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**SURVEY ON FEMALE GENITAL MUTILATION
IN UPPER AND MIDDLE GUINEA**

Discussion of Principal Findings

CPTAFE

**Financing USAID/MotherCare
Technical Assistance PATH**

Conakry, April 1998

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ACRONYMS

ADRA	Adventist Development and Relief Agency
CA	Census area
IAC	Inter-African Committee on Traditional Practices Affecting the Health of Women and Children
CPTAFE	Cellule de coordination sur les pratiques traditionnelles affectant la sante des femmes et des enfants [Coordinating Committee on Traditional Practices Affecting the Health of Women and Children]
DHS	Demographic and health surveys
D K	Don't know
FGM	Female genital mutilation
MG	Middle Guinea
NGO	Nongovernmental organization
N R	No response
PATH	Program for Appropriate Technology in Health
PBUH	'Peace be upon him" (or 'peace and blessings of Allah be upon him" a phrase often uttered or written when the name of the Prophet Mohammed is mentioned)
RAINBO	Research, Action, and Information Network for Bodily Integrity of Women
RGPH	Recensement general de la population et de l'habitat [General Population and Housing Census]
UG	Upper Guinea
UNFPA	United Nations Population Fund

Forward

The following is a preliminary report of data collected by CPTAFE on female genital mutilation (FGM) in Upper and Middle Guinea. According to CPTAFE, they have already begun to use the qualitative findings to revise their IEC messages and inform the development of their next five-year plan. This was the first such research project attempted by CPTAFE, and plans are underway to carry out a similar study in the remaining two natural regions of Guinea.

PATH was asked to provide technical assistance through MotherCare, a USAID-funded project to study and promote safe motherhood. PATH staff helped develop the research proposal and research instruments, as well as co-facilitated the training of the research team and edited this report. CPTAFE has made admirable progress in learning to carry out research and complete the data collection. Both qualitative and quantitative research investigated the knowledge, attitudes, and behavior related to FGM. To date, CPTAFE has entered the survey data they collected into statistical software, and the data have been cleaned in preparation for data analysis. While some preliminary analysis has been conducted, CPTAFE will need to make further efforts to disaggregate the data by region and gender in order to make use of the data for strategic planning purposes.

During 1998, PATH will provide further technical assistance to CPTAFE through an internal PATH grants program. A PATH program officer will travel to Guinea to help CPTAFE review the research activities they implemented, further refine the analysis of the qualitative and quantitative data, and develop a set of recommendations. PATH will also co-facilitate a project start-up workshop for CPTAFE staff working in Equatorial and Forest Guinea to present the lessons learned and help develop a detailed research implementation plan, ensuring that regional issues are addressed.

PATH has facilitated the exchange of research instruments and data to help inform further research that DHS is planning to carry out in Guinea. DHS is planning to do qualitative research about how FGM occurs in the four main regions of Guinea. CPTAFE's data will be examined by DHS to look for guidance in what to expect in conducting field research, and to disaggregate some of the results. Whatever results are found will be shared with CPTAFE and PATH.

Together with CPTAFE's qualitative findings, their survey research will yield insights that will be useful for designing intervention approaches that will be tailored for each region.

Introduction

Excision or "female circumcision" is the removal of part or all of the external female genital organs (labia majora, labia minora, clitoris). It is because of its traumatizing nature that it is justly called female genital mutilation (FGM).

In the face of a recrudescence of the phenomenon of excision, with its harmful effects on the health of mothers and children, individuals and organizations have come forward to vigorously denounce FGM, a traditional secular practice that is common in Africa and certain other parts of the world.

As a traditional secular practice, FGM is deeply rooted in cultural mores, but it is a practice that has profound negative consequences on the sexual life of women, who represent a significant social and economic force.

Indeed, the women and girls who are victims of this traumatic practice may suffer a number of complications and even death. Although there are no statistics to bear out this specific assertion, it should be noted that the maternal mortality rate in Guinea, which is influenced by the practice of FGM, is 666 per 100,000 live births, according to DHS figures for 1992.

Given the magnitude of the phenomenon, courageous individuals, groups of intellectuals, and organizations, in particular doctors, nurses, sociologists, and teachers, have risen up to combat such traditional practices and their harmful effects on the health of women and children.

FGM is a social phenomenon that has stood the test of time. It is so deeply ingrained in cultural traditions that any change in the behavior of the populations who practice it has occurred very slowly, almost imperceptibly.

According to recent world statistics, at least two million girls and young women are at risk of undergoing FGM every year (about six thousand a day). The number of girls and women who are in fact subject to genital mutilation is estimated at 115 million.

There are several types of FGM, which are generally classified in three groups:

1. Clitoridectomy, or Sunnah: removal of part or all of the clitoris.
2. Excision: removal of the clitoris and labia minora.
3. Infibulation: removal of the clitoris and labia minora, with incisions in, or total removal of, the labia majora, and stitching together of the vagina, leaving an opening just big enough to allow the passage of urine and menstrual flow. This is the most extreme form of FGM.

These procedures are performed without anesthesia and cause excruciating physical pain. They are also frequently accompanied by complications such as hemorrhage, infection, tetanus, keloid scarring, frigidity, and infertility. Numerous cases of difficult childbirth have been linked to FGM. In addition, it has been proven that FGM, when performed on groups of girls using the same instrument, can result in transmission of the AIDS virus.

It should also be noted that FGM can cause psychological and behavioral problems. All these complications affect the well-being of the family. Numerous young couples find themselves faced with these kinds of problems.

The origin of this practice, which dates back to ancient times, is unclear and controversial. The rare written texts in which it is mentioned (and then only anecdotally) indicate that the practice may have been instituted by certain tyrannical feudal lords to ensure the fidelity of their wives by depriving them of all sexual feeling.

FGM pre-dates the three major monotheistic religions (Judaism, Christianity, and Islam), proof of this is the existence of a form of FGM known as pharaonic circumcision. None of the sacred religious texts contains any reference to FGM, much less any advocacy of the practice. Indeed, the Prophet Mohammed (PBUH) was reportedly shocked upon learning the details of FGM and ordered that children should suffer less from the practice. This is apparently all the prophet had to say in regard to FGM.

Contrary to popular belief, this practice has no religious basis. **In fact, FGM is not practiced at all in Saudi Arabia.**

Currently, FGM is most widespread in Africa and Asia. However, growing migration has led to an increase in the practice on other continents, notably Europe and North America.

It is well known that FGM is practiced in Guinea, but complete and accurate data on the magnitude of the phenomenon are not available, despite the existence of a national anti-FGM committee (CPTAFE) which was created in 1984. Hence, questions remain concerning the frequency, trends, and sociocultural aspects of FGM.

In response to this reality, and with a view to eradicating the practice of female genital mutilation, CPTAFE conducted this survey, the first of its kind in Guinea. Analyzing the responses that this survey provided to the various questions about FGM has required the use of scientific research tools that have brought the analysis to the very heart of the phenomenon.

At the instance of 25 other African countries that also have anti-FGM programs, the Republic of Guinea, through CPTAFE, has undertaken to evaluate the effects of the phenomenon of excision, fully cognizant of the fact that FGM is still widely practiced in the country.

This survey was financed by USAID through MotherCare, with technical assistance from PATH.

About the Republic of Guinea

[insert map of Guinea here]

Area 245 860 km²

Capital Conakry

Population of the capital (greater urban area - 1994) 1 100,000

Total population (1997 estimate) 7,500 000

Population density (1997 estimate) 30.5 persons/km²

Population density (1994) 26.4 persons/km²

Population growth rate (estimate) 2.4%

Life expectancy at birth (estimate) 45 years

Life expectancy at birth 43.9 years

Birth rate (estimate) 43 births per 1,000 population

Birth rate 47.2 births per 1,000 population
Death rate (estimate) 19 deaths per 1,000 population
Death rate 21.1 per 1,000 population
Religions Muslim, Christian, animist
Infant mortality rate (estimate) 136 per 1,000 live births
Currency Guinean franc
GNP US\$4.12 billion
GNP per capita (1995) US\$550
GNP per capita, rank in the world (1995) 118/164
Total value of exports US\$ 622 million
Total value of imports US\$ 768 million

The Republic of Guinea is bordered to the north by Senegal and Mali, to northwest by Guinea Bissau to the south by Liberia and Sierra Leone, to the east by Côte d'Ivoire, and to the west by the Atlantic Ocean. It is divided into the following four natural regions:

- **Middle Guinea** is a region of plateaus and mountains. The climate is mainly tropical, with mountain microclimates. This region serves as the watershed for Western Africa and is characterized by pastureland, with citrus and vegetable crops.
- **Upper Guinea** is a region of plains and grasslands. The tropical climate is marked by a long dry season and relatively high average temperatures. This is a region of fresh-water fishing and livestock-raising.
- **Forest Guinea** is characterized by dense vegetation and mountains that extend from the mountain range of Middle Guinea. Rainfall is heavy and the rainy season lasts about eight months a year. This is the region that produces many of the country's food and commercial crops: tea, cocoa, coffee, palm hearts, etc. Forest Guinea is also a timber region.
- **Lower or Maritime Guinea** is the alluvial basin of the coastal rivers. It is a region of food and commercial farming (bananas, pineapples, etc.) but ocean fishing is also an important economic activity. Conakry, the capital city, is located in this region.

1 About CPTAFE

CPTAFE is the Guinean national branch of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC). IAC is an international nongovernmental organization (NGO) founded in 1984 in Dakar. It is headquartered in Addis Ababa (Ethiopia). IAC encompasses 26 national committees in Africa and affiliated branches in France, Belgium, Germany, Sweden, New Zealand, Japan, and the United States.

Created in 1984 by generous male and female volunteers, CPTAFE was officially recognized by the Guinean government in 1989, under an order issued by the Ministry of the Interior and Decentralization. CPTAFE has two main objectives

- i) to fight against traditional practices affecting the health of women and children, especially female genital mutilation, early marriage, nutritional taboos, scarification and sexual exclusion of menopausal women
- ii) to promote beneficial traditional practices, such as breastfeeding and respect and care for the elderly and children

The national office is located in Conakry. Four regional branch offices are located in the principal cities of the country's four natural regions (Kindia, Labe, Kankan, and N'Zerekore)

CPTAFE's main strategy is to sensitize people to the problem. To that end, it organizes seminars, colloquiums, conferences, debates, films and theatre productions, and media campaigns (radio television, press)

The social and professional groups who have already been sensitized and have become partners in CPTAFE's efforts include traditional female "circumcisers," religious leaders, political and opinion leaders, journalists, medical and paramedical professionals (nurses, midwives, traditional birth attendants), women's organizations, students, adolescents and young people, etc.

CPTAFE has made four films, namely *Le Fardeau* [The Burden], *Ni le Coran ni la Bible* [Neither the Koran nor the Bible], *Sodia*, and *Lewru dyere*. An anti-FGM play was produced and presented all over Guinea. An anatomical model has been designed to aid in sensitization efforts and is widely used.

"Training information campaign" and "vacation without excision" programs have been conducted and training has been offered for traditional birth attendants.

CPTAFE is developing good working relations with ministerial departments in the areas of health, social issues, youth issues, and communication, among others.

CPTAFE is also collaborating with and receiving support from the embassies of the United States of America, Canada, France, and Japan, as well as USAID, UNFPA, the Association of English-speaking Women, and various international NGOs (such as ADRA and RAINBO).

In 1989, at the suggestion of CPTAFE, the Guinean government issued an official statement condemning FGM.

2 Objectives of the Survey

The objectives established for the survey on FGM are

- To determine the prevalence and characteristics of genital mutilation in the regions of Upper Guinea and Middle Guinea,
- To determine the characteristics of the girls and women subjected to FGM,
- To evaluate knowledge and attitudes about FGM among men and women in the regions surveyed,
- To document and study sources of information on the abolition of FGM and identify sources of information and effective messages (according to the target groups),
- To evaluate the impact of CPTAFE sensitization activities

This survey will make it possible, in the short, medium, and long terms to

- Establish a database on traditional practices affecting the health of women and children in particular FGM,
- Analyze the data in greater depth in order to better understand the behavior of households with regard to the practice of FGM
- Formulate and/or evaluate strategies and actions for halting the practice of female genital mutilation on Guinea,
- Provide information to medical personnel, researchers, and political decision-makers about the physical and psychological complications associated with FGM

The survey included two stages: a quantitative stage and a qualitative stage

3 Administrative Organization

The national office of CPTAFE administered the survey and was also responsible for the technical aspects

The methodology unit trained the interviewers and developed the survey. This training was conducted over 7 days in Conakry and involved 20 interviewers selected from the two regions concerned. The interviewers were mainly health workers and teachers who had already worked with CPTAFE. They were instructed in interpersonal communication and qualitative and quantitative research techniques.

The data processing unit processed the data collected. The director of the unit was a specialist in information science from the National Statistics Bureau, who was assisted by two data entry clerks.

QUANTITATIVE SURVEY

Preliminary Report

1 Survey plan

The same population clusters from the census areas (CA) used in the 1996 General Population and Housing Census (RGPH) were employed for the purposes of this survey. In order to provide an aggregate estimate at the regional level (urban and rural environments), 40 CAs were selected (20 in Kankan and 20 in Labe) in the first stage. In the second stage, from each of the CAs selected in the first stage, 5 households were chosen, which made it possible to obtain a sample of 200 households (100 in each region), in which all persons aged 15-59 were interviewed. Given that the average number of persons per household is 8 in the Kankan region and 6.5 in the Labe region, theoretically the sample consisted of 1,450 persons (800 + 650). The actual number of valid interviews ($N=672$) is shown in Table 1 below.

2 Organization of data collection

Each field team in the country included a supervisor and nine interviewers. The teams were distributed across the two regions, Labe and Kankan. Data were collected in these two regions over a three-month period (June-August 1997).

The instruments used in the collection of information were:

- a questionnaire for households
- a questionnaire for men
- a questionnaire for women

3 Characteristics of the sample

The quantitative survey consisted of a set of questions from questionnaires designed previously for girls, boys, women, and men aged 11-59.

TABLE 1 AGE AND GENDER BY REGION

Location	Upper Guinea Urban Male	Upper Guinea Urban Female	Upper Guinea Rural Male	Upper Guinea Rural Female	Middle Guinea Urban Male	Middle Guinea Urban Female	R
	87(n)	91(n)	104(n)	158(n)	44(n)	64(n)	
Ages							
15-19	12.6%	20.9%	14.4%	17.5%	22.7%	15.7%	
20-25	36.7%	26.4%	15.4%	19.82%	15.9%	17.3%	
26-35	27.4%	28.6%	15.5%	29.8%	15.9%	31.3%	
36-45	9.0%	14.3%	30.6%	24.32%	20.5%	25.0%	
46-55	9.2%	8.8%	14.3%	7.14%	4.6%	4.7%	
56+	4.5%	1.1%	9.6%	1.9%	20.5%	6.3%	
Total	100%	100%	100%	100%	100%	100%	

Prevalence of FGM

Of 314 female respondents in the two regions 98.3% said that FGM is a common practice in their communities. 99.2% of the female respondents in Upper Guinea and 97.7% of those in Middle Guinea.

These findings indicate that despite the efforts aimed at sensitizing the population and discouraging FGM, the practice continues. Moreover, 48.8% of the respondents continue to approve of it (7.3% responded "don't know" or "no opinion").

By place of residence, 100% of the women in urban areas affirm that FGM is a common practice in their communities, against 97.9% in rural areas.

Of the women interviewed, 96.4% had undergone FGM (93.2% of the female respondents in Upper Guinea and 98.6% of the female respondents in Middle Guinea). In Upper Guinea, 1.7% of the women refused to say whether or not they had undergone FGM.

In urban areas, 100% of the respondents had undergone FGM, compared to 95.2% in rural areas. 1% did not respond. The problems experienced by the women interviewed are indicated in the following table.

TABLE 2 PROBLEMS REPORTED BY WOMEN FOLLOWING FGM
(More than one answer possible per respondent)

Problem	Total number of women who reported the problem		Number of women having undergone FGM who reported the problem		Number of women not having undergone FGM who reported the problem		N R
Pain in genital organs	68	21 59%	67	22 04%	1	12 50%	0
Painful menses	120	38 10%	117	38 49%	3	37 50%	0
Painful intercourse	51	16 19%	49	16 12%	2	25 00%	0
Difficulty in urination	40	12 70%	38	12 50%	2	25 00%	0
Difficulty in childbirth	75	23 81%	73	24 01%	2	25 00%	0
Formation of scar tissue on the genital organs	33	10 48%	31	10 20%	2	25 00%	0
Urinary incontinence	17	5 40%	14	4 61%	3	37 50%	0
Leakage of feces from the vagina due to fistula formation	26	8 25%	24	7 89%	2	25 00%	0
Sterility	25	7 94%	23	7 57%	2	25 00%	0
Nervousness	66	20 95%	64	21 05%	2	25 00%	0
Depression	40	12 7%	37	12 17%	3	37 50%	0
Nightmares	86	27 30%	83	27 30%	3	37 50%	0
Lack of sexual pleasure	51	16 9%	49	16 12%	2	25 00%	0
Lack of sexual desire	50	15 87%	48	15 79%	2	25 00%	0
Inability to achieve orgasm	25	7 94%	22	7 24%	3	37 50%	0
Other problems	19	6 03%	17	5 59%	2	25 00%	0

The principal problem experienced by the women is painful menses, which was reported by close to 40% of them followed by nightmares (27 3%) and difficult childbirth (23 8%) Urinary incontinence was the least reported problem (5 4%) This same pattern was found among the women who had undergone FGM who made up the largest proportion of the sample As for the women who had not undergone FGM the number of women experiencing each problem was virtually the same averaging 2 women per problem out of the 8 women who had not undergone FGM

B. QUALITATIVE SURVEY

Preliminary Report

The qualitative survey had the following specific objectives

- To obtain in-depth information on the knowledge, attitudes, and experiences of the target groups with regard to female genital mutilation,
- To acquire new knowledge on FGM,
- To respond to questions arising during the KAP analysis,
- To derive information for the development of strategies aimed at eliminating FGM in Guinea

The instruments used for this stage were

- a focus group interview guide (girls boys, men, women, leaders),
- an individual interview guide (girls, boys, men, women, leaders, health personnel, traditional practitioners FGM)

The qualitative survey was carried out as follows During the quantitative survey two groups were identified and retained in each prefecture, the groups were selected according to age group sex, and place of residence (urban or rural), and each comprised 12-18 persons

- Girls aged 11-15
- Girls aged 16-20
- Women aged 21-34
- Women aged 35-59

- Boys aged 11-15
- Boys aged 16-20
- Men 21-34
- Men 35-59

Subsequently, one or two persons from each group were interviewed at length Two persons from each of the following categories were also interviewed at length

- Female leaders (political/religious/opinion leaders)
- Male leaders (political/religious/opinion leaders)
- Health personnel
- Traditional healers/practitioners

Two female "circumcisers" (one rural and one urban) were interviewed in depth by two professional journalists in each of the two regions (Kankan and Labe)

While the results of the quantitative survey are available in numeric form, the results of the qualitative survey will be presented here in narrative form, by age and socio-professional group

The opinions of the respondents in the two regions have been grouped together and synthesized in order to avoid tedious repetition

1 Opinions of girls aged 11-20 (synthesis)

This age group is well aware of the practice of FGM in both regions and in both urban and rural environments. The terms used to describe the practice are "Sunnigol" (a word derived from the Arab word "Sunnah") in Middle Guinea and "going to the river" in Upper Guinea. According to girls in this age group, the reasons FGM is practiced are custom and tradition, however, some of them think the tradition is outdated and should be discontinued. Others are convinced that this practice comes from the holy books, and the Koran is always cited.

These girls indicate that there are certain families and persons who specialize in this practice. In addition to these persons, they cite health personnel especially midwives and nurses as practitioners of FGM. Some girls said they knew of families that had refused to have their daughters undergo FGM.

This group reports that female circumcision ceremonies take place during school vacation periods in urban areas and after the harvest in rural areas. In fact, these two periods coincide in Guinea (August-October). They indicate that FGM is generally performed early in the morning (7 a.m.).

FGM is performed at various ages ranging from several days to 5 years of age in urban environments and from 3 to 12 years of age in rural environments. The girls interviewed believe that if the circumcision is performed at an earlier age it poses less of a risk and some of them believe that the clitoris can grow back.

They indicate that girls undergo FGM at the home of the female circumciser, at a health center or hospital, in the bush, or by the river. The fact that the procedure takes place in these specific places is indicative of its secret nature. They agree unanimously that only women perform FGM.

The girls say that it is parents (father and mother), grandparents, and aunts who decide to have their girls undergo the procedure, although in rural areas it may be the village leader who makes the decision.

Some girls ask their parents to let them undergo FGM so that they will not be teased or insulted by their peers who have had the procedure. This phenomenon is observed especially in rural areas. After sensitization, some girls will clearly tell their parents that they do not want to undergo FGM. This reaction is more tolerated in urban areas.

As advantages of FGM, the girls in this age group cite the special foods that they are allowed to eat and the new clothing they are given to wear following the procedure. In rural areas, the elaborate ceremonies that often accompany FGM are cited as an advantage.

This group does not know what kind of instrument is used to perform FGM. None of the girls had seen the instrument, but almost all thought it was a knife. They do not know whether the instrument is sterilized before the FGM procedure is performed.

They indicate that the dressings applied after the procedure are painful, but they do not know what substances are used to heal the wounds caused by FGM.

The girls interviewed have noticed that some girls have problems after undergoing FGM, but they describe them in vague terms, referring to their symptoms (pain, headache, dizziness).

This age group knows that the practitioners of FGM are paid, but they do not know exactly how much.

Opinions regarding the need to eliminate FGM vary. Most girls in this group think the practice should be eliminated, given its harmful consequences, but at the same time they are sure that it will be difficult to do so.

With respect to sexuality and FGM, opinions also vary. Reduction of a girl's sensitivity, debauchery, self-control, and pleasure during sexual relations were ideas that came up repeatedly in the discussions.

Girls in this group know that the practice of FGM has evolved and that health personnel have become involved. Many think that at a health center or hospital the girl is put to sleep before the procedure.

These girls said that everyone needs to mobilize to stop this scourge (health personnel, journalists, religious leaders, teachers).

When questioned as to whether other activities might replace FGM, the girls cited gardening, dyeing, and others.

Other than radio and television broadcasts and the sensitization efforts of CPTAFE, they do not know where information on FGM can be obtained.

The general trend in this age group is toward abolition of FGM, but it is clear that there is a shortage of information, even if these girls are generally inclined not to have their own daughters undergo FGM and are willing to participate in various sensitization efforts through the radio, television, newspapers, and theatre productions.

2 Opinions of boys aged 11-20 (synthesis)

For boys in this age group, FGM is the equivalent of circumcision, except that FGM is seen as a problem that concerns only women. They have no idea of the different types of FGM, but they

know that it is performed on girls between the ages of 3 and 13, in both urban and rural areas and that it is done in hidden places (in the bush, at the home of the practitioner by the river) or in a health center or hospital

They are not clear about the basic reasons used to justify FGM, but they frequently cite tradition and custom. Some state clearly that the practice is "just done," i.e. there is no reason for it. These young men affirm that the practitioners of FGM are paid, either in money or in kind.

From the discussions, it is apparent that boys in this age group do not often speak of FGM with girls. This tendency to think of the subject as taboo is more pronounced in rural environments.

For these boys, if a girl decides that she does not want to undergo FGM, she must negotiate with her parents. Frequently cited advantages of the procedure include: it makes childbirth easier; it prevents girls from being unfaithful, etc. This perception is very dangerous because it conditions boys' attitudes toward girls and toward FGM.

Those who had received prior information about FGM were favorably disposed toward marrying a girl who has not undergone FGM, while others in the group had no preference. At the same time, they expressed reluctance to marry a girl who has not undergone FGM for fear that she would be teased by her peers who have had the procedure. This age group has noticed that it is generally from the peers of a girl that one learns that she has not undergone FGM.

Traditional female circumcisers are identified as very wise and respected women, although some consider them witches (in rural environments) or wicked.

Few of the boys in this age group have heard of CPTAFE, but they know that health personnel are very involved in the effort to abolish FGM, to which they have no objection.

3 Opinions of women aged 21-29 (synthesis)

Women aged 21-59 think that excision and male circumcision are virtually the same procedure. The only difference cited between the two procedures is often the difference in sex.

It is interesting to note that very few of the women in this age group know the different types of FGM. However, many think that there are differences in the way FGM is practiced by different ethnic groups. They all knew that the clitoris is cut during the procedure. Some (apparently those who have received information on FGM) prefer to send their daughters to the hospital where they believe aseptic conditions are required and where only a little cutting is done.

Some of the older women in this group, especially those in rural areas, believe that excision makes a woman clean and they do not find the effort to eliminate FGM is well founded.

They indicate that the procedure is performed by the river, in the bush, or in some hidden place because the act is shrouded in secrecy and it should be performed in a place where no one can hear the girls cry. It is also considered necessary to be in a place protected from evil spirits, who might make the girls bleed.

Hospitals and health centers are also cited as places in which FGM is performed by health personnel (traditional birth attendants or midwives, nurses, doctors).

The subject of FGM is rarely discussed, unless there are complications, which are often attributed to various other causes (bad behavior by the girl prior to the operation, violation of certain nutritional taboos).

The women in this group say they rarely or never discuss FGM with their husbands, although some acknowledged that CPTAFE broadcasts have helped to prompt discussion of the subject among peer groups, spouses, sisters, etc.

In rural areas FGM is performed mainly by traditional practitioners who often also play the role of traditional birth attendant.

Whether traditional or modern, rural or urban these practitioners of FGM enjoy great respect according to the women interviewed.

The practitioner is paid, either in cash (3,000-5,000 Guinean francs or 3-5 U.S. dollars) or in kind (chickens, sheep, rice), which occurs mainly in rural areas. During the interviews with this group one respondent said "Of course the circumciser is paid, but that creates jealousy between the circumcisers. One time a circumciser circumcised fifty girls, and she received so many gifts the next morning she was found dead in her hut."

The women interviewed spoke of tradition, custom, control of sexual feeling, good upbringing, and imitation as justifications for FGM. They note that the practice has evolved with the intervention of medical personnel. Girls undergo the procedure at an earlier age (the age has dropped from 13 to 5 years). Before girls were married immediately after their "circumcision." The traditional circumcisers continue to pass down this practice from mother to daughter. Generally it is blacksmiths' families that practice FGM. This group of women has little knowledge about the instruments and medicines used during the operation.

With regard to complications, pain and bleeding were cited most frequently, although some of the women had heard that FGM is linked to sterility, fever, scarring, and fistulae.

The mothers said that they had not been present when their daughters underwent FGM. Although several of those interviewed disapprove of the practice and swear that they will not have it done to their daughters, some of those with "uncircumcised" daughters cited the girls' young age as a reason. It is therefore urgent to take action.

For these women, the advantages for a girl of not undergoing FGM are not always apparent even if they know about the negative consequences that the practice can have

They have differing opinions about whether their sons or husbands should marry a girl who has not undergone FGM

The terms "sexual agitation," "debauchery," and "sexual insatiability" came up repeatedly

The idea of women's rights did not emerge as something understood by the women during the interviews. They agree unanimously that it is very difficult to escape the influence of the family and tradition

Many problems relating to sexuality were mentioned, including frigidity, pain during intercourse and sterility, but they were not necessarily associated with FGM

The women interviewed have noticed that families are increasingly supporting their daughters and helping them to avoid FGM. They believe that it will not be easy to eliminate the practice and they cite the following resource persons who should be at the forefront of elimination efforts: health personnel, parents, teachers, political and religious leaders, women's groups, etc.

Some women said that they had heard of CPTAFE and knew that it is an organization that fights against FGM and other harmful practices, such as sexual exclusion of menopausal women. They are ready to fight alongside CPTAFE.

4 Opinions of men aged 21-59 (synthesis)

In the analysis and synthesis of the opinions of men aged 21-59, several points emerged that were identical to the findings of the interviews with women in the same age group. Hence, only the major points that differed and that represented specifically male viewpoints with regard to FGM will be mentioned here. Some of the most noteworthy comments are reproduced below:

'Excision is women's business and is linked to our traditions and our customs. Like our grandparents, we are obligated to continue the practice even though it should be done carefully to avoid the illnesses that we are hearing about nowadays.'

"Female circumcision is prescribed by the Koran."

The women who perform the excision are exceptional women because some of the girls they perform the operation on are witches, others are pursued by their stepmothers or their aunts or their grandmothers during the excision because they want to lure them into witchcraft. The circumciser must have the power to ward off all these evils."

"We must not imitate the whites in condemning our traditional values such as female circumcision "

The men noted that the decision to have a girl undergo FGM is generally made by women (mother, aunts, grandmothers), although men are always informed of the decision and their agreement is important

They rarely discuss issues relating to FGM with their wives. This attitude is more pronounced among rural men

The men interviewed knew virtually nothing about the various types of FGM or about the medicines and instruments used for the procedure

The same reasons were cited repeatedly to justify FGM: control of a girl's sexuality, good upbringing, control of the family, purification, raising the girl to a more respectable and higher social standing

Some of those interviewed have heard about the drawbacks and consequences of FGM: bleeding, headaches, dizziness, loss of consciousness, sterility, etc. During the discussions they seemed to oppose FGM for their daughters, but their answers in regard to whether their wives should have had the procedure were varied and evasive

It should be noted that the general attitude observed among men in this age group is one of resignation or indifference, with a trend toward greater resistance as the age of the respondent rises

However, some of the men interviewed, especially those who had participated in a sensitization session or heard broadcasts about FGM, expressed willingness to protect their daughters and participate in the fight against this practice

They have heard of CPTAFE, but many of them confused it with the Ministry of Health

5 Opinions of male and female leaders (synthesis)

The extent of leaders' knowledge about FGM is similar to that of the men and women in their communities. Hence, only the complementary information gained from these groups will be reported here

The term "female genital mutilation" seemed scientific to them and they could not understand why the term "female circumcision" would not continue to be used if "everyone understands it." When explanations were provided by the interviewers, almost all of the respondents changed their minds and found the term FGM fitting

All the opinion leaders (village or neighborhood leaders, village or neighborhood elders, political leaders) justify the practice on the basis of tradition and custom, although some cite the prescriptions of the Koran as justification for their statements

The religious leaders interviewed have divergent opinions some maintain that the Koran orders the practice, some say that the Prophet Mohammed personally told female circumcisers to "cut slightly" and "not overdo it " Some refused to comment on the subject In any case, none of the religious leaders who were interviewed at length gave any specific indications about the books that mention the practice

The only attempt at explanation by a religious leader is that the practice dates back to Abraham who reportedly had one of his two wives circumcised

Some religious leaders said they knew about CPTAFE, but they disapproved of talking so extensively about the female sex on radio and television or in the newspapers Others said they were willing to support CPTAFE

The leaders considered traditional practitioners of FGM respected members of their communities

In response to the question of whether FGM should be encouraged or discouraged, contrasting opinions were expressed Some maintained that the practice is part of traditional values and is prescribed by the Koran and should therefore be protected and upheld Others thought that given the harmful consequences of the practice it should be abolished

The leaders interviewed consider parents solely responsible for making decisions about the bodies of their daughters and believe that it is therefore parents who must decide whether FGM should be performed

While some said that they would not allow their sons to marry a girl who had not undergone FGM others said they would have no objection

There did not appear to be any leaders who encouraged FGM but some did oppose the efforts to eliminate the practice From the majority of the interviews conducted, the trend that emerged was toward collaboration with CPTAFE

When the leaders were asked what they might contribute to the fight against FGM most said that they could participate in sensitization sessions or at least facilitate the organization of such sessions in their communities

Although the Guinean penal code contains a law banning FGM (Article 265) none of the interviewed leaders knew about it It is for this reason that all believe that the Guinean government should seek to have such a law enacted

While the female leaders who were interviewed support the fight against FGM, the male leaders tend to stress the need to preserve the prerogatives of men as the heads of their families, and during the interviews they tried to assert their position in their communities

6 Opinions of health personnel (synthesis)

Health personnel were interviewed at length, the major findings are presented below

According to those interviewed, circumcision is different from excision, although a few health workers think that the two procedures are identical. They attribute the practice to tradition and custom, and therefore to sociocultural and religious reasons. Ignorance was also cited as a reason.

They do not know about the different types of FGM, but they are able to describe them correctly. Based on their explanations, the most frequently performed type is excision, or Sunnah, given that they speak of mutilation of the clitoris and labia minora.

They recognize that, in addition to traditional female "circumcisers" and birth attendants, excision is performed by midwives and nurses, who are paid around 5,000 Guinean francs, or 5 U.S. dollars. Some are able to earn as much as 1,000,000 Guinean francs, or 1,000 U.S. dollars per year.

Most of the health workers interviewed know about FGM because of the complications that it causes, which often result in the admission of girls who have undergone the procedure to health centers or hospitals. These complications include bleeding, infections, shock, and fainting, which are not normal conditions in girls.

Late complications are also indicated by women: pain during sexual intercourse, frigidity, dystocia, fistula formation, etc. The health professionals who were interviewed say that, except for the keloid scars, FGM rarely comes to mind in their examinations of female patients. The difficulty resides, therefore, in the fact that the complications are not specific to FGM.

Those interviewed are able to describe very accurately the types of excision they encounter, but they do not know how to classify them in the categories defined by the specialists in FGM.

Among the instruments used, they cite scalpels and scissors in health centers and hospitals and razor blades and knives among traditional practitioners.

These health workers stress that, in their health centers, the instruments used for excision are sterilized and that pre- and post-operative medication is always given. All this to underscore the difference between their practices and those of traditional female circumcisers. **Here it should be noted that the ultimate objective is abolition of FGM, not improvement of the practice, even if such improvement reduces the harmful consequences.**

Almost all the female health workers said they had undergone FGM but they were clearly opposed to having their daughters undergo the practice. These health workers did not indicate that they themselves had suffered any complications.

During the discussions, some midwives and nurses revealed that they had been requested to perform FGM, which indicates that people have been influenced by the medicalization of the procedure advocated in recent years by misinformed health personnel.

Health workers who perform FGM say that, increasingly, parents ask them to cut only a thin layer of skin or to just make it appear that the excision has been performed.

With regard to the fee paid, none of them will name an amount, they say that the amount depends entirely on what the parents of the girl are willing to pay.

For these female health workers, the performance of FGM in a health center or hospital is a way of reducing the severity of the procedure and its complications. When asked about the sensitization efforts of CPTAFE of which they are well aware, all agree on the harmfulness of FGM, and they commit to stop the practice and participate in the fight against it.

None of the health workers interviewed knew of the existence of any law prohibiting FGM.

They believe that in order to eliminate FGM, it will be necessary to carry out a vigorous effort to sensitize and inform people and, where necessary, to repress the practice.

The health personnel interviewed also suggested that alternative income-generating activities should be found for traditional practitioners of FGM who are willing to give up the practice and be retrained.

7 Interviews with traditional practitioners

After an analysis of the extensive interviews conducted by two specialized journalists with four traditional practitioners of FGM (one rural and one urban practitioner in each of the two regions Kankan and Labe), it was evident that all their comments were important. Hence they are synthesized below.

I have been a circumciser since birth. My knife was handed down to me by my mother who received it from her mother, and so on back to our ancestors. Today there are a lot of amateurs performing circumcisions, they are the ones that are causing injuries to the girls and they are the ones that are making everyone turn against female circumcision nowadays. I am 45 years old but I have circumcised more than 1,000 girls and not one of them ever got sick, not one died. The parents of these girls have a lot of respect for me and give me many gifts."

"We circumcisers are chosen by God to perform this service for girls, to make them pure so that they can pray well. As long as a girl has her clitoris, she cannot pray. We also help men to keep their equilibrium."

"Female circumcision is prescribed by the Koran and therefore by God, we do the work that God has entrusted to us. It is not by coincidence that one becomes a circumciser. To circumcise, you have to be endowed with great supernatural wisdom because, first of all, you have to be able to ward off the sorcerers and evil spirits and demons that are lurking around the girls who are to be circumcised, if you don't, the spirits will always cause problems, which are manifested as hemorrhage, fainting, and hysteria. Sometimes the circumcised girls have their jaws clenched so tightly that they can't even talk, because there are so many evil spirits. That is why we circumcisers and I'm talking about real circumcisers we prepare properly on the eve of the circumcision. We soak the knife in infusions that we prepare, we put the girls in a special hut that we make impenetrable to the evil spirits."

"The age at which a girl is circumcised depends mainly on the parents, but it ranges from 3 to 15 years. Personally, I can circumcise a girl at any age."

"The circumcision is performed in hidden places: in the bush, the circumciser's hut, on the banks of a river or stream, etc."

"There are no complications from the circumcision except those caused by the circumcised girls themselves. Some of them scratch their wounds or they lie the wrong way. There can be problems with urination, but we have a very effective medicine against that. Unfortunately, I can't tell you what it is, it's a secret."

"We don't ask anything special of the parents except the traditional ten kola nuts. Anything else they give us they give because they want to."

"Since the health professionals have demonstrated that female circumcision is harmful we have no choice but to follow them. I am not clinging to the profession of circumciser, as you say. I am willing to be retrained to become a midwife or health worker, but for that to happen, someone will have to help me."

"There are several types of circumcision: i) cutting the clitoris, ii) cutting the clitoris and the inner labia, and iii) cutting the inner labia, the outer labia, and the clitoris. But we don't do any suturing here. We apply dressings made from leaves and after a week the girl is completely healed."

"If you see that there is not much depravity or debauchery in Guinea, it's thanks to female circumcision. The 'heat' that girls feel inside is so strong that it has to be reduced through circumcision."

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'We perform the circumcision in a health center or hospital to reduce the suffering of the girls and to prevent complications such as hemorrhage, tetanus, infection, etc Unfortunately we are considered on the same level with the traditional female circumcisers who have never been to school Since everyone says that FGM has severe consequences for the health of women and children, we can stop doing it In fact, many parents today ask us not to cut anything Often we just make it appear that we have cut, but then the parents have to be very careful because their girls may be taken back to the village on the pretext that the first excision was not done properly "

"If you explain to the parents that excision has terrible consequences, the parents will not bring us their daughters, and we won't go looking for them "

"I have daughters but I won't perform their circumcision myself I will take them to another circumciser that I trust "

"I have heard of CPTAFE We are willing to cooperate with the government If the government says that we should stop circumcising, we will do it But they have to think of us, because we have to continue to live and feed our families There are some circumcisers who depend on circumcision for their livelihood "

'Personally I have never heard of a law that prohibits female circumcision in Guinea In any case no law can prohibit what God has authorized "

'Circumcision has evolved with time What our grandparents did is no longer done in our time I've thought a lot about everything that I've seen and heard about female circumcision in the past two years and I've checked for myself and am convinced that what we are doing is not in the Koran My younger brother who studied at MISR (Egypt) confirmed to me that what CPTAFE says is true there is nothing written in the Holy Koran about female circumcision "

'That's why I am ready to abandon it and join in your fight I'm willing to talk about it lots of places even on radio and television '

These statements by practitioners of FGM present a clear overview of the situation of female genital mutilation in Guinea in terms of their conception of the phenomenon and their knowledge attitudes and practices