. If the overall goal had been the question of how to approach the community rather than if at all, the advocates for an intervention concerning FGM would have to step back. This is due to the concept of a PRA being a participatory community-based process with the involvement of the population from the beginning of the activities. A follow-up of the PRA at some later stage can provide insight into whether the population's favourable attitude towards FGM has changed.

## **3.2 Quantitative Data**

In times of logical frameworks for project planning, most indicators like FGM prevalence tend to be quantitative; consequently, the project manager is in dire need of tools to measure the indicators in an adequate and cost-efficient manner. Quantitative data make indicator creation easy. Quantitative surveys follow in their design often the tradition of the demographic national health surveys, which are a well-used tool for policy makers.

The most popular and appropriate tool for quantitative data collection for FGM programmes is the *interview of individuals using a standardised questionnaire* as described in Chapter 2.

### **3.2.1 FGM Prevalence Measured During a Sub-national Reproductive Health Survey**

The Central Bureau of Statistics of **Sudan** conducted a quantitative baseline survey of the reproductive health status with the financial and technical assistance of UNFPA (Islam, Uddin 2001). Besides assessing the general reproductive health status of the female married population, one of the objectives of this survey was to gather information about FGM. The last national DHS of 1990 indicated that 89% of married women had undergone circumcision in Sudan. This specific survey was restricted to three geographical areas, both rural and urban. 3,000 ever-married women were questioned with standardised questionnaires.

The FGM prevalence rate ranged by locality and ethnicity and from two-thirds to almost all of the women of a population sub-group. Results showed that among one cluster a slight shift had occurred from the pharaonic type (FGM Type III, WHO) to a less severe form of FGM. Also differences of FGM prevalence according to religion, household possessions and education were recorded. These results were confirmed in an in-depth data analysis, achieved by comparing multiple variables with logistic regression (see also chapter 2). Reasons for supporting the practice are that FGM is a custom, cleanliness, religion and tradition. Reasons mentioned to discontinue the practice are mainly health complications, religious reasons, painful personal experience and the practice being against a woman's dignity. Husbands were less likely to support continuation.

The political background of a non-committed government in the fight against FGM is discussed and the prevailing socio-economic dependence of women in Sudan is criticised. Interventions against FGM are mainly carried out by NGOs. The authors conclude that the prevalence rate of FGM will only drop if the status of women changes. Recommended strategies are the dissemination of information and the generation of discussion. Other strategies include presenting health risks, especially of the pharaonic type, and religious facts in mass media campaigns and educational curricula. Not only women, but fathers, mothers, boys and grandparents should be targeted and a concerted effort of governmental and non-governmental stakeholders should take place.

#### *Analysis:*

The extensive information collected stems from quantitative data, which was collected with a questionnaire covering many RH issues. Only ever-married women are respondents in this survey. This means that in-depth knowledge of the social and cultural background on FGM, that could have been provided by other target groups like men or youth, was not obtained as well as specific information from girls, elderly women or key informants like religious or community leaders.

Nevertheless, the recommendations and the discussion are very valuable. Programme planners in Sudan can now conduct some qualitative research prior to an FGM intervention and can base themselves on the quantitative information available through this kind of survey.

### **3.2.2 FGM Prevalence Survey**

The objective of the GTZ Primary Health Care Project in Benin is to improve the basic health of the population in rural and semi-urban areas. The project applied a quantitative survey to gather baseline data information about the prevalence of FGM, to identify the reasons behind this traditional practice and to try and work out perspectives for change in the behaviour concerning FGM (Djagba, 2000). Through a questionnaire quantitative information was collected with a questionnaire from 500 women above 15 years of age in the regions of Kandi and Karimama in **Benin**, considering a mix of urban and rural in the sense of a household survey. The standardised questionnaire covers information on socio-demographic features, FGM, professional activities and living conditions in the household, and has similarities to national household and health surveys.

The research hypotheses were:

1. Many socio-cultural factors determine the continuation of FGM in Benin.
2. Economic factors encourage circumcisers to continue.
3. The women living in the study area are aware of the negative consequences of FGM and are ready to abolish the practice.

Some results from the study showed that religion had a strong influence on whether one was informed about FGM. Women of Protestant and traditional religion were better informed about FGM than Muslim and Catholic women. Two-thirds of the women had undergone circumcision at an average age of eight years. In the younger groups below 20 years, the age-specific prevalence is only around a third, whereas over three-quarters of the elderly women were circumcised. Only half of the educated women are circumcised, in comparison to two-thirds of illiterate women. Striking differences amongst the tribes was shown. Nine circumcisers were also questioned. They had inherited their profession, which they say is not their main economic source of income. Change seems likely because most women have been circumcised because of tradition and only a quarter now thinks that it is a good practice whereas two-thirds want FGM to be suppressed.

The recommendations given by the author to the target communities, NGOs and the government are to foster integration of women in community-based programmes. The NGOs should focus their efforts and follow the women's recommendations in the study. Decentralised committees should be trained on how to sensitise the population. And the government should reinforce health structures to be integrated in the fight against FGM, draw a law against FGM and integrate local authorities in the fight.

*Analysis:*

This purely quantitative study provides the reader with information on a population of women above 15 years; therefore, the study does therefore not include the target group of young girls in the major age group from 8 to 14 years threatened by FGM. Other sub-groups of the community like men, youth, religious and traditional leaders have also not been questioned. The husband's attitude towards FGM according to the spouse's knowledge is given as second-hand information. Interesting information is provided about the economic status of circumcisers, which proves that circumcision is not their main profession and therefore excludes a possible program of re-conversion of circumcisers. The information about the influence of education, age, religion and economic status is very revealing. The documentation of the lower age proportionate to a lower FGM prevalence reveals the ongoing process of discontinuation of FGM.

Thus, it might be worth determining through FGDs the attitudes of different sub-groups of the community and their leaders in order to specify how an intervention could support the process of change.

An extensive quantitative national survey on FGM was conducted in **Burkina Faso** in 1996 (Déra, Ilboudo, Kaboré, Outtara, Yé, 1997). The Comité National de Lutte contre la Pratique de l'Excision (CNLPE) and the Ministry of Social and Family Af-

fairs conducted this national survey with the financial support of UNICEF and the technical support of the National Institute for Statistics and Demography. After 20 years of fighting against FGM in the country without tangible results, more knowledge about the phenomenon FGM regarding its magnitude, the involved population, and the reasons was needed. The attitude and practices of the population concerning FGM were to be studied. 1,143 households were visited, 1,654 women, 394 men, 174 opinion leaders and 14 circumcisers were questioned with five different types of questionnaires (a household survey and four questionnaires of the above named groups containing some open questions to gain some additional qualitative data).

A great number of valuable data was collected and presented in the analysis of the report. The overall prevalence of FGM was measured at 66%.

*Analysis:*

To conduct a national survey of this dimension is an expression of the governmental commitment in the fight against FGM. The advantage Burkina Faso now has over other countries is a detailed set of data covering all ethnic groups and geographical areas. Programme managers can base themselves on the existing quantitative data and put their efforts into focussed qualitative research before intervening.

The report does not contain recommendations for the future. These are found in the National Plan of Action. As Burkina Faso is a major zone of intervention by FGM programmes, a follow-up survey in some years will eventually mirror the process of change, especially through the indicator of age-specific FGM prevalence.

### **3.2.3 DHS-FGM Module**

The Demographic Health Survey (DHS) is a standardised large-scale national survey, which gathers information about a number of areas of the reproductive health status of the female population (15-49 years). It has been applied in a large number of countries by the national institutions or ministries with the technical support of Macro International, US. It is an important tool for policy makers in the health sector. In some countries it has been used up to three times approximately every five years and can therefore measure long-term trends of important health indicators like child mortality, maternal mortality, family planning, nutritional status and vaccination status. Each survey covers representative geographical areas with up to a total number of 15,000 interviewed women.

Up to now modules on FGM have been inserted in more than 19 recent DHS surveys. The DHS provides estimates of the national FGM prevalence of ever-married women (15-49 years), details about FGM of the eldest daughter, the women's attitude about continuation of the practice, intention to circumcise their daughters in the future and reasons why the practice continues. Data are analysed comparing educational background, residence, religion and employment with variables concerning FGM. All relevant data and information is made available on a CD-Rom that can be ordered from Measure International at: [datacds@orcmarco.com](mailto:datacds@orcmarco.com).

These are questions from the FGM Module in the Kenyan DHS of 1998:

In many communities girls are introduced to womanhood by participating in some ceremonies and undergoing specific procedures. Now, I want to discuss with you the circumcision of girls.

- |  |   |
|--|---|
| 1. In this community is female circumcision practiced?   | Yes No  |
| 2. Are you circumcised?  | Yes No (if no continue with question 4)   |
| 3. How old were you when you were circumcised?   | Age in completed years or Does not know   |
| 4. Is (Name of eldest daughter) circumcised?   | Yes No (if yes continue question 7)   |
| 5. Do you plan to have (Name of eldest daughter) circumcised?  | Yes No (If no continue question 12)   |
| 6. How old was she when she was circumcised?   | Age in completed years or Does not know   |
| 7. Who performed the circumcision?   | Doctor<br>Trained Nurse/Midwife<br>Traditional midwife<br>Traditional circumciser   |
| 8. Where was the circumcision performed?   | Own home<br>Another's home<br>Home of circumcision practitioner<br>Other (specify) or Does not know   |
| 9. Which instruments were used to perform circumcision?  | Own blade/razor<br>Shared blade/razor<br>Scalpel<br>Knife<br>Other (Specify) or Does not know   |
| 10. During the circumcision of (name of eldest daughter) which parts of the body were removed?                                 | Record parts as reported on lines provided  |
| 11. Before (name of eldest daughter) was circumcised, was she informed about the details of the circumcision procedure?        | Yes No  |
| 12. Do you think female circumcision should be continued?  | Continued (go to 13), Discontinued (go to 14)<br>Does not know  |
| 13. Why do you think female circumcision should be continued   | Good tradition, Custom and Tradition<br>Religious demand, Cleanliness<br>Better Marriage Prospects, Better marriage life<br>Greater pleasure of husband, Preservation of virginity<br>Prevention of immorality, Other (Specify),<br>Does not know<br>Any other reasons? |
| 14. Why do you think female circumcision should be discontinued?   | Bad tradition, against religion<br>Medical complications, Painful personal experience<br>against dignity of women, Prevents sexual satisfaction<br>False Status/Limits Education<br>Other ____ (Specify) does not know, any other reasons?                              |
| 15. In the last 12 months have you discussed the practice of female circumcision with anyone?<br>Record all persons mentioned: | No one If yes, with whom?<br>Respondent's husband, Respondent's mother<br>Respondent's mother-in-law, Other relative of respondent<br>Other relative of husband, Other (specify)  |

**Box 6: FGM Module DHS Kenya 1998**

#### *Analysis:*

The DHS is an instrument with worldwide reputation for implementers of reproductive health programmes and policy makers. Often it provides the only quantitative information about FGM at the national level. Some researchers have raised doubts about the FGM module concerning its validity as samples can be geographically restricted, are rather small or do not cover the whole country or ethnic spectrum. The questions applied only provide limited information. In-depth analysis of the cultural and social setting is missing.

Therefore, all DHS surveys should include FGM modules in countries where FGM is prevalent. Rephrasing of questions adapted to country settings should be done prior to the data collection with the help of national expertise. Technical cooperation projects, NGOs and other partners in the field of FGM should take up their mandate to lobby for appropriate questions to be included in the DHS questionnaire. Planned programme interventions can base their estimates on the DHS while conducting surveys of baseline data collection in smaller geographical areas and additional target groups to verify and specify the provided information for programme design.

### **3.3 Method Mix**

In a number of studies a mix of quantitative and qualitative methods is used. The combination of applied methods is usually as follows:

Quantitative data collection with  
*Interviews of individuals using a standardised questionnaire and*

Qualitative data collection with  
*In-depth interviews with individuals/key people and /or  
Focus group discussions*

The collection of both qualitative and quantitative data provides the researcher with a rather complete picture of a complex issue like FGM. The collection of quantitative data like FGM prevalence, average age of circumcision, and the percentage of persons who will discontinue the practice in the future facilitates monitoring of results and measuring the outcome of an intervention. Socio-cultural patterns obtained through FGDs give insight into the history and future perspective of this traditional practice. Of major interest for possible strategies and future collaborators for the intervention are the views of different key people in the community.

#### **3.3.1 FGM Baseline Survey**

A baseline study to investigate the practice of FGM in five provinces of **Burkina Faso** was conducted by the Centre International de Formation en Recherche Action (CIFRA) and the GTZ FGM sector project (Ouedraogo, Kaboré, Sanon, 2001). A number of NGOs and initiatives against FGM in Burkina Faso supported by the FGM sector project had expressed the need for baseline data collection in order to plan, monitor and evaluate their interventions better. The survey was carried out in five provinces of the country. The views of different target groups of the community

were sought to explore the socio-cultural context of FGM and possible strategies for the intervention. Key people of the community like religious leaders, circumcisers, and health workers were questioned to gather an in-depth knowledge of opinions and attitudes of influential persons in the community. Quantitative baseline data like the age-specific FGM prevalence rate were obtained in order to measure the trend developing before, during and after the intervention.

To gather this complex information, a combination of quantitative and qualitative tools were chosen:

- Interviews of individuals using a standardised questionnaire
- In-depth interviews with key people
- Focus group discussions.

With a standardised questionnaire, 879 women between the ages 15 and 49 years were interviewed, sampled from 649 households. 16 opinion leaders and four circumcisers were interviewed in-depth. 27 FGDs were held with men, women and youth, and according to education and sex. The study aimed to determine the FGM prevalence in girls below the age of 11 years in comparison to the older age groups, reasons for the continuation of the practices, knowledge of negative consequences of FGM, the rituals around FGM and possible strategies in the movement against FGM.

Interview Guide:

Record first: personal data, age, sex, tribe, religion, state of marriage, children

Subject 1: *Perception and knowledge about FGM*

- Is FGM prevalent in your village? Why?
- During which seasons are girls circumcised?
- At what age are they circumcised?
- What are the advantages of FGM?
- What are the disadvantages of FGM?
- During the last 10 years how has the practice changed?
- Is it declining or the same?
- What reasons do you think are responsible for the decrease or the continuation of FGM?

More subjects cover: ritual, religion and practice, knowledge of strategies and stakeholders in the fight against FGM

**Box 7: Examples of questions from an open-question interview<sup>2</sup>**

The FGM prevalence in girls was estimated at 16% in comparison to the overall prevalence of 66%. Regional differences showed that in two districts 30% of the girls under 11 were already circumcised. The mentioned reasons for the continuation of the practice were tradition, religion, the perception of female genital organs being unclean and other rumours. 80% of the respondents of the survey recognized the

<sup>2</sup> Translated from the study to investigate FGM in five provinces of Burkina Faso (Ouedraogo, Kaboré, Sanon, 2001)

health dangers of FGM. Demand for more information about FGM and for increased sensitisation was expressed. Due to fear of legal repercussions, public rituals were no longer taking place. The research team recommended embedding the fight against FGM in public health measures. Local structures should join and campaigns, including men and opinion leaders, should focus on the fact that no religion enforces FGM. The health workers and the structures of the alphabetisation campaign were identified as appropriate partners.

*Analysis:*

The results discuss the issue FGM in five provinces of Burkina Faso from many perspectives. Recommendations are given in general as well as in detail, according to the geographical area of intervention.

The study covers in a deeply explorative manner qualitative and quantitative aspects of FGM and fulfils therefore the need of the implementing NGOs for baseline information. Local differences and views of different target groups can now be taken into account when planning for future interventions. Exhaustive qualitative information has been drawn from interviews and FGDs. Recommendations are specific and especially useful to the implementing NGOs. A follow-up or repeat survey will provide measurement of indicators for trend monitoring of the age-specific FGM prevalence rate, which can therefore be an indicator for long-term success of the initiatives.

In Upper **Egypt** another baseline study with a mixed approach, exploring the prevalence and determinants of female circumcision (Ragab, Abdel-Fatah, El Kassas, 2000), was conducted. The researchers wanted to quantify the problem of FGM and to identify its socio-cultural determinants in order to be able to design an appropriate intervention. To obtain both qualitative and quantitative information about FGM, they chose a quantitative survey with standardised questionnaires in combination with in-depth interviews and focus group discussions. 1,616 respondents in households were interviewed after multi-stage sampling (i.e., first a purposive sample of the villages in the area of study was chosen and then a representative sample from the households in a village by randomly sampling 5 clusters from each village was chosen). Representatives of the questioned target groups were men (married and unmarried), women and unmarried girls. For the in-depth interviews 35 men and women were randomly chosen.

The in-depth interviews and FGDs provided a number of reasons for the continuation of FGM like religious necessity, beautification, control of sexuality, better health and sexual intercourse. Those, who wished the practice to be discontinued, mentioned reasons such as health problems and marital problems. According to them, FGM is not based on religion and is a harmful traditional practice. 98% of the female respondents affirmed that they had been circumcised. 90% of mothers, 71% of unmarried men and half of the unmarried girls intended to circumcise their future daughters. Main decision-makers are the grandmothers, whereas men only play a marginal role in this process. The main providers of the practice are medical doctors (39%). The practice continues, even though the knowledge on the complications of FGM is high. The recommendations include awareness-raising through health messages, integrating IEC about FGM in health programs and involvement of community leaders.

#### *Analysis:*

The study provides an in-depth picture of the deeply rooted traditional practice of FGM in this area of Egypt. It clearly demonstrates the contradiction of the well-known health problems due to FGM, while continuing the practice. It also shows the high degree of medicalisation due to this awareness. Striking in comparison to many other countries is the extremely high FGM prevalence rate, with little hope for future change according to the decision-makers. The high prevalence rate and the intention to continue the practice mirror the results of the last DHS, which measured at 97% the FGM prevalence rate among ever-married women and at 82% the wish to continue the practice.

The recommendations of the study, which propose mainly the “harmful traditional approach,” do not seem appropriate as the study already shows the high degree of awareness on the negative health consequences. To insist on this approach can lead to a higher degree of medicalisation.

### **3.3.2 Community Survey with Experimental Design**

The presented baseline surveys have been carried out with the intention to provide a programme management team with the necessary information to plan and design an appropriate intervention. Qualitative and quantitative indicators can be chosen later to monitor and evaluate whether the intervention had an influence on certain aspects like age-specific FGM prevalence, attitudes and behaviour concerning the continuation or discontinuation of the practice. Measuring the change of these indicators after a certain time of intervention will only give an approximate notion of the impact of the specific intervention, as external factors could have led to those changes. These factors can be due to other stakeholders’ activities and value changes in the community brought about through cultural processes.

Another way to measure the impact of a FGM intervention is therefore an *experimental design*, which measures changes in a zone of intervention and in a so-called control zone. The control zone (preferably an area where no interventions against FGM are taking place) should be very similar (e.g., tribe, rural or urban, professions) to the intervention zone and not too geographically close; otherwise, the activities in the intervention zone can have an impact on the control zone. In a follow-up survey of both intervention and control zones, one is able to measure the differences between the two. The impact of the intervention can be determined and other external factors, that could have created changes in FGM indicators, are filtered out.

In **Burkina Faso** the NGO Mwanganza, Unité d’Enseignement et de Recherche en Démographie (UERD), Population Council and the GTZ FGM sector project decided to document the impact of a community education programme. This community education programme approach was developed in the Senegal and implemented by the NGO TOSTAN. The intention was to replicate this successful approach in 20 villages in Burkina Faso in order to stir a process of behaviour change and monitor the impact of the education programme. To demonstrate and document the impact in this new geographical area of intervention, the researchers chose an experimental design as described above. The report (Congo, Ouoba, Banza, Guiella, Diop, 2001) presented here is the first one of the planned two surveys.

The objectives of the study were to:

- Create a database for the stakeholders.
- Evaluate the impact of the intervention, regarding issues of FGM, reproductive health and human rights.
- Evaluate the favourable measures to enhance a process of change in society.
- Promote mass mobilisation for a public declaration to abandon FGM.

The approach was mixed quantitative and qualitative. The quantitative part was covered by a survey of over 1,600 persons in the zone of intervention and about 500 persons in the control zone. Respondents were men and women, who were either already enrolled in the community education programme, their partners or non-inscribed persons. The qualitative part consisted of 192 in-depth interviews of community resource persons, men and women enrolled in the programme and their spouses, health workers, village leaders and other resource persons. 24 focus group discussions were held with female and male representatives of the population and enrolled men.

The extensive report bears a wealth of information. FGM prevalence of women between 15-49 years was measured at 79%. More than half of the women and 40% of the men approved of the practice, even though it is illegal in Burkina Faso. The FGD and in-depth interviews reveal deep insights into the attitudes and knowledge concerning FGM and demonstrate the changes that have occurred. The age of circumcision has been lowered. The process of change is on-going because of the known health effects, legal implications and the disappearance of circumcisers. Only 23% of girls have been circumcised according to their mothers. The researchers point out that some results have to be looked at with caution as fear of the law and shame might have biased various answers.

**Comments:**

This study is unique with its experimental design and the provision of information not only about FGM but also of other reproductive health issues and human rights. The researchers take great care in giving limits and describe the differences found in the future experimental zone and the control zone. One could criticise the fact that the baseline deals with persons, who are already either inscribed or intend to inscribe in the future community education programme. This means that some intervention in the form of a sensitisation or publicity for the programme must have taken place. Therefore the data collected cannot be called full-heartedly baseline data.

To measure the impact of an FGM intervention is a major effort and its outcome will provide information and guidance also for other FGM programme managers in the future. Investing in an experimental set-up during the reapplication of a successful community intervention in order to document its impact is definitely worthwhile the financial resources. It will open new avenues concerning which impact or directly project-related outcomes a FGM intervention could have and will also help to focus on best practices in FGM programmes based on evidence.

### 3.4 Action Research

The methodological approach of action research has many of the features of the studies presented before. Tools used are those of qualitative, quantitative or mixed baseline data collection. Action research goes beyond baseline data collection. It entails a combination of research geared towards an intervention, participatory planning and implementation, which afterwards is again studied with appropriate tools like a follow-up survey, additional research to explore further aspects and activities. It involves the researcher as an actor in the intervention.

Two action research studies were conducted by members of NGOs participating in an international course for action-oriented research in CIFRA (Centre international de Formation en Recherche Action), Ouagadougou, Burkina Faso, 2001. This training centre has been teaching the methods of action research for over a decade to health professionals from all over West Africa. The training module at CIFRA is completed with the development of a research proposal. The trainees then go back to their organisations and places of work to conduct their research and start off their activities based on the recommendations. When they return to CIFRA for the second phase of the training, they are able to present their action research to the other participants for peer review.

The programme advisor to the NGO APJAD (Association pour la Promotion de la Jeunesse Africaine et le Développement) participated in the training at CIFRA (Bagnomboé, 2001). His research project was to collect baseline information for the development of strategies for mobilisation of young people against FGM in the department of Orodara, **Burkina Faso**, with a population of 16,000. The NGO APJAD collaborates with the GTZ FGM sector project in the area of FGM.

The document is a proposal for the first steps of the action research, i.e., the development of tools, research planning and proposal writing. To gather information about the knowledge and attitude of young people on FGM, their state of information about FGM programmes and their possible contribution to the fight against FGM, the researcher chose a mix of quantitative and qualitative methods. He developed two tools, i.e., a semi-structured questionnaire and a guide for focus group discussions. The research questions were: how does the youth perceive FGM; what are their attitudes and practices; how do young people perceive intervention programmes concerning FGM; and, which role could they imagine themselves playing during this intervention. After calculating the representative sample size, he intends to interview a number of single girls and boys between the ages 15-24 years. Several focus group discussions are planned with youth (divided by sex and state of education) and youth leaders.

#### *Analysis:*

The project takes a small-scale and local approach with a limited target group. Some features like sample size calculation are missing, but will be supplied later. As only young people are interviewed, the perception of the other community members towards FGM and the involvement of youth in the fight against FGM are not taken into account. The methodology for the baseline data collection will provide qualitatively

tive and quantitative data and is therefore appropriate and focused on the planned intervention.

Another participant of the action research course at CIFRA conducted a very different baseline data collection. To explore the existing strategies in **Mali** to overcome FGM, she decided not to carry out a study in the field, but rather collect information that is already available (Moussa, March 2000). The method consists of a literature review and qualitative interviews following an interview guide.

Representatives of the five governmental and non-governmental implementing agencies of FGM programmes were visited and interviewed. Information was collected about their zone of intervention. A comparison of their methodological approaches, the analysis of their impact and finally the development of new strategies are presented in the study. The analysed literature is presented in the form of a historic overview of the activities concerning FGM in Mali. The results of the interviews show the FGM strategies used in Mali. Some organisations have used for their interventions IEC sessions. Other NGOs have ventured into re-conversion of circumcisers using micro-projects, capacity building of mobilisers and health personnel, research, care of FGM victims and shelters. The results are critically discussed. The short-comings of the existing strategies are turned into recommendations for new strategies.

*Analysis:*

This research method of literature review and interviews has produced a range of useful information before embarking on an additional intervention. The study is a valuable contribution to the on-going FGM activities in Mali as it summarizes and critically questions existing strategic approaches. The experiences documented here would be even more useful, if the implementing agencies would have collected baseline data before starting their activities in the field.

This kind of research is recommendable to any new actor who enters a FGM country scene before the intervention starts. The interviews with existing organisations and institutions can lead to a valuable process of networking with stakeholders and encourages the exchange of good practices.

### **3.5 Operational Research**

Operational research is characterised by an exact definition of the measurement of variables that enables another researcher to replicate the assessment procedures (Polgar and Thomas, 1995). The researcher has to provide details in which way measurements are replicable, accurate and applicable to the measurement task in hand or easy to use. This approach is applied when one of the main goals of the research is to develop a research tool that is made available for general use, e.g., a study carried out in one geographical region is to be applied in other regions by other researchers in order to have at hand a whole set of studies covering a larger geographical area at a later stage.

Two studies will be presented together as they stem from the same project and their objectives and methodological approaches are identical.

An operational research project to abolish FGM exists since 2000 in **Kenya** with the assistance of GTZ. The Kenyan partner is the Ministry of Health (MOH), which has presented its National Action Plan against FGM in 1999. The MOH/GTZ FGM project has been designed as an operational research project in order to develop and test research and programme approaches, including monitoring and evaluation tools in preparation for a more extensive intervention. Other activities of the project are networking, supporting the national plan against FGM, developing a training guide for health workers and establishing a database of IEC materials and of on-going national activities.

The Ministry of Health had chosen two districts in the Rift Valley province as intervention zones. The project carried out a baseline survey in each of the two districts before the start of an intervention. In 2000 the Baseline Survey on Female Genital Mutilation Practices in Transmara District, Rift Valley Province of Kenya (Beckmann, Bwana, Kamau, Makumi, Mbugua, 2000) was performed, followed by the Baseline Survey on Female Genital Mutilation Practices in Koibatek District, Rift Valley Province of Kenya, 2001 (Kamau, Olenja, 2001).

The objective of the two baseline studies was to establish FGM prevalence, the knowledge, attitude and practice of FGM, mortality due to FGM, monitoring and evaluation indicators, and possible strategies for intervention in each district. To gather in-depth knowledge about the socio-cultural setting of FGM in each district together with the collection of prevalence data, the research team chose a mixed approach of a quantitative survey and qualitative in-depth interviews and FGDs.

A two-stage stratified sampling approach was employed to select the study sites (in total 3 clusters from 3 pre-selected divisions in each district) and then the respondents (using a systematic random technique from every second household). In each district approximately 300 fathers, 300 mothers, 300 young adult males and 300 young adult females aged between 12 and 20 years were interviewed with a standardised questionnaire. Five FGDs for fathers, mothers, young adults (split by sex) and religious leaders were held. 25 in-depth interviews with key informants (health workers, religious leaders, parents, young adults, community leaders and traditional practitioners of FGM) were performed.

In the **Trans Mara District** the study established very high prevalence rates of FGM (74%). The prevalence among women was double (99.3%) as high as that of the girls' (48.4%). The median age at circumcision was 13 to 14 years for all ethnic groups included in the study. 65% of the mothers had undergone excision (FGM Type II, WHO) compared to only 5% of the girls. In contrast, the majority of the girls (95%) had undergone clitoridectomy (FGM Type I, WHO). The decision-makers whether to circumcise are the fathers. FGM is practiced because it is seen as a good tradition, customs and tradition demand it, for social acceptance and for marriage prospects. Health workers have circumcised 10% of the girls, a trend which is increasing. More people are abandoning the practice in the present times as girls' education is increasingly valued. More girls are getting married without being circumcised. 56% of the parents were of the opinion that FGM should continue, but around half of the youth

(53%) would like FGM to stop. The respondents proposed appropriate strategies to continue the process of change, including an alternative rite of passage.

In **Koibatek District** the FGM prevalence among the mothers was found to be 67%, but only 2.2% among the young girls. The researchers attribute this difference to an attitudinal change within the community where a new value system values formal education more than female circumcision. The local community regards FGM as retrogressive. In response as to whether respondents would circumcise their future daughters, 94% of the girls, 88% of the boys, 86% of the mothers and 73% of the fathers reported having no such intentions. Community leaders and local administrators have been disseminating messages against FGM in the past. Successful messages include the notion that FGM limits a girl's education and can spread infections like HIV. For the women it is encouraging to know that they can marry being uncircumcised. Formal education and a negative attitude of christian churches towards FGM have contributed to changes in attitudes towards the practice of FGM. The authors recommend that since the practice is essentially extinct in this district, it will be vital to outline the lessons learned to initiate change elsewhere. They recommend no further intervention.

*Analysis:*

The two baseline studies of the operational research project in Kenya are based on a mixed qualitative and quantitative research design. During the interviews of mothers, fathers, and young male and female adults, valuable quantitative information from the majority of the target groups was collected. The in-depth interviews and FGDs reach out to other important community members for qualitative data. The large number of results of the two baseline surveys can be regarded as a favourable base to participative programme planning in the community. The exhaustive description of the measurement of variables concerning FGM in the reports allows other researchers to re-apply the research design in their own area of intervention.

An astonishing result was the low age-specific FGM prevalence rate of young girls (2.2%) in Koibatek district. The last Kenyan DHS measured an overall prevalence of 62% of women of 15-49 years, which matches the FGM status of women in reproductive age in Koibatek (67%). This result shows the additional value of measuring age-specific FGM prevalence in a younger age group than of the age group explored in the DHS to gain the full picture of FGM prevalence in the community. In the case of Koibatek District, the results of the baseline data collection have revealed that even without any external intervention FGM can become almost extinct within one generation.

## 4. Recommendations and Conclusion

### 4.1 Recommendations

Recommendations can be formulated on the basis of the lessons learned from the presented studies for baseline data collection. The following list is not exhaustive, but refers to the theoretical background of chapter 2 and to the practical background of chapter 3. The recommendations include positions of the WHO and other international organisations towards research in the health sector and also for baseline data collection of FGM programmes.

#### ● **What role can the baseline data collection play in the choice of a strategic approach for a FGM intervention?**

Baseline data collection can provide the programme manager with information on the extend of the practice (FGM prevalence), the reasons for continuation, the circumcisers, the main decision-makers, the circumcision procedure, myths and rumours, known health consequences or mortality, attitudes and perception of the study population and possible strategies for intervention. Based on this information, the choice is made on which strategy is useful and on how the FGM programme will be designed.

#### ● **What is the appropriate research methodology?**

As shown in the selective baseline studies, baseline data collection is optimal when it covers qualitative and quantitative data. Only both methods combined give the full picture of FGM and the process of behaviour change in a complex cultural context. The tools include standardised questionnaires for quantitative data, and interview guides for in-depth interviews with key informants and FGDs for qualitative data. In case some specific information is already available, baseline data collection can complement it.

#### ● **Which target groups need to be addressed?**

The community consists of a number of FGM specific target groups clustered around the family (e.g., mothers, fathers, daughters, sons) or according to demographic notions (e.g., male and female adults, male and female youth). Other important target groups are circumcisers, religious and traditional leaders, the elderly, youth leaders and health workers.

#### ● **How can baseline data collection influence the intervention in the community?**

The process of collecting data for an intervention involves the community already before any activities start. Individuals are confronted with questions about a traditional practice they used to see as a normal part of their life. In FGD community members will discuss the advantages and disadvantages of FGM, its continuation, social values attached to FGM, mortality due to FGM, and these issues are discussed

in a much more open manner than usual, even if in some societies this discussion would be a taboo or inadequate. The process of change concerning FGM can already start or be influenced by these open discussions or methods of data collection. When the report of the study is fed back to the community, further discussions might occur and avenues might be opened for participatory programme planning and a participatory intervention.

● **What determines the right choice of the research questions, variables and possible indicators?**

Following the research process (see chapter 2), research questions evolve out of the initial assessment of the study area and the information already available. If the research question is to know more about the extent of FGM in the community, it is necessary to measure the age-specific FGM prevalence (variable). The change of the indicator of the age-specific FGM prevalence in a certain age group over time can then be used to monitor the long-term result of the intervention. If the research question is to find out why the practice continues, it is necessary to measure and describe the reasons for the continuation given by different community members or target groups (variable). An indicator is then set. It is important to mix quantitative and qualitative indicators to evaluate an intervention at a later stage, as changes might occur in a different speed or to a different extent, depending on what the indicator measures.

● **How can tools be developed for monitoring and evaluation?**

Monitoring and evaluation tools are necessary to have an on-going overview of what is happening during the intervention and what is part of the process of change influenced by the intervention. Depending on the chosen strategic approach, tools can be developed to measure short-term activities and their outcome. In a community development programme this can be a checklist used by a community mobiliser to record how many meetings with whom have taken place, whether issues around FGM have been discussed and decisions taken, and the proposition of an alternative rite of passage. Another example can be a health worker's regular reports about known death or health problems arising from FGM. It is useful to monitor in a participatory manner because it involves members of the community in recording processes and changes in their community.

● **How can cost-effective evaluation take place?**

Baseline data collection needs human and financial resources, which are not always available to carry out a large-scale survey. As the action-research examples show, baseline data collection does not necessarily need extensive efforts. FGDs with the target groups can provide a programme manager with enough information to start. Quantitative information can sometimes be found through national surveys or DHS and taken as a proxy. Another possibility is to convince other researchers, planning to carry out a survey about health or agricultural issues in the geographical area of intervention, to add some questions concerning FGM. Cost-efficiency can only be determined by the importance of baseline data information for the intervention and the related costs. As has been demonstrated with the examples of the selective studies, baseline information is essential to plan and carry out an intervention on FGM.

## 4.2 Conclusion

After the concept of reproductive health evolved at the International Conference on Population and Development (ICPD) in Cairo in 1994, FGM has been more in the international focus, especially with respect to reproductive rights. For many years NGOs lead the movement to try and put an end to FGM. They have increasingly found partners in development agencies to support their initiatives. Many health projects have included FGM in their community-based activities or collaborate with the NGOs in the field. The quest for appropriate strategies in the field of FGM intervention has been given more interest, which has also increased the demand for appropriate ways to determine the intervention strategy based on evidence. The baseline studies presented in this document give an overview of the international efforts to improve evidence-based decision-making for strategies of FGM intervention and to use research-based tools for monitoring and evaluation in order to determine the success or failure of these programmes.

The diversity of the selected baseline studies in research methodology and outcomes show that researchers and programme managers use different methodological approaches in baseline data information in order to gather the information needed for programme design. There is not necessarily one right way to collect baseline data. Organisational and financial aspects can play a role in the decision on which research design should be applied. In this document recommendations have been made on which methodological research approaches are most appropriate to use for baseline data collection in FGM projects. The most important is to gather both quantitative and qualitative data. The cultural context in which FGM takes place deserves to be explored from different viewpoints to gain the full picture. The community where FGM prevails is not only the provider of information, but even more important the partner in the planned intervention. Encouraging participatory ways of research can at the same time enhance participatory community-based interventions, which are appropriate to foster the process of change. Most baseline studies have not been followed by a long-term programme intervention to overcome FGM. Thus, it is not yet possible to make assumptions about their outcome and the role the baseline information. Baseline data collection, development and application of appropriate indicators for monitoring and evaluation reveal in what ways FGM interventions can make a measurable difference and which strategies are most appropriate.

FGM is seen as an intersectoral issue beyond the health sector; therefore, not only health projects or FGM specific NGOs should continue their research-based efforts to improve their interventions, but other stakeholders as in the field of education or community-based development should include baseline data collection concerning FGM in their surveys. National health surveys are increasingly taking up the task to gather information about FGM. They provide decision-making tools for policy makers, whose decisions are bound to influence the extent to which the health of the population continues to be affected by FGM.

## **Annex 1: Steps in baseline data collection**

- Step 1 ➤ Review existing literature
- Step 2 ➤ Information, identification of stakeholders, and logistical preview
- Step 3 ➤ Determination of time period (including school girls/boys at holidays, circumcision period), accessibility of terrain, rainy season, and security after a visit to the area
- Step 4 ➤ Check existence of data on the geographical area, census, and indicators
- Step 5 ➤ Detailed research design
- Step 6 ➤ Data collection
- Step 7 ➤ Data analysis
- Step 8 ➤ Presentation of data locally and nationally, publication, dissemination
- Step 9 ➤ Design of intervention including monitoring and evaluation of the process
- Step 10 ➤ Follow-up survey

## Annex 2: List of baseline studies discussed

The baseline studies mentioned in this document are listed according to the countries of origin. Their relationship to GTZ projects or other collaborators is written in brackets.

The figures in italic point to the chapter of the document where the studies are presented and discussed.

1. **Senegal** (GTZ Health Project Senegal) *3.1.1 Focus Group Discussions*  
L'excision dans la région de Kolda au Sénégal, Perceptions, Attitudes et Pratiques, Claudia Kessler-Bodiang, Gerd Eppel, Abdou Salam Guèye, August 2000. (can be downloaded at [www.gtz.de/fgm/publications](http://www.gtz.de/fgm/publications))
2. **Burkina Faso** (GTZ FGM Sector Project) *3.3.1 Method mix-FGM baseline survey*  
Etude de Base sur la pratique de l'excision dans cinq provinces du Burkina Faso, Dénéba Ouedraogo, Yimian Kaboré, Èème Sanon, January 2001.  
  
**Burkina Faso** (Mwanganza, UERD, Population Council, GTZ FGM Sector Project)  
*3.3.2 Method mix- Community survey with experimental design*  
Expérience d'un programme d'éducation à base communautaire, Rapport de l'Enquête de Base, draft, Zakari Congo, Djingri Ouoba, Baya Banza, Georges Guiella, Nafissatou J. Diop, September 2001.  
  
**Burkina Faso** (CIFRA, GTZ FGM Sector Project) *3.4. Action research*  
Project de recherche action sur les stratégies de mobilisation des jeunes contre l'excision, Cas du département de Orodara, Bakiono Bagnomboé.  
  
**Burkina Faso** *3.2.2 FGM prevalence survey*  
Enquête Nationale sur l'Excision au Burkina Faso, rapport d'analyse, Lassane Déra, François Ilboudo, Idrissa Kaboré, Adama N. Outtara, Aminita Yé, November 1997.
3. **Benin** (GTZ Health Project Benin) *3.2.2 FGM prevalence survey*  
L'excision au Bénin: Identification des facteurs explicatifs et perspectives, Dja g-ba K. Bruno, 2000.
4. **Mali** (CIFRA) *3.4. Action research*  
La persistance de la mutilation génitale féminine au Mali: Quelles nouvelles stratégies?, Adama Moussa, March 2000.
5. **Chad** (GTZ Health Project) *3.1.2 Mixed qualitative approach*  
Initiation Féminine Résultats des Recherches sur les possibilités d'amélioration de l'initiation féminine dans le Moyen Chari, Négué Fatimé Kolmagne, Kemoral Jadjobaye, September 1997.

6. **Guinea-Conakry** (GTZ Health Project Guinea-Conakry) *3.1.2 Mixed qualitative approach*  
 Etude qualitative sur les perceptions des populations de Faranah sur l'excision féminine, Daman Keita, September 1999.
7. **Kenya** (GTZ FGM Project Kenya) *3.4 Action research*  
 Baseline Survey on Female Genital Mutilation Practices in Trans Mara District, Rift Valley Province of Kenya, Samuel Bwana, Sabine Beckmann, Jane Kamau, Margaret Makumi, Margaret Mbugua, October 2000.  
  
**Kenya** (GTZ FGM Project Kenya) *3.4 Action research*  
 Baseline Survey on Female Genital Mutilation Practices in Koibatek District, Rift Valley Province of Kenya, Joyce Olenja, Jane Kamau, 2001.
8. **Ethiopia** (GTZ Health Project Ethiopia) *3.1.3 Participatory Rural Appraisal*  
 Participatory assessment on Reproductive Health issues in Dendi and Ambo Woreds, West Shoa Zone, Oromia Regional Health Bureau, WIBD Consult, 1999.
9. **Egypt** *3.3.1 Method mix-FGM baseline survey*  
 Chapter Five: Prevalence and determinants of female circumcision: a case study from upper Egypt (Assiut Governate), Ahmed Ragaii Ragab, Mohammed Nāguib Abdel-Fatah, Sanaa El Kassas, Research Monograph series No 29, CDC 29<sup>th</sup> Annual Seminar Proceeding on Population and Sustainable Development in the Beginning of the New Millennium, CDC Publications, 2000.
10. **Sudan** *3.2.1 FGM prevalence measured during a Reproductive Health survey*  
 Female Circumcision in Sudan: Future prospects and strategies for eradication, M. Mazharul Islam, M. Mosleh Uddin, International Family Planning Perspectives, Volume 27, Number 2, June 2001, pages 71-76.

### **Annex 3: References**

*Addressing Female Genital Mutilation: Challenges and Perspectives for Health Programmes, Part 1: Select approaches*, GTZ Sector Project FGM, 2001, [www.gtz.de/fgm](http://www.gtz.de/fgm)

*Female Genital Cutting (FGC): Findings from DHS Surveys, 1990-2002*. Measure DHS+ Providing information for informed decisions in population, health, nutrition. Measure DHS+, ORC Macro Inc., [www.measuredhs.com](http://www.measuredhs.com)

*Fight Against Female Genital Mutilation in Burkina Faso, National Policy to combat and law to suppress the practice of female circumcision*, presentation at the International Technical Meeting: "Towards the Development of Indicators for Evaluation and Monitoring of FC/FGM programs," Ouedraogo, Marie Berthe, Cairo, 2001.

*Introduction to research in the health sciences*, Stephen Polgar, Shane A. Thomas, 1995.

*Learning about social change: A research and evaluation guidebook using female circumcision as a case study*, Susan Izett, Nahid Toubia, 1999.

*Monitoring and evaluating programmes attempting to eliminate FGM*, Bathija Heli, WHO, 2001.

*Using Operations Research to Strengthen Programmes for Encouraging Abandonment of Female Genital Cutting* Population Council/Frontiers in Reproductive Health, Nairobi 2002, [www.popcouncil.org/pdfs](http://www.popcouncil.org/pdfs)