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Exploratory Study of Countries Lacking Data on Female Genital Mutilation in the Middle East and Africa

Nazia Rose Naeem
Old Dominion University

EXPLORATORY STUDY OF COUNTRIES LACKING DATA ON FEMALE GENITAL MUTILATION IN THE MIDDLE EAST AND AFRICA

by

Nazia Rose Naeem
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Approved by:

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Karen A. Polonko (Director)

_____
Lucien X. Lombardo (Member)

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Elizabeth A. Monk-Turner (Member)

ABSTRACT

EXPLORATORY STUDY OF COUNTRIES LACKING DATA ON FEMALE GENITAL MUTILATION IN THE MIDDLE EAST AND AFRICA

Nazia Rose Naeem
Old Dominion University, 2011
Director: Dr. Karen A. Polonko

Female genital mutilation (FGM) is the cutting off of female genitals for nonmedical purposes (WHO 2008). FGM is a gender specific practice, which has no health benefits and severe consequences. In addition, the victims of this form of physical, sexual, psychological, and emotional violence are predominantly children between birth and age 15 (WHO 2008). Female genital mutilation is an egregious act, which must be eradicated. This study sought to begin the process of securing preliminary estimates for FGM in countries that lacked data on FGM in the Middle East and Africa, thereby shedding light on this extremely detrimental and oppressive practice.

The data collection process was to develop a list of Non-Governmental Organizations (NGOs) dealing with FGM, women's and/or children's rights in general for the 29 countries lacking data in the Middle East and Africa. A survey on the prevalence, predictors, and reasons for the continuation of this practice was developed and distributed

to NGOs via email. This process ultimately yielded a respondent from one NGO in 16 of the 29 countries. However, a number of the respondents work for general human rights NGOs.

Of the 16 countries, respondents in only four of these countries admitted that they knew of even one case of FGM that occurred in their country. Responses on what groups the NGOs thought are more likely to practice FGM were consistent with prior research in pointing to Muslim religion, women with lower education, rural region, and lower household wealth. Reasons these 16 respondents gave for the continuation of this practice were also similar to reasons given in prior literature including community/tradition, religion, increasing female marriage prospects, controlling female sexuality, and to keep female genitals clean. A hypothesis was generated to explain possible differences on prevalence in FGM that may exist in regions in the Middle East, North Africa, and Sub Saharan Africa. Furthermore, the key to the eradication of FGM based on the survey responses is to have community leaders and religious leaders speak out against the practice. In addition, we must promote equality amongst men, women, and children.

This thesis is dedicated to my loved ones

Allah Dad Chaudry and Saeeda Begum

Rahim Dad Khan and Noor Jahan Begum

Mohammed Naeem and Tahira Naeem

Shazia, Jahanzab, and Samra

Children of the World

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

Female genital mutilation (FGM) is a crime committed against young girls, which goes largely undetected by society. Female genital mutilation is the term that most accurately describes what happens anatomically to the girl and refers to all procedures involving partial or total removal of the external female genitalia or other injury to female organs for non-medical reasons (WHO 2008; IRIN 2005; UNICEF 2005). The procedure is generally carried out exclusively on girls between birth and age 15, and in response to legislative efforts by governments to stop this practice in some countries, it is occurring at increasingly younger ages (WHO 2008). FGM is both physical and sexual abuse of girls, which has considerable adverse short-term and long-term effects (WHO 2008). The list of consequences for women ranges from pain, shock, urinary retention, ulceration of genital, injury to adjacent tissue, septicemia, infertility, obstructed labor, hemorrhaging, infection, to even death (UNICEF 2005; WHO 2008). These serious consequences affect the female at various levels, seeping into almost every aspect of their lives, whether it is emotional, physical, and/or psychological.

Moreover, FGM is widespread. As UNICEF (2005) summarizes,

> "Female genital mutilation/cutting (FGM/C) occurs throughout the world. WHO estimates between 100 million and 140 million girls and women alive today have experienced some form of the practice. It is further estimated that up to 3 million girls in Sub Saharan Africa, Egypt and Sudan are at risk of genital mutilation annually" (4).

Given the estimates for these countries alone, it is imperative that efforts are made to gather prevalence rates for countries lacking data.

In conjunction with a multiplicity of human rights organizations like Amnesty International and Human Rights Watch, the World Health Organization (2008) includes female genital mutilation as a profound human rights violation. According to these organizations female genital mutilation (FGM) violates a series of well-established human rights principles, norms, and standards, including the principles of equality and non-discrimination on the basis of sex, the right to life when the procedure results in death, and the right to freedom from torture or cruel, inhuman or degrading treatment or punishment.

As Barstow (1999) argues, female genital mutilation (FGM) is gender-specific child abuse, child exploitation, and torture. A culture of patriarchy has been linked to FGM because it reflects deep-rooted inequality between the

sexes and constitutes as an extreme form of discrimination against and control over women. Especially in the Middle East and North Africa there are various forms of oppression placed upon women in the misogynistic societies; such as FGM, honor killing, stoning, and extreme limitation in movement (IRIN 2005). Adultarchy is also a tenant within these societies because children are the ones at the center of this abuse perpetrated by adults. In such cultures, women and children are considered property and are handled as such. Men are in control over women and girls; furthermore, adults are in control over children. Those in control in society see the benefits of female genital mutilation with respect to controlling female sexuality and ensuring virginity. These issues are consistent with patriarchal control of women and the adult's control of children.

Furthermore, neurobiology/physiology (Perry 1997) and social learning theory (Bandura 1979) capture the essence of why FGM is performed on women by women. Essentially the victims are becoming the perpetrators of the abuse. Thus, Perry (1997) insists that it is the malleable foundation of the child's brain, which is altered by internalizing the abuse through the overdevelopment of the brainstem and the midbrain causing hostility and hyperarousal. This is

caused by the trauma inflicted by FGM. In addition, the social learning theory (Bandura 1979) would predict that children model the behavior of adults and continue the cycle of violence.

Prior research on FGM has focused primarily on documenting the many adverse short-term and long-term consequences of FGM (IRIN 2005). Other studies have attempted to secure data on prevalence of those that have been subjected to this form of abuse (WHO 2008; IRIN 2005; UNICEF 2005). It is often simply *assumed* that FGM is rare to nonexistent in countries without research on the prevalence of FGM, particularly in the Middle East (WADI 2010). This is reinforced by the fact that government officials often deny that FGM exists in their country, yet refuse to allow research on this issue, including refusing to incorporate modules on FGM or any aspect of child sexual or physical abuse in the Demographic and Health Survey and Multiple Indicator Cluster Survey (DHS/MICS) or other national surveys (Yoder, Abderrahim, and Zhuzhuni 2004). It is inappropriate to assume that young girls are not in danger of FGM without some evidence and such evidence is made exceedingly difficult to obtain in many countries. While data are currently available for some countries in the Middle East and Africa, many countries in the region

still lack any data on the prevalence rates of FGM (WADI 2010; WHO 2008; Yoder et al. 2004).

In addition, due to the limited number of countries for which we have data on FGM, there is relatively little research on the social factors associated with FGM, i.e., the predictors of FGM in the countries for which we have data. Given the profound adverse consequences of FGM, it is necessary to investigate the *causes* of FGM in order to help eradicate this barbaric act. Having systematic data on the factors associated with FGM as well as the prevalence of FGM in as many countries as is possible will provide much needed additional insight.

PURPOSE OF THE STUDY

The purpose of this research was to begin the process of securing preliminary estimates of female genital mutilation for countries lacking data on FGM in the Middle East and Africa, thereby gaining new insight into this extremely detrimental and oppressive practice. In addition, the study will see if gathering estimates of FGM and related information about FGM from NGOs is a viable technique in countries where more frequently used survey research techniques (MICS/DHS) are not used.

SIGNIFICANCE OF THE STUDY

It would be a significant contribution to our understanding of FGM if some preliminary estimates, however tentative, were obtained for countries for which we lack data. There is dearth of literature on the causes of FGM and this study will be a contribution. Theoretically this form of female child sexual and physical abuse will be explored through the lenses of neurobiology/physiology, social learning theory, patriarchy/misogyny, and adultarchy. In addition, suggestions related to reducing FGM will be developed.

The next chapter is the literature review, which will provide the foundation of understanding for this study.

CHAPTER II

REVIEW OF THE LITERATURE

Most of the prior literature on female genital mutilation (FGM) has focused on either trying to establish prevalence rates or on documenting the considerable and grave consequences of the procedure and ways to eradicate the practice (WADI 2010; WHO 2008; UNICEF 2005; Yoder et al. 2004; Hosken 1979). Relatively little research has been done sociologically in exploring the factors associated with FGM. What research has been done on predictors, while welcome, appears most often in NGO documents rather than refereed journals and results are often presented in ways difficult to assess independent of brief descriptions (i.e., significance levels are not given). Thus far, connections between FGM and sociodemographic variables such as women's education, household wealth, place of residence, religion, and ethnicity have been explored although primarily descriptive in nature. Conceptual frameworks include level of inequality regarding women and children's rights.

The objective of this chapter is to review the literature on FGM in the Middle East and Africa and identify key trends and findings. Research on FGM will be

obtained through published and unpublished scholarly, government, and NGO documents. This review will provide insight on how to secure additional estimates of FGM for countries in the Middle East and Africa for which data is currently lacking. Therefore, the expansive literature review will allow us to broaden our understanding of the causes of FGM and to establish a pattern of the distribution of this monstrous act.

PREVALENCE OF FGM

Estimating the prevalence of FGM has been a difficult task. It is imperative to estimate the prevalence of FGM to understand the extent of the phenomenon and the number of women and children at risk. Francis Hosken published *The Hosken Report* in 1979; this was the first effort made to estimate prevalence of FGM at a national level. The report shed light on the prevalence of FGM in 28 countries. However, it was perceived that this report was based on subjective evidence. Furthermore, Demographic Health Surveys (DHS) and the Multiple Indicator Cluster Surveys (MICS) began using a series of questions on FGM in selected countries in northern Sudan in 1989. By the end of 2004, DHS/MICS surveys had asked questions on FGM in 18 countries.

To date, the Demographic Health Surveys (DHS) and the Multiple Indicator Cluster Surveys (MICS) with the FGM modules have been conducted in 29 countries (Appendix A). These surveys focused on two types of prevalence indicators. The first addresses FGM prevalence levels among women between the ages of 15-49 who have undergone FGM. The second addresses the proportion of women 15-49 with at least one daughter who has undergone FGM. Decades later there is still not enough research and data on the presence of FGM in the Middle East and Africa.

FGM to a certain extent is a universal phenomenon that impacts the lives of women and children. In North Eastern Africa, prevalence varies from 97% in Egypt to 80% in Ethiopia. In Western Africa, prevalence varies from 99% in Guinea to 5% in Niger. In addition, the prevalence rates for South Eastern Africa are relatively lower ranging from 32% in Kenya to 18% in the United Republic of Tanzania (UNICEF 2005). To reiterate, as UNICEF (2005) summarizes,

> "Female genital mutilation/cutting (FGM/C) occurs throughout the world. WHO estimates between 100 million and 140 million girls and women alive today have experienced some form of the practice. It is further estimated that up to 3 million girls in Sub Saharan Africa, Egypt and Sudan are at risk of genital mutilation annually" (4).

This illustrates the urgency of eradicating a practice that affects the lives of millions of women and children.

WOMEN'S EDUCATION

The pattern in the research done by UNICEF (2005:Table 1B) suggests that women with higher education are significantly less likely to have been subjected to FGM. UNICEF (2005) states, "FGM/C prevalence levels are generally lower among women with higher education, indicating that circumcised girls are also likely to grow up with lower levels of education attainment" (9). In Tanzania the likelihood of women to have undergone FGM was significantly higher among women who were illiterate; and, as education level increased, support of FGM decreased (Msuya et al. 2002:160). In addition, Snow et al. (2002) found that, in Nigeria, "The highest proportion of FGC (66.6%) was found among women with the least education (primary or less schooling)" (96). Another Nigerian study found the same relationship, "…the higher the education of the women, the less likely they are to practice female circumcision" (Okemgbo, Omideyi, and Odimegwu 2002:111). In Egypt, women's educational status is associated with the prevalence of FGM (EFCS 1996). A study found that if women were educationally empowered it would help towards the eradication of FGM (Islam and Uddin 2009). Furthermore, a study in Ghana found, "…educational attainment among females to be the most important social correlate of

cutting, with lower rates of cutting with higher education" (Adongo et al. 1998:26).

Generally, the pattern in the research done by UNICEF (2005) suggests mothers' with higher education are significantly less likely to subject their daughters to FGM. UNICEF (2005) also states, "Mother's level of educational attainment, moreover, appears to be a significant determinant of the FGM/C status of daughters" (9). In addition, "It is generally observed that women with higher education are less likely to have circumcised daughters than women with lower or no formal education" (UNICEF 2005:9). Yoder et al. (2004) states, "Overall, it can be seen that daughters of mothers who are more highly educated are less likely to be circumcised than daughters of mothers with little or no education" (29). Tag-Eldin et al. (2008) went on to assert that in Egypt, "Parents with low or no education are the most likely to have circumcised their daughters with prevalence rates ranging between 59.5% and 65.1%, while parents with higher degrees of education are the least likely to have their daughters circumcised and the prevalence rates ranged between 19.5% and 22.2%" (271). A Nigerian study found that higher parental educational status is associated with lower rates of daughter's FGM (Ehigiehba, Selo-Ojeme, and Omorogbe 1998).

The one contrary finding DHS reported found that FGM was higher amongst more educated women in Nigeria (Yoder et al. 2004). According to the DHS, "The lack of a relationship in Nigeria may be due to the confounding factor of ethnicity, because FGC is practiced by the Yoruba groups, who are also more likely to be educated" (Yoder et al. 2004:28). Ethnic groups may try to maintain their ethnic identity by continuing to practice FGM.

FATHER'S EDUCATION

Father's education has also been found to be negatively related to daughters FGM status. In Egypt, fathers with higher education were significantly less likely to subject their daughters to FGM (Tag-Eldin et al. 2008). Furthermore, the study found that, "Educational levels of mother and father were negatively associated with FGC" (Tag-Eldin et al. 2008:272).

HOUSEHOLD WEALTH

In general, the pattern in the research done by UNICEF (2005:Table 1B) suggests women of a higher socioeconomic status are less likely to be genitally mutilated. Household wealth was measured by consumer wealth (ownership of television, car, and so forth). Wealth is an

interesting variable because women can be both born into or married into wealth. Therefore, it is more accurate to look at current parent household wealth in regards to how it impacts the daughters FGM status and the household wealth of the parents of the wife and husband while growing up for the woman's current status (UNICEF 2005).

Once again, data for Nigeria are contrary to this pattern found for most countries as in Nigeria FGM is highest amongst the wealthy. This same trend was found in Sudan, the authors' state, "Women living in wealthier households…are more likely to be circumcised" (Islam and Uddin 2001:76). Since FGM is found within the upper class families, it is postulated that less advantaged families may be adopting FGM to increase their daughter's marriageability to higher-status individuals (Williams and Sobieszczyk 1997; Mackie 1996).

PLACE OF RESIDENCE

By and large, the pattern in the research done by UNICEF (2005:Table 1A) suggests that women living in urban residence are less likely to be genitally mutilated than in rural areas. In addition, UNICEF (2005:Table 2A) found that women living in urban areas were less likely to have their daughters mutilated. In Mali, "More rural than urban

women were cut…" (Jones et al. 1999:22). Okemgbo et al. (2002) found that a region in Nigeria had higher rates of FGM amongst the rural residents. Similarly in Egypt, higher rates of FGM were found in rural schools than in urban schools (Tag-Eldin et al. 2008). All of the findings suggest that rural residence is a risk factor for FGM. In addition, a rural residence may suggest a more traditional society that tries to maintain practices like FGM. Place of residence is an important variable that requires further exploration.

Nonetheless, in Nigeria and Yemen higher rates of FGM were found amongst the urban residents (UNICEF 2005). According to UNICEF (2005) this alternate pattern may be due to the urbanization of these countries and the influx of rural residents into urban areas. Although opposite results to the general patterns for other countries tend to be found for Nigeria across virtually all of the factors.

RELIGION

The consistent pattern in the research done by UNICEF (2005:Table 1C) suggests, Muslim women are more likely to be genitally mutilated than non-Muslim women. Just like for education and residence, religion has a strong relationship with FGM, possibly the strongest. A study

conducted in Tanzania found the likelihood that women had undergone FGM was significantly higher among Muslim women (Msuya et al. 2002; Klouman, Manongi, and Kleep 2005). In a Sudanese study carried out by Islam and Uddin (2002) FGM was found to be almost universal in both provinces that were predominantly Muslim -- 99.6% in Shendi and close to 90% in Haj-Yousif. Finally, when logit regression is performed, although no variable has a significant net effect on the near universal FGM rates in Shendi, for both Haj-Yousif and Juba, controlling for all of the other factors, Muslim women are still more likely to be subjected to FGM in both the predominantly Muslim and predominantly Christian provinces. This study is consistent with UNICEF (2005) in finding that Muslim women in the Middle East and Africa are at a much greater risk of FGM than women of other religions.

Overall, the pattern in the research done by UNICEF (2005) suggests Muslim mothers are significantly more likely to subject their daughters to FGM. UNICEF (2005) asserts, "Muslim women are more likely to have circumcised their daughters than woman of other religious affiliations" (10). A study of ever-married women in 3 provinces of Sudan found that 71% in Haj-Yousif, 64% in Shendi, and 2% in Juba, wanted to have their uncircumcised daughters

circumcised (Islam and Uddin 2009). More than 90% of the population in Haj-Yousif and Shendi is Muslim, whereas, more than 90% of the population in Juba is Christian; in addition, FGM was predominantly found amongst Muslim women in these provinces (Islam and Uddin 2009). This links Islam to the perpetuation of FGM throughout generations. Therefore, Muslim women are more likely to have their daughters mutilated.

According to many Muslim scholars, the prophet is alleged to have said, "Reduce but do not destroy; this is enjoyable to the woman and is preferable to the man" (Bodman et al. 1998:44). Also, "Muslim groups that practice this custom often cite religious justifications and may precede the ceremony with a prayer or recitation of verses from the Qur'an" (Bodman et al. 1998:42). A study in Guinea conducted a multivariate analysis and found the continuation of FGM was supported on the basis that it is a religious requirement; 84% of the respondents were Muslim (Gage and Rossem 2006). According to Osten-Sacken and Uwer (2007), "Most studies speak of *justifications* and *rationalizations* for FGM but do not speak of causes since this could implicate Islamic rules relating to women and sexual morality" (4). Nonetheless, it is important to remember, "Even though the practice can be found among

Christians, Jews and Muslims, none of the holy texts of any of these religions prescribes female genital mutilation and the practice pre-dates both Christianity and Islam" (WHO 2008:6).

To reiterate, these findings make two things clear, while FGM can be found in the Middle East and Africa among adherents of all religions including Muslim, Christian, Aminist, and Traditional, FGM is consistently and significantly higher and more pervasive among Muslim women in these regions. This is an indication that more efforts need to be made to conduct research on FGM in predominately Muslim regions like the Middle East.

With regards to religion, Nigeria is the outlier where majority of the women who had undergone FGM were Coptic Christian with the lowest proportion of FGM among Muslim women (Snow et al. 2002). Women who were Fundamentalist Pentecostal Christians were significantly more likely to have been subject to FGM than women who were Catholic and Protestant Christians, Muslims and of other traditional religions. Fundamentalists in this country also tend to differ from most other denominations of Christianity in terms of being much more traditional. It is stated that, "Pentecostal churches in Nigeria is relatively recent, almost all of its adherents will have undergone FGC (FGM)

long before joining the churches" (Snow et al. 2001:97). This link between FGM and one group of Christians, Fundamental Pentecostals is important to pursue, as Pentecostal Churches are relatively new and increasing. Also, this provides potentially another insight that may help us understand the dynamics of religious practices associated with FGM. Practice of FGM amongst Pentecostals may be higher than other Christians in Nigeria and higher than Muslims due to the fact that they could be new converts (Snow et al. 2001) or due to other factors such as ethnicity, education, levels of misogyny, etc. The Pentecostals may have been a part of another group of Christianity or Islam, when the act of FGM took place. If this were the case than the findings would be inline with previous literature. Nonetheless, it is imperative to remember that FGM is predominately found amongst Muslim women.

ETHNICITY

According to UNICEF (2005), "Among all socio-economic variables, ethnicity appears to have the most determining influence over FGM/C distribution within a country" (11). Understanding the various ethnic groups and the trends of FGM within these groups is imperative. The ethnic groups

have their own normative traditions and the age at which FGM is performed within these groups seems to vary. One of the strongest predicators of FGM status in Tanzania was ethnicity (Klouman, Manongi, and Kleep 2005). Tribal differences regarding the age of mutilation and prevalence were noted in Tanzania. FGM for non-Chagga women was performed when they were children; whereas FGM for Chagga took place when they were older. In Nigeria (in West Africa), "There were stark differences in the prevalence of FGC by ethnicity" (Snow et al. 2002:94). Understanding ethnic variation would be very beneficial. As UNICEF (2005) states, "Ethnicity is a significant variable that can inform the design of programmatic interventions in accordance with the specifics of the target population" (12). However, ethnicity cannot be measured across borders because it does not overlap. Nonetheless, ethnicity is tied to the cultural and religious fabric of a community and may be the overarching predictor of FGM.

REASONS WOMEN AND MEN GIVE FOR SUPPORTING FGM

Education, household wealth, place of residence, religion, and ethnicity are associated to the prevalence of FGM in the Middle East and Africa. These predictors are inline with the reasons provided by male and female

respondents for the continuation of FGM (UNICEF 2005). Citing religious reasons as a justification for FGM can be linked to findings on the actual relationship of patriarchy. Patriarchy is associated with reasons such as, controlling female sexuality, hygiene/cleanliness (assuming female but not male genitals are inherently unclean), better marriage prospects, greater pleasure for husband, and virginity/chastity. All of these reasons relate to control of the female sexuality and would most likely be related to the woman's educational level. A third cluster of reasons given involve "community and tradition" as the major contributors of FGM—that's the way it has always been done.

"Custom and tradition" was the most mentioned explanation provided by the men and women for the persistence of FGM (UNICEF 2005). In Egypt, 1,600 women cited the motivations behind FGM as tradition (32.9%), religion (28.6%), hygiene (18.3%), and diminution of libido (6.6%) (Bodman et al. 1998:41). Another Egyptian study asserts, "Religious reasons, traditions and social pressure are the main motives for performing FGC" (Tag-Eldin et al. 2008:271). Furthermore, Islam and Uddin (2001) found that for two of the three Sudanese provinces with a predominantly Muslim population "it is custom" was chosen

as the source for the continuation of FGM; alternatively, very few referred to religion as a motivational factor. An additional Sudanese study found that, "Among the reasons most frequently cited for the continued adherence to the custom are that it serves as an important initiation to the adult community and that it serves to construct, enhance, or reinforce femininity, female purity, or virginity in conjunction with cultural norms that govern family honor, women, in general, and female sexuality and marriageability, in particular" (Williams and Sobieszczyk 1997:968). But these are not "custom" but indicators of patriarchy. In Tanzania, "Perpetuation of tradition (67%) and the opportunity of teaching about marriage and life during the ritual (40%) were the most common reasons given for the intention to continue with the practice" (Msuya et al. 2002:161). In nations like Mali (2001) and to a lesser extent Mauritania the most common reason is religion; however, the option to select "custom and tradition" as a motivational factor was made unavailable. Whereas, the 1995 survey conducted in Mali provided the option to select "custom and tradition" and it was the most common reason cited; which is similar to the patterns seen throughout the countries practicing FGM.

Education is another reason provided by men and women for the continuation of FGM. The major findings indicated that lower educational attainment of the mother was one of the major predictors of FGM. The data specifies that mother's with higher educational attainment were less likely to be mutilated or mutilate their daughters. However, the patriarchal structure within these societies has been established around the basis of depriving women of resources like education. Data indicates, "…women's support of the practice declines as their education and economic status rise" (Islam and Uddin 2001:75). Place of residence was also cited as a reason for the continuation of FGM. Essentially, if a female lived within a rural community she would be more likely to have undergone FGM. This is inline with the theoretical perspective since rural communities are more likely to be deeply rooted with patriarchal practices. Men created religion, for men and have become the main preachers. Men might be altering the "religious truth" to gain support for such a misogynistic practice; especially when no support of FGM has been found in any religious texts.

SUMMARY AND CRITIQUE OF THE LITERATURE

Since the introduction of *The Hosken Report* (1979) not much progress has been made in the field of research on FGM. There was a dearth of data on the causes of FGM versus the consequences. While entire articles were dedicated to discussing the severe long and short-term consequences of FGM, limited literature evaluated the causes. It is imperative to also discuss the causes because it will aid in the creation of an eradication strategy. Although there is not much research on the causes of FGM, the studies that do exist provide a basis for grounding this practice within the sociological literature, allowing for the possibility of generating new hypotheses. In integrating these prior findings, new insights can be attained.

Education was analyzed through two vantage points: how a woman's educational status predicated her own FGM status and how a women's educational status predicated her daughters FGM status. As per data from UNICEF (2005:Table 1B), in 13 out of 20 countries analyzed, FGM was related to education. FGM was found to be associated with Islam in a majority of the studies; however, in Nigeria it was linked to one sect of Christianity (Snow et al. 2001:97). Place of residence seemed to be a confounding factor; however, it

was underdeveloped. The limited literature that did discuss place of residence, found that FGM was more prevalent within a rural setting; however, Nigeria and Yemen were exceptions. Authors seem to use ethnicity as a crutch for any disparities found amongst the countries. Although, it would be interesting to see how ethnicity could dictate such disparities; it is difficult to do so because ethnicity does not seem to overlap across borders.

Although, education, household wealth, place of residence, ethnic group, religion, and other reasons were explored in regards to the continuation of FGM, it is important to remember, "In seeking to understand why members of a certain society continue to practice FGC, the explanations are shaped by where the observer has chosen to look" (Yoder et al. 2004:13).

Moreover, it would be helpful if factors such as women's education, household wealth, place of residence, religion, and ethnicity were examined to measure the prevalence of FGM. Therefore, future studies conducted on FGM should measure all these factors when trying to determine the presence of FGM in countries lacking data. This would be especially helpful in determining correlations between countries.

THEORETICAL FRAMEWORK

Female oppression has been entrenched in the social fabric for generations. Female genital mutilation (FGM) is just a form of oppression within societies. This form of oppression seems to be unique to the cultures of the Middle East and Africa, just as foot binding was to Asia (Mackie 1996). Similarities between FGM and foot binding would be: both practices are universal in areas that they are practiced, practiced by even those that do not agree with it, control sexual access to females and insure chastity, necessary for proper marriage and to maintain family honor, associated with tradition and religion, viewed as an ethnic marker by some, and more (Mackie 1996). Overall, FGM and foot binding are centrally geared towards the control of women (Mackie 1996).

Neurobiology/physiology (Perry 1997) and social learning theory (Bandura 1979) capture the essence of FGM performed on women by women. Essentially the victims are becoming the perpetrators of the abuse and these theoretical perspectives explain the phenomenon. Conflict theory of sexual stratification (Collins 1975) explains the presence of FGM through the lens of patriarchy/misogyny and adultarchy.

According to Perry (1997) childhood experiences create the individual's paradigm. Different forms of trauma and neglect affect the development of the brain in different ways. Thus, this form of physical and sexual abuse leads to the overdevelopment of the brainstem and the midbrain causing hyperarousal and hostility. Majority of the time FGM is performed on girls between birth and age 15. During this malleable stage in their life exposure to such extreme physical and sexual abuse can give them the ability to cognitively perform FGM on others.

Social learning theory (Bandura 1979) has expressed the aptitude of children to replicate the behavior of their parents or other adults. Thus, when the mother or other adult performs FGM on the child, they model the behavior by carrying out the same practice on their own children. Social learning theory lends us to believe that those who have been mutilated will be more likely to view it as socially acceptable and in turn, perform FGM on others. Parents and adults are supposed to nurture the child and protect them from harms way; thus, the child absorbs the message that this is an acceptable form of violence and continues the cycle of abuse.

Conflict theory of sexual stratification (Collins 1975) addresses the necessary components for understanding

the presence of FGM within these societies. In addition, there are two overarching ideologies that explain the practice of female genital mutilation: patriarchy/misogyny and adultarchy. Both of these perspectives essentially deem women and children as property. As Bodman, Kassamali, and Tohidi (1998) purport, "It (FGM) has been discussed as a form of child abuse; as an infringement of basic human rights, that is, gender-based violence; and in terms of gender dynamics, as a deliberate attempt to curtail the sexuality of women in some patriarchal societies" (39). This property can be mutilated at the will of the "owner" (men).

Collins' (1975) conflict theory of sexual stratification is instrumental in understanding the high prevalence of FGM in some places. Conflict theory is based upon the premises that resources equate to power. Thus, solely based upon sex, men are able to obtain domination and power over women. The literature suggested that higher educational achievement of women reduced the prevalence of female genital mutilation (Msuya et al. 2002; Snow et al. 2002). Therefore, if women were offered the same opportunities as men, FGM would be less prevalent or non-existent. The patriarchal structure has created a consciousness that has led women to believe that their main

resource is their sexuality and without this resource they have no bargaining power with a man. Russell (1986) states that men use sexual domination and control over women; in this case FGM is just an extension of this form of control. Men use rape and sexual violence to exert control over women and therefore remove their resource (Collins 1975; Russell 1986). As stated by Toubin (1995) "Female genital mutilation - also commonly known as female circumcision - is an extreme example of efforts common to societies around the world to manipulate women's sexuality, ensure their subjugation and control their reproductive functions" (5). The female's genitals are the resources being removed and the men are robbing them of their sexuality.

Conflict theory of sexual stratification creates the foundation for explaining ideologies like patriarchy and misogyny (Collins 1975). Patriarchy has been entrenched in society for centuries. Mackie and LeJeune (2008) assert that, "Patriarchy, as both a structural institution and intentional act, is often used to explain the practice of FGM/C" (6). Bodman et al. (1998) make a strong argument for the presence of such a structure in the Middle East, "The roots of the patriarchal structure of society thus are to be found deep in the social history of southwest Asia" (4). The society created by man dictates all behaviors and

actions. The sexist ideal of men states that women are less valuable, incompetent, and inferior. Control and domination is the key in a patriarchal society, this view fundamentally finds women to be disposable. This sense of domination is available to men on two members of society: women and children. These members of society are deemed weak and dependent upon men. The patriarchal structure utilizes various practices to restrain and oppress women and children. The practice of female genital mutilation is a component of this patriarchal structure. The cutting of female genitalia is a way to obtain control of a woman both physically and mentally. This practice ensures a man the ultimate power in deciding an action that is quite personal and painful. Basically, every part of a woman belongs to man and can be dictated at their whim. Misogyny, which is an extreme extension of patriarchy, depicts the lower status and hatred for women in the Middle East and Africa. This hatred causes acts like FGM to be so prevalent. When the level of violence has reached such extreme proportions like hacking off female genitalia then the problem has escalated beyond discrimination and gender inequalities. The female is objectified and not viewed as a human being. The acceptance of this mutilation is rooted in the low level of respect and honor for the female gender. Only the

strong hatred for women can condone a practice that leaves physical and psychological scars.

Conflict theory can be applied to the stratification between adults and children, known as adultarchy. As stated before conflict theory equates resources with power; therefore, it is clear that children are a greatly oppressed group and easy targets based on their lack of power. Children are dependent upon adults for basic necessities. This leaves them helpless in society to protect themselves from abuse by adults. It is a societal norm to exert control and power over children. Therefore, since men use sexual violence to oppress women, FGM is utilized to oppress female children. Adultarchy exists in societies that are dominated by adults that do not consider the consequences that certain decisions or actions make on the youth. Societies, which are adult centered, may lead to higher rates of child sexual abuse like FGM. This is because the children are deemed insignificant and their needs are not considered. These societies neglect to address issues that are surrounding children like FGM. Adultarchy allows us to understand why policies are not created to prevent and cope with FGM. If such policies are created it is the enforcement of the policies that is lacking. The presence of adultarchy in these societies

provides insight into the dynamics of female genital mutilation.

The theoretical perspectives illustrate women and children as an inferior group dominated by men. The patriarchal structure is entrenched into the minds of these children and causes them to become perpetrators in adulthood. In addition, it displays how acts like female genital mutilation can exist and continue for centuries.

The literature review identifies certain factors like women's education, household wealth, place of residence, religion, ethnic groups, and level of patriarchy to the presence of FGM. The level of patriarchy is indicated through the reasons for the presence of FGM: FGM preserves virginity, prevents promiscuity, increases marriage prospects, brings pleasure to the husband, and hygiene.

The contribution of the current research is to provide data on prevalence of FGM on countries lacking data, particularly the Middle East and the southern regions of Sub Saharan Africa. Furthermore, this research is exploratory to see if countries lacking data in the Middle East and Africa are consistent with prevalence and correlates of FGM found in countries we do have data for. If significant amounts of data were collected from the survey, then this research will also help us understand why

FGM continues in some countries and why it does not in others, and this information will help with policy implications. Although, this research is exploratory it should shed light on this practice and promote further research in the area.

It was hypothesized that FGM will be present in all of the 29 countries in the Middle East and Africa for which estimates will be secured. These rates were to be in line with their neighboring countries; therefore, it was postulated that countries in the Middle East have low rates of FGM, countries in North Africa have high rates of FGM, and countries in Sub Saharan Africa have medium rates of FGM.

While keeping this literature and theoretical grounding in mind, this research attempts to bring about estimates of FGM and hopefully reasons for its continuation for countries lacking data on FGM in the Middle East and Africa, and to help shed a light on this extremely detrimental and oppressive practice.

The next chapter will further explore the methodology that will be used to address these areas of interest.

CHAPTER III

METHODOLOGY

This chapter discusses the research methods for carrying out this study on FGM including research design, research population, measurement, and analysis.

RESEARCH POPULATION

A list of countries by region in the Middle East and Africa was extrapolated from the UNICEF website (www.unicef.org/infobycountry). Based on the countries that DHS/MICS did not have data for, a list of countries lacking data on FGM in the Middle East and Africa were identified. The list included four of seven countries in North Africa: Algeria, Libya, Morocco, and Tunisia; eleven of thirty-four countries in Sub Saharan Africa: Botswana, Burundi, Congo, Equatorial Guinea, Gabon, Lesotho, Madagascar, Namibia, Rwanda, Seychelles, and Swaziland; and fifteen of sixteen countries in the Middle East: Bahrain, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, Turkey and United Arab Emirates (Appendix B).

Non-Governmental Organizations (NGOs) were selected as sources of information about FGM versus Governmental

Organizations to eliminate bias. A NGO is a nonprofit organization that pursues wider social aims without a political agenda. Whereas, governmental organizations in countries that do not collect data on FGM would have a stake in reporting that FGM did not occur in their countries (Yoder et al. 2004). My study was focused on finding an alternative to researching FGM without surveying population samples; therefore, NGOs seemed like a good alternative. NGOs working with women and children would be more likely to interact with women and have more direct information about the practice of FGM. If there are traces of FGM within the nation it is more probable that the NGO respondent would have encountered FGM at some point and would be more apt to answer questions candidly about FGM. Although, many NGOs are limited in their scope and authority they were still the best option to get preliminary insights into the presence of FGM within the nations missing data.

Once it was decided to survey persons in NGOs, a list of Non-Governmental Organizations (NGOs) most likely to encounter FGM in each of these 29 countries was developed. Unfortunately, at least to my knowledge, there were no lists of specific NGOs working to prevent FGM, especially in the countries where no data are available and no surveys

have been conducted. As such, one of the contributions of my research was to create a list of NGOs to survey for each country. The aim was to survey *at least* one NGO within each nation that worked specifically on FGM, and lacking that, to survey more general NGOs that advocated for women and/or children and who might have knowledge of FGM. Every attempt was made to be as thorough as possible in identifying NGOs to include in this study. The following section discusses the steps that were used to identify NGOs that would be contacted.

NON-GOVERNMENTAL ORGANIZATION SEARCH

First, eight NGOs were identified through professional contacts of my thesis committee members. Of the eight NGOs only one completed the survey.

Second, regional organizations in the International Society for the Prevention of Child Abuse and Neglect (ISPCAN) membership list in the Middle East and Africa were identified. The list serve was located through the ISPCAN website (www.ispcan.org) and was made available to members only; therefore, as a member I was able to gain access. ISPCAN works with professionals to eradicate all forms of violence against children: physical abuse, sexual abuse, neglect, street children, child fatalities, child

prostitution, children of war, emotional abuse, and child labor. ISPCAN did not provide email addresses for the ISPCAN regional offices. Therefore, I called the ISPCAN main office in Aurora, Colorado to inquire about their efforts in my countries of interest. I was informed that I could email (ispcan@ispcan.org) the main office, which will then be able to forward the survey to regional office/members in my countries of interest. I did call the main office back 10 times and received a response 3 times. I was informed that the survey link had been dispersed to regional offices/members in my countries of interest. Therefore, I sent 33 individual survey links via email to ISPCAN with a country name in the subject line and received 0 responses.

Third, Child Rights Information Network (CRIN) was used to identify national coalitions of children's rights advocates in the target countries. Once I entered the website (www.crin.org), I was able to locate CRIN members by regions or country name. CRIN is an international network that envisions a world in which every child enjoys all of the human rights promised by the United Nations, regional organizations, and national governments alike. CRIN is a global network of over 2,100 organizations that regardless of primary focus support the United Nations

Convention on the Rights of the Child. In addition, CRIN collects and disseminates information relevant to children's rights activities and research in 150 countries. However, CRIN is a vast network that works in other areas besides just for the welfare of children. Various children's NGOs are a part of the CRIN network and can be located by country. Through the CRIN membership list individual NGOs from each country were targeted in this research. This yielded 86 NGOs covering 22 countries, of which 82 with valid e-mail addresses were contacted. 80% of these NGOs worked with children, 4% worked with women, and 16% worked in the general area. Two respondents from this list completed the survey.

Fourth, the United Nations Children's Funds (UNICEF) regional/country offices were located through the UNICEF website (www.unicef.org). UNICEF is a leader in anchoring the rights of children and the leaders in children advocacy. UNICEF has 190 offices located around the world; therefore, individual country offices in the countries of concern were located in the Middle East and Africa. UNICEF offices contributed to a total of 29 NGOS with at least one for each of the 29 countries. Of the 29 UNICEF offices, 25 had valid emails and 2 offices completed the surveys.

Fifth, NGOs dealing directly with female genital mutilation were identified through Google searches. The search included (country name/region + female genital mutilation or female genital cutting or female genital circumcision). Although, 20 NGOS working on the issues related to FGM were identified, none of them were involved in our countries of interest (Appendix C). Therefore, these 20 NGOs were emailed for possible contacts that they may have in our countries of interest and none responded. In addition, only 1 FGM NGO working in a country of interest was located and it did not respond to the survey either.

Sixth, general NGOs that work for the rights or general well being of women, health, and violence in the Middle East and Africa were investigated. These NGOs were located through the search engine Google. The search included (country name/region + violence against women or women's rights or women's NGOs). Refer to Appendix D for the basic websites visited to locate these NGOs from Google. A total of 40 NGOs were located and 27 NGOs had valid emails. Of the 27 NGOs, 4 NGOs participated in the study.

Seventh, wide-ranging NGOs that work for the rights or general well being of children, health, and violence were

identified through search engines like Google. The search included (country name/region + violence against children or children rights or children NGOs). Refer to Appendix D for the basic websites visited to locate these NGOs from Google. Of the 36 NGOs located, 29 provided valid email addresses and 2 completed the survey.

Eight, broad-spectrum NGOs with general human rights efforts in the Middle East and Africa were identified through Google. The search included (country name/region + human rights or peace or equality NGOs). Refer to Appendix D for the basic websites visited to locate these NGOs from Google. Of the 60 NGOs located, 54 provided valid email addresses and 5 completed the survey.

These sources led to the list of contacts, which included 293 NGOs. Of the 293 NGOs referred to in one or more of the above sources, 34 had invalid email addresses, leaving a total of 259 NGOs to send the survey to. See Appendix C for list of the 259 individual NGOs contacted. I requested that the NGOs that received the survey, forward it to their colleagues within other organizations who might have knowledge of FGM practices. In one instance, a respondent from the women's NGO forwarded the survey to 300 of the organizations members resulting in still no responses.

Table 1, provides an overview of the NGOs located, contacted, and responses received from the Middle East and Africa. General human rights NGOs and women's NGOs contributed most, whereas the ISPCAN regional offices/members contributed none. ISPCAN took responsibility to forward the survey to its regional offices or members working within our areas of concentration, this was also confirmed through my telephone conversation. Therefore, it is assumed either no one responded or the survey was not distributed to its members as suggested.

RESEARCH DESIGN

All 259 NGOs with a valid email address were emailed and within the text of the email, a link to the survey, generated through Survey Monkey was provided. This email with the link to the survey was resent every week for eight weeks, to the 259 NGOs identified. Through this process a total of ten responses were obtained.

Due to the severely low response rate i.e., less than 4%, I started making phone calls to the NGOs. Through the initial contact list of 259 NGOs, at least one NGO in all of the 29 countries was contacted. The NGO that I called was based on the availability of a valid phone number and

Table 1. Types of NGOs.

NGO Type	Number of NGOs Located	NGOs with Valid Email	Number of Responses	Percent Of Total Responses
Professional Contacts	8	8	1	6.5%
International Society for the Prevention of Child Abuse and Neglect	33	33	0	0%
Child Rights Information Network	86	82	2	12.5%
United Nations Children's Fund	29	25	2	12.5%
Prevent FGM Organizations	1	1	0	0%
General Women's NGO	40	27	4	25%
General Children's NGO	36	29	2	12.5%
General NGO	60	54	5	31%
N =	293	259	16	100%

if they worked specifically with children/women. Although, calling more than one NGO in every country would have been suitable, limited resources and time were a deterrent. One NGO was contacted in 19 countries, 2 NGOs in 9 countries, and 3 NGOs in 1 country (Table 2). During each phone call I requested to speak with the head of the NGO. I was placed with the NGO head in 3 of the 6 instances. I explained the intent of my research and the way they could contribute. If the individual seemed intrigued then I further discussed issues of FGM within their nation. Whether or not he/she said FGM existed within their nation, I asked for their personal email address so I could send them the survey link via email. Due to the language barrier it was difficult to communicate with 4 of 6 the NGOs. In addition, I utilized the help of a male friend to contact the NGOs as well. I was hoping that he might have a better chance of getting information from the male respondents. Although, he was treated with respect, he did not make progress either. Leading me to conclude that the reluctance was due more to the topic than the gender of the interviewer.

Over a period of four weeks an additional six responses from the 41 NGOs contacted through telecommunication were secured. Overall, through the use

Table 2. Responses secured through telecommunication.

Region/Country	Number of NGOs Contacted	Number of Responses
North Africa		
Algeria	2	0
Libya	1	0
Morocco	3	1
Tunisia	1	0
Sub Saharan Africa		
Botswana	2	0
Burundi	2	0
Congo	1	1
Equatorial Guinea	1	1
Gabon	1	0
Lesotho	1	0
Madagascar	1	0
Namibia	1	0
Rwanda	2	1
Seychelles	1	0
Swaziland	1	0
Middle East		
Bahrain	1	0
Iran	2	1
Iraq (Kurds)	1	0
Israel	1	0
Jordan	1	0
Kuwait	1	0
Lebanon	1	0
Oman	1	0
Palestine	2	1
Qatar	1	0
Saudi Arabia	2	0
Syria	2	0
Turkey	2	0
United Arab Emirates	1	0
N =	41	6

of email and phone calls, only sixteen responses were obtained in spite of the fact that NGOs were contacted multiple times over an eight-week period.

The 16 respondents were from 16 different countries in the Middle East and Africa. Of the 16 responses, 6 were obtained through the use of telecommunication. Therefore, it is easier to make distinctions of these 6 responses, since there was contact. Of the 6 respondents secured through telephone calls 4 were male and 2 were females. Three of the four males were the heads of their NGO. Overall, 5 of the 16 respondents worked for NGOs dealing with general human rights issues. Of the 16 responses, 4 responses were from women's NGOs, 2 from CRIN, 2 from UNICEF, 2 from children's NGOs, and 1 from professional contacts (Table 1).

The goal was to try to obtain a response rate of at least 80%; however, the response rate was only 6% (16/259). At least one response was obtained from "16" of the "29" targeted countries for which data or reported surveys on FGM were not available. Therefore, the findings cannot even be generalized to the subgroups of NGOs I hoped to study.

NON-GOVERNMENTAL ORGANIZATION SURVEY

At the beginning of the survey, respondents from NGOs were informed about the study and assured that responses would be kept confidential. The term FGC "Female Genital Cutting" was used in this survey to refer to FGM, in hopes of being culturally sensitive. The survey questions were in line with the surveys conducted by DHS/MICS; however, the only major difference was the research population. The survey asked NGO representatives for their best estimate on the prevalence of FGM in their respective country, which groups were more likely to practice FGM than others, and reasons why they thought it did or did not exist. A full version of the questionnaire can be found in Appendix E and coded version can be found in Appendix F.

MEASURES

FGM Perceived Prevalence

The first question asked the respondent if they knew of at least one case of FGM. If they stated yes, then they were asked questions in regards to percent FGM, type, or factors perceived to be related to FGM prevalence, and why they thought it existed/continued in their country. If the respondents said that they did not know of even one case of

FGM in their county, then they were asked why they thought FGM did not exist in their country and what factors prevented the practice of FGM in their country.

The first question asked: "Have you heard of any case of FGC in your country?": If they answered yes, they were then asked: "Overall what do you think is the total percent of females in your country that have undergone FGC?" 1 to 10%, Not Prevalent coded as (1); 11-25%, Slightly Prevalent coded as (2); 25 to 50%, Somewhat Prevalent (coded as 3); 51 to 75%, Prevalent coded as (4); 76 to 100%, Very Prevalent coded as (5).

In addition, the respondents were asked: "Overall, which of the following is the most common type of FGC in your country?" Type I: Clitoridectomy - part or total clitoris is cut off (clitoridectomy) coded as (1); Type II: Part or total removal of both the clitoris and inner lips (labia minora) coded as (2); Type III: Infibulation or Pharaonic circumcision - clitoris is removed, some or all of inner and outer vulval lips (labia minora and labia majora) are cut off and the vaginal opening is partially closed after excision coded as (3).

Factors Perceived Related To FGM Prevalence

Based on the prior literature (reviewed in Chapter 2), at least 5 variables have been shown to influence rates of FGM – place of residence, women's education, household wealth, religion, and ethnicity. If the respondent stated that FGM existed in their country regardless of the perceived prevalence, each was then asked: "For each of the following, based on your best knowledge, please put a check mark next to any group more likely to have higher rates of FGC in your country compared to others in the category:" (Table 3).

FGM Reasons For Continuation

Using categories based on prior literature reviewed in Chapter 2, respondents were then asked why they thought FGM continued in their country. Specifically, "What do you think is the most important reason why FGC continues in your country? Rank from 1 to 5: 1 being the least important and 5 being the most important" (A) Community/tradition: social acceptance in community; uphold tradition. (B) Religion: religion requires it. (C) Female Marriage Prospects: better marriage prospects; ability to marry upward. (D) Control Female Sexuality: preserve female virginity; prevent premarital sex. (E) Female Genitals

Table 3. Predictors of FGM.

Variable	Code
Place of Residence	1 = Urban, 2 = Rural, and 3 = No difference
Women's Education	1 = None, 2 = Primary, 3 = Secondary, and 4 = No difference
Household Wealth	1 = Poorest, 2 = Middle, 3 = Upper, and 4 = No Difference
Religion	1 = Muslim, 2 = Protestant, 3 = Catholic, 4 = No difference, 5 = Other
Ethnicity	Open-Ended

Unclean: to make female genitals clean and hygienic. (F) Other: this was an option to list other factors that were not presented. These responses were coded as: 1 = Least Important, 2 = Slightly Important, 3 = Somewhat Important, 4 = Important, and 5 = Very Important. The option "other" was left open-ended.

Factors That Would Reduce Or Prevent FGM

Respondents were also asked: "Do you think any of these would help reduce or prevent FGC in your country?" Increased primary and secondary education of girls; Education of girls on FGC; Education of mothers on FGC; Education of fathers on FGC; Religious leaders speaking out against the practice; Political leaders speaking out against the practice; Community leaders speaking out against the practice; Laws against the practice; NGO activities; and option to list other was made available. The responses were coded as: 0 = No and 1 = Yes. The option "other" was left open-ended.

FGM Does Not Exist Within Country

If the respondent stated that they did not know of even one case of FGM in their country, they were asked the same set of questions except in relation to why it did not

exist in their country and what factors prevented or reduced the practice of FGM in their country.

The respondent was asked, "What do you think is the most important reason why FGC does not exist in your country? Rank from 1 to 5: 1 being the least important and 5 being the most important" (A) Community/Tradition: no social acceptance in community; not supported by tradition. (B) Religion: religion does not require it. (C) Marriage: does not increase marriage prospects. (D) Control Female Sexuality: female virginity and sexuality can be controlled through other factors. (E) Female Genitals: female genitals become unclean and unhygienic. F) Other: this was an option to list other factors that were not presented. These responses were coded as: 1 = Least Important, 2 = Slightly Important, 3 = Somewhat Important, 4 = Important, and 5 = Very Important. The option "other" was left open-ended.

In addition, respondents were asked: "Do you think FGC does not exist in your country due to ANY of these factors?" Increased primary and secondary education of girls; Education of girls on FGC; Education of mothers on FGC; Education of fathers on FGC; Religious leaders speaking out against the practice; Political leaders speaking out against the practice; Community leaders

speaking out against the practice; Laws against the practice; NGO activities; and option to list other was made available. The responses were coded as: 0 = No and 1 = Yes. The option "other" was left open-ended.

ANALYSIS

After receiving responses from the 16 NGO representatives, a qualitative analysis of responses was conducted by examining the perceived prevalence, factors relating to presence or absence as well as factors that have helped or may help reduce or prevent FGM. The focus was on possible similarities and differences in responses by region - the Middle East, North Africa, and Sub Saharan Africa. At the end of the exploration of results, variations in rates within regions were discussed in terms of a general sense of the measures of variables found to influence the rates of FGM in prior literature. Countries for which data were obtained were analyzed individually to see how they corresponded with what would be expected. This was an exploratory study with no causal inferences from data collected. Attempts were made to draw tentative conclusions for countries for which I obtained data. The basic purpose of this research was to shed light on the perceived causes and presence of FGM as well as policy

implications for the most effective eradication strategy and further research.

The following chapter will discuss the findings and results from the data collection.

CHAPTER IV

RESULTS

This chapter discusses the results of the qualitative analysis as described in the previous chapter.

NON-GOVERNMENTAL ORGANIZATION'S CONTACTED

As described in the methods chapter, the process of securing NGO contacts in the Middle East and Africa was quite arduous. NGOs that did provide detailed information were not helpful either, as the contact information was out of date or invalid for 10% percent of the NGOs. In regards to the responses, 2 of the 6 NGO respondents that I spoke with were male which may have biased results toward finding no prevalence. This can be attributed to the patriarchal structure in the Middle East and Africa, which allows men to hide practices of female oppression under a veil of secrecy. In addition, there is a level of shame associated with speaking to females about issues like genitals; therefore, I was able to get a male friend to speak to 2 of the 6 NGOs. Nonetheless, it seems that he was not able to make much progress either.

Unfortunately, information from these respondents did not allow for insight into whether not admitting to knowing

of even one case of FGM existing in their countries was due to an actual low prevalence, the respondent's ignorance of the issue, or their reluctance to admit this for a variety of reasons including the fact that the act is illegal and/or concealed within that country and they might have feared for their SAFETY. Certainly at least one case of FGM is likely to have been performed in most of these countries if for no other reason than immigration from countries with high prevalence of FGM like Egypt and Sudan.

NON-GOVERNMENTAL ORGANIZATION RESPONSES

Of the 29 countries surveyed in the Middle East and Africa, one response was received from a representative of an NGO in 16 countries (Table 4). These countries, by region, are: Middle East (7): Iran, Iraq, Jordan, Lebanon, Palestine, Saudi Arabia, and Syria; North Africa (3): Algeria, Morocco, and Tunisia; and Sub Saharan Africa (6): Congo, Equatorial Guinea, Lesotho, Namibia, Rwanda, and Seychelles.

FGM Does Exist Within Country

Of the NGOs in the 16 countries that responded, only four, i.e., Algeria, Equatorial Guinea, Iraq and Lesotho, answered yes to, "Have you ever heard of any case of FGC

Table 4. NGO responses from the Middle East and Africa.

Region/Country	Number Of NGOs Responded
North Africa	
Algeria	1
Libya	0
Morocco	1
Tunisia	1
Sub Saharan Africa	
Botswana	0
Burundi	0
Congo	1
Equatorial Guinea	1
Gabon	0
Lesotho	1
Madagascar	0
Namibia	1
Rwanda	1
Seychelles	1
Swaziland	0
Middle East	
Bahrain	0
Iran	1
Iraq	1
Israel	0
Jordan	1
Kuwait	0
Lebanon	1
Oman	0
Palestine	1
Qatar	0
Saudi Arabia	1
Syria	1
Turkey	0
United Arab Emirates	0
N =	16

performed in your country?" The NGOs in the other 12 countries in the Middle East, North Africa, and Sub Saharan Africa stated that they had never even heard of any case of FGM performed in their nation (Table 5).

To suggest that not even *one case of FGM* was performed in over 75% of these countries is highly unlikely and not consistent with what prior research would lead us to expect. However, we must keep in mind that 5 of the 16 respondents worked for general human rights NGOs and the individual responding just might not have been aware of the issue. Also, responses were only obtained from ONE person in a country, I had hoped for a cluster of NGO responses in each country. In addition, these countries did not allow DHS/MICS to include the FGM modules in the demographic research conducted; therefore, this proves the strong hold of the patriarchal structure, which allows acts like FGM to go undetected.

As per Table 5, percents given for FGM were 1-10% for Equatorial Guinea and Lesotho; 11-25% for Algeria; 26-50% for Iraq. The NGOs reported that type I FGM, which is the least evasive form (but still can cut off the clitoris), was practiced in Algeria, Lesotho, and Iraq; whereas, type II was practiced in Equatorial Guinea.

Table 5. Presence of FGM.

Region/Country	FGM Even 1 Case	FGM Prevalence	FGM Type
North Africa			
1. Algeria	Yes	11-25%	Type I
2. Morocco	No	N/A	N/A
3. Tunisia	No	N/A	N/A
Sub Saharan Africa			
4. Congo	No	N/A	N/A
5. Equatorial Guinea	Yes	1-10%	Type II
6. Lesotho	Yes	1-10%	Type I
7. Namibia	No	N/A	N/A
8. Rwanda	No	N/A	N/A
9. Seychelles	No	N/A	
Middle East			
10. Iran	No	N/A	N/A
11. Iraq	Yes	26-50%	Type I
12. Jordan	No	N/A	N/A
13. Lebanon	No	N/A	N/A
14. Palestine	No	N/A	N/A
15. Saudi Arabia	No	N/A	N/A
16. Syria	No	N/A	N/A

Respondents from Algeria, Equatorial Guinea, Iraq, and Lesotho were than asked questions in regards to groups more likely to practice FGM, the reasons that it continues, and ways to eradicate the practice.

When examining the countries that indicated a prevalence of FGM, 3 of 4 respondents, thought that it was predominantly practiced amongst those in rural communities, women with least education, and the poor (Table 6). Note that the only factor thought to be related to increased levels of FGM by all 4 respondents was the Muslim religion while none of the four thought that region was relevant.

Regarding how important, if at all, respondents perceived factors for the continuation of the practice. Community/tradition requires it and FGM is a mechanism to control female sexuality were two of the most cited reasons amongst 3 of the 4 respondents (Table 7).

Finally, they were asked questions about factors that may reduce or prevent the practice of FGM. All the respondents indicated that primary and secondary education of girls, education of girls on FGM, education of mothers on FGM, education of fathers on FGM, political leaders speaking out against the practice, and community leaders speaking out against the practice were the most advantageous factors in eradicating the practice. Whereas,

Table 6. Groups with higher rates of FGM.

Region/ Country	Place of Residence	Women's Education	Household Wealth	Religion	Region
North Africa					
Algeria	Rural	Least Educated	Poorest	Muslim	No Diff
Sub Saharan Africa					
Equatorial Guinea	No Diff	No Diff	No Diff	Muslim	No Diff
Lesotho	Rural	Least Educated	Poorest	Muslim	No Diff
Middle East					
Iraq	Rural	Least Educated	Poorest	Muslim	No Diff

[1]Abbreviation

[1] No Diff = No Difference

Table 7. Reasons for the continuation of FGM.

Region/Country	Comm/Trad	Religion	Marriage	Sex	Genital
North Africa					
Algeria	5	5	5	5	4
Sub Saharan Africa					
Equatorial Guinea	5	2	2	5	2
Lesotho	3	3	2	2	2
Middle East					
Iraq	5	4	4	5	4

[2]Abbreviation

1 = Least Important, 2 = Slightly Important, 3 = Somewhat Important, 4 = Important, and 5 = Very Important.

[2] Comm/Trad = Community/Tradition; Religion = Religion Requires it; Marriage = Increases Marriage Prospects; Sex = Way To Control Sexuality; Genital = Make Genital Clean.

3 of the 4 respondents believed that religious leaders speaking out against the practice and NGO efforts would be valuable. In addition, 2 of the 4 NGO respondents found laws against the practice would be helpful (Table 8). It is clear that action is needed in the arena to eradicate FGM. It is important to point out that education is central to this argument.

FGM Does Not Exist Within Country

As per Table 5, the NGO respondents from Congo, Iran, Jordan, Lebanon, Morocco, Namibia, Palestine, Rwanda, Saudi Arabia, Seychelles, Syria, and Tunisia answered no to "Have you ever heard of any case of FGC performed in your country?" These countries answered alternate questions in regards to why FGM does not exist in their country and reasons that may have reduced or prevented the presence of FGM.

As per Table 9, "What do you think is the most important reason why FGC does not exist in your country?" 10 of 12 respondents indicated that FGM does not exist within their country because community/tradition does not require it. The next most cited reason amongst 7 of the 12 respondents was that religion does not require it. There was a noticeable difference in the reasons that the

Table 8. Percent NGOs agreeing that specific factors may reduce or prevent FGM.

Region/ Country	Edu Grl	FGC Grl	FGC Mom	FGC Dad	Rel Led	Pol Led	Com Led	Law	NGO
North Africa									
Algeria	1	1	1	1	1	1	1	0	1
Sub Saharan Africa									
Equatorial Guinea	1	1	1	1	1	1	1	1	1
Lesotho	1	1	1	1	0	1	1	0	0
Middle East									
Iraq	1	1	1	1	1	1	1	1	1

[3]Abbreviations

0 = No and 1 = Yes.

[3] Edu Grl = Increased Primary and Secondary Education of Girls; FGC Grl = FGC Education of Girls; FGC Mom = FGC Education of Mothers; FGC Dad = FGC Education of Father; Rel Led = Religious Leader Speaking Out Against Practice; Pol Led = Political Leader Speaking Out Against Practice; Com Led = Community Leader Speaking Out Against Practice; Law = Laws Against FGC; NGO = NGO Activities.

Table 9. Most important reasons why FGM does not exist.

Region/Country	Comm/Trad	Religion	Marriage	Sex	Unclean
North Africa					
Morocco	3	5	1	1	1
Tunisia	5	5	4	5	4
Sub Saharan Africa					
Congo	5	5	3	3	3
Namibia	5	4	3	4	4
Rwanda	5	5	5	4	4
Seychelles	5	5	5	5	4
Middle East					
Iran	1	1	1	1	1
Jordan	5	4	4	4	1
Lebanon	5	4	3	3	3
Palestine	5	1	5	5	5
Saudi Arabia	5	5	4	4	2
Syria	5	5	2	2	2

[4]Abbreviation

1 = Least Important, 2 = Slightly Important, 3 = Somewhat Important, 4 = Important, and 5 = Very Important.

[4] Comm/Trad = Community/Tradition Does Not Require It; Religion = Religion Does Not Require It; Marriage = Does Not Increase Marriage Prospects; Sex = Other Ways to Control Sexuality; Unclean = FGM Makes Genitals Unclean and Unhygienic.

Table 10. Percent of NGOs who denied FGM existed in their country agreeing that specific factors reduced or prevented FGM.

Region/ Country	*Edu Grl*	*FGC Grl*	*FGC Mom*	*FGC Dad*	*Rel Led*	*Pol Led*	*Com Led*	*Law*	*NGO*
North Africa									
Morocco	0	0	0	0	0	0	1	0	0
Tunisia	1	1	1	1	1	1	1	1	1
Sub Saharan Africa									
Congo	1	1	1	1	1	1	1	0	1
Namibia	1	1	1	1	1	1	1	0	1
Rwanda	1	1	1	1	1	1	1	1	1
Seychelles	1	1	1	1	1	1	1	0	1
Middle East									
Iran	0	0	0	0	0	0	0	0	0
Jordan	0	0	0	1	1	0	1	0	0
Lebanon	1	1	1	1	1	1	1	1	1
Palestine	0	0	0	0	0	0	0	0	0
Saudi Arabia	0	0	0	1	1	0	1	0	0
Syria	0	0	0	0	1	1	1	0	0
N Yes =	6	6	6	8	9	7	10	3	6

[5]Abbreviations

0 = No and 1 = Yes.

[5] Edu Grl = Increased Primary and Secondary Education of Girls; FGC Grl = FGC Education of Girls; FGC Mom = FGC Education of Mothers; FGC Dad = FGC Education of Father; Rel Led = Religious Leader Speaking Out Against Practice; Pol Led = Political Leader Speaking Out Against Practice; Com Led = Community Leader Speaking Out Against Practice; Law = Laws Against FGC; NGO = NGO Activities.

respondent from Iran cited. The respondent did not find any of the factors to be beneficial in the reduction or prevention of FGM within their country. Although, their response may be based on the fact that they do not believe it ever existed or exists; therefore, they might have found these questions to be irrelevant.

Finally, they were asked questions about factors that may have helped reduce or prevent the practice of FGM in their country (Table 10). Respondents in 10 of the 12 countries perceived community leaders speaking out against the practice and 9 of the 12 countries' respondents said religious leaders speaking out against the practice were considered the most valuable factors in the reduction or prevention of FGM. Laws against FGM were considered the least beneficial factor since it was selected by only 3 of the 12 NGO respondents.

The next chapter will focus on the discussion of the results of this study and how they reflect the hypothesis. It will also present a conclusion of the study and applicable policy implications.

CHAPTER V

DISCUSSION AND CONCLUSIONS

This chapter draws suggestions based on the results as well as limitations, advocates for further research, and policy implications pertinent to Female Genital Mutilation (FGM) in the Middle East and Africa.

This research was exploratory in nature. The purpose of this paper was to begin the process of focusing attention and shedding light on the prevalence of FGM in the Middle East and Africa for which rates and data were unknown. The survey was sent out to 259 NGOs and responses were only received from 16. Consequently, the 16 responses were for 16 different countries.

It was hypothesized that FGM will be present in all of the 29 countries in the Middle East and Africa for which estimates will be secured. These rates were to be inline with their neighboring countries; therefore, it was postulated that countries in the Middle East have low rates of FGM, countries in North Africa have high rates of FGM, and countries in Sub Saharan Africa have medium rates of FGM. The hypothesis could not be tested due to the low response rate; therefore ethnicity was further explored.

NGOs in the Middle East were not forthcoming about the presence of FGM. Although, an NGO from Iraq is the only one in the Middle East said to have known of cases of FGM. The respondent concluded that FGM was mainly found in rural areas, amongst least educated women, the poor, or Muslim individuals (Table 5); however, the respondent indicated that it was specific to the Kurdish community of Iraq. This is consistent with well-published research on the presence of FGM among Iraqi Kurds (WADI 2010). As such, the NGO respondent may have been less afraid to discuss the presence of FGM and have insight into an area previously explored.

Since the NGO respondents in Iran, Jordan, Lebanon, Palestine, Saudi Arabia, and Syria i.e. 6 of 7 countries in Middle East denied knowing even one case of FGM, and securing estimates in this area was an important objective of this study, these results do not provide the insight hoped for on prevalence of FGM in the Middle East vs. Africa. Nevertheless, stating that they do not know of even one case is highly unlikely and thus their answers do not provide any insight into actual prevalence. On the other hand, maybe their answers reflect that FGM is less common in the Middle East. If this was the case, and this is a big if, it would be important for future research to

have a sense of what factors might lead us conceptually to suspect significantly less FGM in the Middle East than in Africa. Specifically, factors that could lead to predictions of different rates include different manifestations of extreme patriarchy and ethnicity.

Regarding former, the Middle East has other mechanisms, aside from FGM, to control women's sexuality and independence including wearing the veil, severe limitation of movement, and honor killings (Osten-Sacken and Uwer 2007). The women are required to be escorted by a male relative and cover themselves up at all times. This form of oppression already limits the female's autonomy and provides men with the same level of control, which is attributed to FGM. In addition, the fear of honor killings reinforces the control men possess in the Middle East (Patel and Gadit 2008). Therefore, if there are multiple mechanisms of control present, FGM should be prevalent as well. FGM could be an additional measure of control that is utilized in these countries. Nonetheless, it is still not logical to suggest that there is no prevalence of FGM in the Middle East if for no other reason than immigration, but this does suggest that manifestation of extreme patriarchy is an important variable to pursue in predicting variations in rates between the Middle East and Africa.

NGOs in North Africa and Sub Saharan Africa were not insightful about the prevalence of FGM. Nonetheless responses from participants who did state that FGM existed, i.e., Algeria, Equatorial Guinea, and Lesotho, about which groups most likely had higher rates of FGM were consistent with prior research in terms of indicating women with least education, percent rural, low household wealth, and percent Muslim (Table 6). It was unexpected to have NGOs claim 0% prevalence of FGM in North Africa and Sub Saharan Africa: Congo, Morocco, Namibia, Rwanda, Seychelles, and Tunisia. These nations are in very close proximity to nations with a FGM prevalence ranging from 1 to 96%.

A secondary factor that may prove useful in predicting differences in rates in regions in the future is ethnicity. Although FGM is indicated to be practiced amongst Muslims, it is important to note that ethnicity within the percent Muslim may play a role – specifically, Arab vs. non-Arab (Osten-Sacken and Uwer 2007; IRIN 2005).

As discussed earlier there are other mechanism of female control like wearing the veil, extreme limitation in movement, and honor killings (Osten-Sacken and Uwer 2007). Therefore, if this is correct then if a certain percent of Arab within the Muslim population is accounted for then the patterns of FGM can be better explained and predicted.

However, this theory can only be applied to the Middle East and North Africa. To recount, the predictors of FGM prevalence are women with least education, Muslims, rural residence, and low socioeconomic status; all of these predicators were present in the countries examined in the Middle East and North Africa. Nonetheless, the respondents indicated that there was little to no FGM found in these countries. Therefore, the one factor that separates countries in North Africa and Middle East from North, East, and West Africa is percent Arab. Thus, it is vital to explore percent Arab as a possible predictor of FGM. Percent Berber, Kurdish, and Bedouin should also be examined since these ethnic groups are also present in the countries of interest and have been shown to practice FGM.

As per UNICEF 2005, "Among all socio-economic variables, ethnicity appears to have the most determining influence over FGM/C distribution within a country" (11). With ethnicity being a confounding factor, it is predicted that lower levels of FGM will be found in the Muslim Arab populations. Therefore, due to the high percentage of Arab, it was postulated that Iran and Iraq would have low levels of FGM, while Jordan, Lebanon, Palestine, Saudi Arabia, and Syria would have very low levels of FGM. Iran and Iraq are believed to be different then the other

nations in the Middle East due to the presence of the Kurds and Bedouins within these countries. Nonetheless, all the countries are predicated to have some level of FGM.

The Kurds and Bedouins are a nomadic tribe, which have been believed to carry traces of FGM. IRIN (2005) asserts, "Although predominately performed in Africa, FGM is also carried out on rural Kurdish women in northern Iraq and among certain tribes in other Arab countries like Yemen, the United Arab Emirates, Bahrain, and Qatar" (15). Therefore, it can be suggested that the Kurdish and Bedouin populations in Iran and Iraq would contribute to a low prevalence of FGM within the countries. Thus, it was no surprise to see little to no traces of FGM in the Middle East, except in Iraq.

Variations in ethnicity in North Africa and the Middle East could be seen as providing support for expecting FGM to be lower in these areas and be able to explain the discrepancies. The rates of FGM are predicted to be lower amongst the Arab populations; therefore, in North Africa percent non-Arab seems to be associated with higher rates of FGM. Majority of the non-Arab tribe is Berber; therefore, the Berber tribe was also examined in correlation to FGM in North Africa.

Berber is a tribal and semi-nomadic/nomadic group found in majority of the countries in North Africa, for which FGM data is lacking. The Berbers originated around the Nile; therefore, it would be assumed that there would be a presence of FGM amongst the Berbers. Mainly because of the deep roots and high prevalence of FGM found amongst the Egyptians. Therefore, if there is a presence of FGM outside of Egypt in North Africa, it must be occurring amongst the Berber. The Berber, like the Kurds of Iraq have been stigmatized. Nonetheless, since the Berber are such a small and stigmatized group it does not seem unlikely for NGOs to report no FGM in North Africa when it is in fact occurring. Therefore, finding traces of FGM in Algeria is predictable due to the Arab Berber population. However, it is interesting to see that the NGO respondent indicated no FGM in Morocco, when there is a very large Arab Berber population and its close proximity to nations like Mauritania with a FGM prevalence of 72%.

It must be reiterated that respondents that indicated they did not know of even one case does not mean that it does not exist within that country. Respondents could have not reported prevalence due to the taboo associated with the issue, ignorance of the issue, and not feeling comfortable about communicating the issue through

telecommunication and/or electronic communication. In addition, there is a veil of secrecy that must be maintained and individuals that lift this veil may face punishment within their respective countries. Therefore, the respondents had a lot at stake if they were to reveal the prevalence of FGM within their country. Furthermore, this illustrates the strength of the patriarchal structure within these societies, which allows acts like FGM to remain undetected. FGM is a universal phenomenon that exists to a certain extent in all countries.

While providing less insight into prevalence of FGM for countries lacking data than hoped, this was an exploratory study that at least provides some indication that FGM does exist for 3 additional countries often argued to have no FGM, that these 16 NGO representatives agree with the importance of factors associated with FGM from prior research, and suggests several variables to pursue in research on FGM the Middle East and Africa.

LIMITATIONS

There are apparent limitations in this study. The most obvious limitation would relate to the ability to draw descriptive or inferential conclusions from sample data about a larger group. The NGO survey may be limited in

scope. Only the NGOs that are identified through larger social networks are the ones that were included in the international survey. In addition, due to time and resource restrictions the focus was limited to NGOs in the Middle East and Africa for nations lacking data on FGM. The research process was also very limited in the sense that it included only NGOs that I was able to locate. There could have been other mechanisms of research, especially through the use of Google; however, every effort was made to exhaust all sources. Therefore, telecommunication was introduced to the methodology to compensate for the severely low response rate. Also since majority of the NGO respondents did not specialize in women and children, they could have been ignorant to the issue of FGM or reluctant to report it. This would impact the research since the goal is to determine whether or not FGM exists. The respondent's estimates were treated as preliminary, albeit crude, to get a sense of FGM within the country. Thus, the intent of this survey was to identify the presence of FGM and not the scope or prevalence. In addition, a majority of the NGO respondents whom I spoke with were male. It may not have a bearing on the results; however, it is imperative to point out the presence of male

respondents due to the patriarchal culture of the Middle East and Africa.

Furthermore, research on FGM has been limited in capacity for decades. Researchers have been facing obstacles in studying FGM due to cultural, religious, economic, and political reasons. Thus, my exploratory efforts were also met with great hurdles. The low response rate could be attributed to many factors. First off, it was an electronic survey sent overseas. Although, NGOs provide an email address they might not be able to check it regularly or the email could have been sent to their spam mail. To decrease the likelihood of this issue I resent the survey eight times over an eight-week period and changed the subject line each time. Second, during the course of the study there was a political uprising in the Middle East and North Africa. This may have caused offices to shut down or overshadowed the importance of this survey. Nonetheless, every effort was made to eliminate room for error or bias.

FURTHER RESEARCH

Although this study is exploratory in nature it did shed light on the presence of FGM in 3 of the 16 countries in the Middle East and Africa, for which there was no data

or research (previous research by WADI (2010) predicts a FGM prevalence of 72.2% amongst the Kurdish tribe of Iraq). The survey exemplifies that lack of data does not mean that there is a lack of FGM in the Middle East and Africa. However, the NGOs may have not been the best group to survey. Possibly the NGO search could be expanded and there could be a more strict use of telecommunication. In addition, it seems that majority of communication in the Middle East and Africa is conducted through the use of mobile phones. Therefore, possibly getting a hold of mobile phone numbers would have yielded more responses. Although, obtaining more contacts or responses from women and children's NGOs would have been instrumental. Nonetheless, it was assumed that NGOs in these regions have the most contact with females and children; thus, they should have the preeminent understanding of the practice if it does exist. Furthermore, if further research were to be conducted in the area it would be vital to administer the survey in Arabic or the language of origin within that country. This mechanism may enhance the response rate overall and amongst female counterparts within the NGOs as well. It has been very difficult to locate NGOs in our countries of interest and obtain responses. This paper is

just a vehicle to promote further research in the field of FGM, especially in nations which are still lacking data.

POLICY IMPLICATIONS

Results from this study suggest that FGM is an ongoing issue. In addition, FGM has been found in all parts of the world like Australia, Canada, Europe, and the United States due to globalization and migration (WADI 2010). In order to deal with the migrants who practice FGM, countries like the United Kingdom and Australia have created laws against FGM (WHO 2008). FGM is essentially just another extension of violence against women and children perpetrated by a misogynistic society. Nonetheless, it is apparent that immediate action must be taken to eradicate this form of violence.

The respondents indicated that community leaders and religious leaders speaking out against the practice have been or would be beneficial in the eradication of FGM. Change must be initiated from the individuals holding a powerful position within the community. These leaders are pillars of the community and their message will resonate with the members of the community. It is vital to build support in the communities against FGM. Change occurs at the grassroots level and it takes an entire community's

support and dedication to eliminate an act, which is so entrenched within the social fabric.

In addition, equal education for girls and boys would be instrumental. Providing education to women would help them create a social standing and understanding of the world around them. Furthermore, education eliminates ignorance and provides men and women with tools to build a better and safer future for all.

It is vital to remember that female genital mutilation is a gender specific practice, which has no health benefits and severe consequences. In addition, the victims of this form of physical, sexual, psychological, and emotional violence are predominantly children between the ages of 0 to 15. Female genital mutilation is an egregious act, which must be eradicated. The key is to promote equality amongst men, women, and children.

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APPENDIX A. 29 COUNTRIES WITH DATA ON FGM IN MIDDLE EAST AND AFRICA

Region/Country	Percent FGM
Middle East: 1	
Yemen	23
North Africa: 2	
Egypt	96
Sudan	89
Sub Saharan Africa: 26	
Benin	13
Burkina Faso	73
Cameroon	01
CAR	26
Chad	45
Cote d'Ivoire	36
Djibouti	93
Eritrea	89
Ethiopia	74
Gambia	78
Ghana	04
Guinea	96
Guinea-Bissau	45
Kenya	32
Liberia	58
Mali	85
Mauritania	72
Niger	02
Nigeria	19
Senegal	28
Sierra Leone	94
Somalia	98
Togo	06
Tanzania	15
Uganda	01
Zambia	01

APPENDIX B. 29 COUNTRIES LACKING DATA ON FGM IN MIDDLE EAST AND AFRICA

Region/Country
North Africa: 4
Algeria
Libya
Morocco
Tunisia
Sub Saharan Africa: 11
Botswana
Burundi
Congo
Equatorial Guinea
Gabon
Lesotho
Madagascar
Namibia
Rwanda
Seychelles
Swaziland
Middle East: 14
Bahrain
Iran
Iraq (Kurds)
Israel
Jordan
Kuwait
Lebanon
Oman
Palestine
Qatar
Saudi Arabia
Syria
Turkey
United Arab Emirates

APPENDIX C. NGOS CONTACTED BY NGO TYPE

Children's Rights Information Network (CRIN)
North Africa
Algeria
Association for the Promotion and Progress of Children in Khenchela ass_enfance@yahoo.fr
Centre d'Information et de Documentation sur les Droits de l'Enfant et de la Femme (CIDDEF) http://www.ciddef.com/
Libya
Al-amal Charitable Organization for Orphans Care nuritop64@yahoo.com
Morocco
Association de forum de l'enfance (ASSFE) forum_enfance@maktoob.com
Espace Associatif espasso@iam.net.ma
Femme Action (WA)
l'Observatoire National des Droits de l'Enfant (ONDE) onde@iam.net.ma
Palm Friends (APDPAE) nouhi100@yahoo.fr
The African Childhood Network (ACN) hmd_mkk@yahoo.co.uk
The Mickey and Friends Organization (Mickey& Friends) info@mickeyandfriends.org
Tunisia
Amnesty International - Tunisian Section Admin-tn@amesty.org
Sub Saharan Africa
Botswana
Botswana-Baylor Children Clinical Center of Excellence chepi@baylorbostwana.org.bw
Burundi
Appui au Développement de l'Enfant en Détresse (ADED) sepmutgil@yahoo.com
Association Communautaire Pour la Promotion et la Protection des Droits de l'Homme (ACPDH) acpdh_bdi@yahoo.fr
Orphans or Children of the world's parents (FEPAM) fepam_rama@yahoo.fr
Association Communautaire Pour la Promotion et la Protection des Droits de l'Homme (ACPDH) acpdh_bdi@yahoo.fr
Young Christians Association in Central Africa ajecabu@yahoo.fr
Congo

Alliance Congolaise pour les Droits de l'Enfant coldni89@impsat.net.co
Centre des Droits de l'Homme et du Développement (CDHD) ebayeni@yahoo.fr
Childhood and Life Association aev_asso@yahoo.fr
Lesotho
National Coalition of Lesotho ngoc@leo.co.ls
Lesotho National Council of Women
Madagascar
Actions Pro Tovo_actions@hotmail.com
Conseil Regional pour l'Information et l'Orientation des Droits Humains et Actions (CRIODHA) mimosa@dts.mg
Mauritius
Alliance for Children savecm@intnet.mu
Bethleem Daycare Center bethleem2001@yahoo.com
Centre d'Education de Developpement pour les Enfants Mauriciens (CEDEM) coll@intnet.mu
Groupement d'ONG pour l'Enfant apeim@intnet.mu
Halley Movement halley@bow.intnet.mu
Namibia
Legal Assistance Centre (LAC) info@lac.org.na
Rwanda
Never Again International poppy@neveragaininternationa.org
Streets Ahead Children's Centre Association (SACCA) markrwanda@yahoo.co.uk
Youth Association for Dissemination of Development Information (YADDI) administration@yaddi.net
Seychelles
National Council for Children (NCC) ncc@seychelles.sc
Middle East
Bahrain
Bahrain Child Society bahrainchild@gmail.com
Bahrain Youth Society For Human Rights solidarity@byshr.org
Be Free Center (BFC) contact@befreecenter.org

Iran
Society for Protecting the Rights of the Child info@irsprc.org
Iraq
Al-Mahaba For Orphans Organization lfoo_1@yahoo.com
International Friendship Society missan_iraq2006@yahoo.com
Israel
Centre for Children and Youth jack@jdc.org.il
Children's Rights Coalition info@dci.org.il
Defence for Children International info@dci.org.il
Early Childhood Resource Centre info@ecrc-jer.org
National Council for the Children ncc@children.org.il
Save the Children USA scfbgs@palnet.com
Civic Forum Institute cfip@cfip.org
Jordan
National Task Force for Children ntc@nets.com.jo
National Coalition for Children Jordan nimets@ntfc.org.jo
Save the Children - Jordan savethechildren@orange.jo
UNICEF MENA Regional Office menaro@unicef.org
Kuwait
Human Bidoon Human Rights Organization kbhro@hotpop.com
Association of Gulf Women and Family admin@cogir.org
Lebanon
Amel Assocaition info@amel.org.lb
Assocaition du foyer de l'efant libanais zeinarh@hotmail.com
Child Rights Associations Collective spl@inco.com.lb
Development Action Without Borders nabaa@nabaa-lb.org
Save The Children Lebanon twebster@savechildren.org
Social Service for the Welfare of the Child SesoBel@cyberia.net.lb

World Vision patricio_cuevas-parra@wvi.org
Oman
Aasthan Latif Welfare Society (Alast) info@alwspk.org
Children First wzafar@childrenfirst.org.pk
NGOs Coalition on Child Rights nccr@live.com
Save the Child - Save the Nation scsn21@gmail.com
Society for the Protection of the Child sparc@comsats.net.pk, admn@sparcpk.org
International Peace and Human Rights Organization piphro@yahoo.com
Palestine
Defense for Children International http://www.dci-pal.org/ **
Palestinian Network for Children's Rights info@pncr.org
Secretariat for the National Plan of Action Npapal@palnet.com
Spaffor Children's Centre spafford@jrol.com
ADDAMEER addameer@p-ol.com
Al-Haq http://www.alhaq.org/etemplate.php?id=58**
Al Mezan Center for Human Rights Mezan@palnet.com
Badil info@badil.org
Palestine Human Rights Monitoring Group admin@phrmg.org
Saudi Arabia
Anti-Child Abuse in Saudi Arabia Acuora5@hotmail.com
Syria
Syrian Women's Observatory nesasy@gmail.com
Turkey
International Children's Center icc@icc.org.tr
National Coalition for the Rights of the Child womanchild@superonline.com
Committee Contacts
North Africa
Morocco
Jamila Ahmed Bia jamilabia@gmail.com

Women's Mental Health Care abdelouadoud@gmail.com
Tunisia
Aida Gorbel aida.gorbel@laposte.net
Middle East
Bahrain
Dr. Fadhella fadheela@batelco.com.bh
United Arab Emirates
Advisor, Social Policy and Strategic Planning Ghassan.khalil@cds.gov.ae
Child Help Line afafalmarri@yahoo.com
Dubai Foundation for Women and Children fatma.hassan@dfwac.ae
Mohd Arakan brsan2020@gmail.com
Female Genital Mutilation NGO
Congo
The Female Genital Cutting Education and Networking Project http://www.fgmnetwork.org/mail/index.php *comment box*
General FGM Efforts
Amnesty International aimember@aiusa.org
CENTER for PROFS info@centerforprofs.com
Clitoraid Africa africa©clitoraid.org
Clitoraid Middle East middleeast©clitoraid.org
Equality Now info@equalitynow.org
FGC Education and Networking Project http://www.fgmnetwork.org/mail/index.php (Contact Box)
Global Alliance Against Female Genital Mutilation http://www.global-alliance-fgm.org/Contact.aspx (Contact Box)
Hammer Forum Kasten@hammer-forum.de
The Inter-African Committee on Harmful Traditional Practices (IAC) osarenren@un.org
International Action Against Female Genital Mutilation info@intact-ev.de
International Women's Health Coalition info@iwhc.org
LebKom Lebendige-kommunikation@gmx.de
National Organization of Circumcision Information Resource Centers

info@nocirc.org
Rainbo http://www.rainbo.org/contact/ (Contact Box)
Stop FGM Now StopFGMNow.Com
Stop Mutilation j.cumar@stop-mutilation.org
Tostan Contact@tostanfrance.fr
United Nations Population Fund hq@unfpa.org
Weltfriedensdienst infor@wfd.de
World Health Organization gehnerm@who.int
General Children's NGO
North Africa
Algeria
SOS Children's Village info@sos-childrensvillages.org
Morocco
Association for Supervision of Children and Youth (United Assoc for Coaching Children & Youth)
CARE Morocco info@caremaroc.org perez@caremaroc.org
Tunisia
The African Network for the Prevention and Protection against Child Abuse and Neglect Bed25@excite.com
The Tunisian Association for Children's Rights contact@atude.org
Sub Saharan Africa
Botswana
SOS Children's Village-Botswana info@sos-childrensvillages.org
Burundi
SOS Children's Village-Burundi info@sos-childrensvillages.org
Cape Verde
SOS Children's Villages sos-no@soscapvert.org
Congo
The African Network for the Prevention and Protection against Child Abuse and Neglect wimalafr@yahoo.fr
Child Helpline International leticia@childhelplineinternational.org
Equatorial Guinea
SOS Children's Village

info@sos-childrensvillages.org
Lesotho
The African Network for the Prevention and Protection against Child Abuse and Neglect
Madagascar
SOS Children's Village info@sos-childrensvillages.org
Mauritius
The African Network for the Prevention and Protection against Child Abuse and Neglect anppcanmb@intnet.mu
SOS Children's Village-Mauritius soschild@intnet.mu
Namibia
Joint Compassion Keepers International - Love for a Child jck@iway.na
Rwanda
The African Network for the Prevention and Protection against Child Abuse and Neglect menkusinov8@yahoo.com
Swaziland
Save the Children - Swaziland childsav@realnet.co.sz
SOS Children's Village info@sos-childrensvillages.org
Middle East
Iran
Children of Persia info@childrenofpersia.org
Research Institute for Enhancing Women's Lives info@riwl.org
The Society for the Protection for Handicapped Children and Youth info@tavanyab.com
Iraq
Save The Children Iraq twebster@savechildren.org
Israel
SOS Children's Village-Israel sosisr@inter.net.il
Jordan
Jordan River Foundation info@jrf.org.jo
The SOS Children's Village Association of Jordan sosjor@nets.com.jo
Kuwait
Kuwait Society for the Advancement of Arab Children haa49@qualitynet.net
Lebanon
Lebanese Association of SOS Children's Villages

soslib@dm.net.lb
Palestine
Early Childhood Resource Center http://www.ecrc-jer.org/ **
Palestinian Coalition on the Rights of the Child dci@dci-pal.org
SOS Children's Village-Palestinian Territories info@sos-palestine.org
Qatar
Childhood Cultural Centre info@c-c-center.org
Qatar Foundation for Child and Women Protection Info@qfcw.org.qa
Syria
Child Protection Community contact@cpcsyria.com
SOS Children's Village info@sos-childrensvillages.org
Turkey
SOS Children's Village-Turkey soskdit@superonline.com
General Women's NGO
North Africa
Algeria
Association Indépendante pour le Triomphe des Droits des Femmes (AITDF) ourida_dz@yahoo.fr
Association Pour l'Emancipation De La Femme(AEF)
Association SOS Femmes en Détresse sosfemmes@hotmail.com
Libya
Amnesty International Aiusa@aiusa.org
Morocco
Association Democratique Des Femmes Du Morocco (ADFM) adfmcasa@menara.ma
Tunisia
National Union of Tunisian Women unft@email.at.tn
Sub Saharan Africa
Botswana
Emang Basadi Women's Association Ebasadi@global.co.za
Women's Against Rape (WAR) war@info.bw
Women's NGO Coalition (WNGOC) womens_ngo_coa@info.bw
Young Women's Christian Association of Botswana ywca@botsnet.bw
Burundi

Collectif des Associations et ONGs Féminines du Burundi (CAFOB) cafob@cbinf.com
Women Promotion Centre K_wodec@yahoo.fr
Young Women's Christian Association of Burundi ywcabdi@yahoo.fr
Congo
Fuuvi Ou Efants des Parents du Monde fepam_rama@yahoo.fr
Women Promotion Centre ejanoed@yahoo.fr
Lesotho
Federation of Women Lawyers fidales@leo.co.ls
Madagascar
Young Women's Christian Association of Madagascar fikrizama.ywca@dts.mg
Mauritius
Young Women's Christian Association veronique.magny.antoine@mu.pwc.com
Namibia
Khomas Women in Development criaawhk@iafrica.com.na
World Young Women's Christian Association of Namibia ywcanam@mweb.com.na
Rwanda
Pro-femme Twese Hamwe adelite@khi-intranet.rw
Rwanda Women Network Rwawnet@rwanda1.com
Young Women's Christian Association of Rwanda ywcarwa@yahoo.fr
Middle East
Iran
Center for the Advancement of Rural Women Comment box
Homa Darabi Foundation http://www.homa.org/ **
Institute for Women's Empowerment (IWE) mab.ngotc@gmail.com
Iran Women's News Agency info@womennews.ir
Omid-e-Mehr Foundation farnazgordan@omid-e-mehr.org
Organization for Defending Victims of Violence odvv@neda.net
Iraq
Erbil- Women Empowerment Organization info@weoiraq.com
The Organization of Women's Freedom in Iraq

yanar2002@hotmail.com
Women for Women International - Iraq
Israel
AISHA - The Arab Women's Forum wscad@netvision.net.il
The Center for Women's Health Information of Bnei Brak healâ€¦@nana.co.il
Israel's Women Network (IWN) office@iwn.org.il
Jordan
Arab's Women Organization of Jordan awo@nets.com.jo
Jordan Young Women's Christian Association ywcanat@go.com.jo
Microfund For Women info@microfund.org.jo
Kuwait
Kuwait Women's Voluntary Society
Union of Kuwaiti Women's Association info@ukwa.org
Women Cultural and Social Society □ q8iwomen@qualitynet.net
Lebanon
Green Line greenline@greenline.org.lb
Institute for Women's Studies in the Arab World iwsaw@lau.edu.lb
The Lebanese Council of Women info@lcw-cfl.org
Oman
Arab Women Organization Oman info@arabwomenorg.net
Omani Woman Society
Palestine
Women and Family Affairs Center admin@wafac.org
Qatar
Qatar Red Crescent info@qrcs.org.qa
Saudi Arabia
Al Nahda Philanthropic Society for Women alnahda@alnahda-ksa.org
Umm Al-Qura Society for Women
Syria
Syrian Family Planning Association sfpaa@scs-net.org
General Human Rights NGOs
North Africa
Tunisia

Arab Institute for Human Rights aihr.infocenter@gnet.tn
Sub Saharan Africa
Botswana
Population Services International psibotswana@psi.co.bw
Burundi
Association des Medecins de Village ebanankenge@yahoo.co.uk
National Association for the Communication and Education for Human Rights (ACEDH) acedh2001@yahoo.com
Population Services International info@psiburundi.org
Cape Verde
Associação Cabo-Verdiana Para a Protecao Da Familia (VERDEFAM) verdefam@mail.cvtelcom.cv
Equatorial Guinea
Population Services International scompaore@psiguinee.org
Gabon
Caritas Internationalis caritasgabon@yahoo.fr
Lesotho
Population Services International dwalto@psi.org
Madagascar
CARE Madagascar caremad@care.mg
Namibia
Namibian Rights and Responsibilities Inc Nambianrr.org.na
National Society for Human Rights nshr@nshr.org.na
Population Services International z.akinyemi@sfh.org.na
Rwanda
Actionaid - Rwanda dominic.timms@actionaid.com
Population Services International staci@psirwanda.org
Swaziland
Population Services International info@psi.sz
Middle East
Bahrain
Bahrain Human Rights Watch Society (BHRWS) info@bhrws.org
Iraq
Al-Rafidain Center

naserabood@yahoo.com
Alkarama for Human Rights Iraq geneva@alkarama.org
Cultural Center For Human Rights (CCHR) muhaned_ahmed@yahoo.com
Culture for All info@cultureforall.org
Development Without Borders Institution DWBI (Iraq) (DWBI) dwbi.iraqichild@gmail.com
Iraqi National University for NGOs (INU-NGO) hazim.alluhebe@gmail.com
The Iraqi Red Crescent info@iraqirc.org
Iraqi Al-Amal Association□ baghdad@iraqi-alamal.org
Israel
ANERA anera@anera.org
Bat Shalom info@batshalom.org
BTSELEM mail@btselem.org
International Social Service - ISRAEL lavine@int.gov.il
Physicians for Human Rights - Israel mail@phr.org.il
Jordan
American Near East Refugee Aid anera@anera.org
Bunin bunian@index.com.jo
CARE Jordan anis@care.org.jo
Jordan Hashimite Fund for Human Development info@johud.org.jo
Kuwait
Alkarama for Human Rights Kuwait info@alkarama.org
Kuwait Rights humanrights-kw@hotmail.com
Kuwait Red Crescent Society barges@krcs.org.kw□
Lebanon
Al Mabarrat Association mabarrat@mabarrat.org.lb
American Near East Refugee Aid anera@idm.net.lb
Association Amel info@amel.org.lb
Fraternity

info@fraternitylb.org
Terre des hommes Lebanon info@tdh.ch
Palestine
Adalah: The Legal Center for Arab Minority Rights in Israel adalah@adalah.org
ANERA anera@anera-jwg.org
The Arab Association for Human Rights http://www.arabhra.org/HRA/Pages/ContactUs.aspx**
Birzeit University, Institute of Community and Public Health icph@birzeit.edu
CARE Palestine care@carewbg.org
Palestinian Center for Human Rights pchr@pchrgaza.org
Saudi Arabia
Alkarama for Human Rights Saudi Arabia geneva@alkarama.org
Fatat Al-Khaleej Society info@fatatalkhaleej.org
Human Rights First Society humanrightsfirst_saudiarabia@yahoo.com
Saudi Red Crescent Authority info@srca.org.sa
Syria
Alkarama for Human Rights Syria geneva@alkarama.org
Turkey
Tuvana Okuma Istekli Cocuk Egitim Vakfi dhabib@tocev.org.tr
Toplum Sagligi Arastirma ve Gelistirme Merkezi ngmae2002@yahoo.com
International Society for the Prevention of Child Abuse and Neglect
International Society for the Prevention of Child Abuse and Neglect *ispcan@ispcan.org*
Middle East
Saudi Arabia
National Family Safety Program mahamuneef@gmail.com
Turkey
Turkish Society for Prevention of Child Abuse and Neglect - (TSPCAN) fsahin@gazi.edu.tr
United Nations Children's Fund
North Africa
Algeria
UNICEF Country Office

Algiers@unicef.org
Libya
UNICEF Country Office Tripoli@unicef.org
Morocco
UNICEF Country Office rebat@unicef.org
Tunisia
UNICEF Country Office tunis@unicef.org
Sub Saharan Africa
Botswana
UNICEF Country Office Gaborone@unicef.org
Burundi
UNICEF Country Office gkodwa@unicef.org
Cape Verde
UNICEF Country Office petra.lantz@cv.jo.un.org
Congo
UNICEF Country Office Brazzaville@unicef.org
Equatorial Guinea
UNICEF Country Office Malabo@unicef.org
Gabon
UNICEF Country Office Libreville@unicef.org
Lesotho
UNICEF Country Office amagan@unicef.org
Madagascar
UNICEF Country Office Antananarivo@unicef.org
Namibia
UNICEF Country Office nmbregistry@unicef.org
Rwanda
UNICEF Country Office Kigali@unicef.org
Swaziland
UNICEF Country Office Mbabane@unicef.org
Middle East
Bahrain
UNICEF Country Office riyadh@unicef.org
Iran

UNICEF Country Office Tehran@unicef.org
Iraq
UNICEF Country Office badhdad@unicef.org
Israel
UNICEF Country Office info@unicef.org.il
Jordan
UNICEF Country Office amman@unicef.org
Kuwait
UNICEF Country Office Riyadh@unicef.org
Lebanon
UNICEF Country Office Beirut@unicef.org
Oman
UNICEF Country Office muscat@unicef.org
Palestine
UNICEF Country Office Jerusalem@unicef.org
Qatar
UNICEF Country Office Riyadh@unicef.org
Saudi Arabia
UNICEF Country Office Riyadh@unicef.org
Syria
UNICEF Country Office Damascus@unicef.org
Turkey
UNICEF Country Office Ankara@unicef.org
United Arab Emirates
UNICEF Country Office riyadh@unicef.org

APPENDIX D. CHILDREN'S, WOMEN'S, AND GENERAL NGOS GOOGLED

Children's Websites Googled
African Child Policy Forum http://www.africanchildforum.org/site/
African Network for the Prevention and Protection against Child Abuse and Neglect (ANPPCAN) http://www.anppcan.org/chapter_offices
Child Rights Information Network (CRIN) http://www.crin.org/NGOGroupforCRC/ViewOrgsByC.asp?typeID=7
Directory of African NGOs http://www.un.org/africa/osaa/ngodirectory/index.htm
Duke Universityhttp://library.duke.edu/research/subject/guides/ngo_guide/ngo_database.html
Girl Child Network Worldwide http://girlchildnetworkworldwide.org/
Middle East Children's Alliance http://www.mecaforpeace.org/
SOS Children's Villagehttp://www.sos-childrensvillages.org/What-we-do/Pages/default.aspx
The United Nations Children's Fund (UNICEF) http://www.unicef.org/infobycountry/index.html
Women's Websites Googled
African Women's Development and Communications Network (FEMNET) http://www.femnet.or.ke/
African Women's Development Fund (AWDF) http://www.awdf.org/
The Arab Women's Forum wscad@netvision.net.il
Arab Women's Solidarity Commission http://www.awsa.net/
Associated Country Women of the World, ACWW www.acww.org.uk
Association for Women's Rights in Development (AWID) http://www.awid.org/eng
Coalition of Women for Peace www.coalitionofwomen.org/home/english/about/general_info
Directory of African NGOs (Women's Issues) http://www.un.org/africa/osaa/ngodirectory/index.htm
Duke University http://library.duke.edu/research/subject/guides/ngo_guide/ngo_database.html
Gender Based Violence Prevention Network http://www.preventgbvafrica.org/
Global Alliance on Women's Health (GAWH) www.gawh.org

Global Fund for Women http://www.globalfundforwomen.org/
Institute for Women's Studies in the Arab World http://www.lau.edu.lb/centers-institutes/iwsaw.html
Kurdish Women's Rights Watch (KWRW) www.kwrw.org
Legal Assistance Centre (LAC) http://www.lac.org.na/about/default.html
Middle East NGOs (MENGOS) http://www.mengos.net/
National Union of Tunisian Women http://www.unft.org.tn/en/home/home.html
NGOs in Africa http://unpan1.un.org/intradoc/groups/public/documents/un/unpan007722.pdf
Organization for Defending Victims of Violence http://www.odvv.org/Default.aspx?ctrlId=1&AspxAutoDetectCookieSupport=1
The Organization of Women's Freedom in Iraq http://www.equalityiniraq.com/
Solidarity For African Women's Rights/ Coalition on Violence Against Women (COVAW) http://www.soawr.org/en/soawrmember/coalition_on_violence_against_women_cova
Women Living Under Muslim Laws www.wluml.org/english/index.shtml
Women's Centre for Legal Aid and Counseling (WCLAC) www.wclac.org
Women's Global Network for Reproductive Rights (WGNRR) http://www.wgnrr.org/
Women's NGOs in Africa http://www.un.org/africa/osaa/ngodirectory/dest/Women.htm
General NGOs Googled
ADDAMEER http://www.addameer.org/
African Medical & Research Foundation (AMREF) www.amref.org
Al-Haq http://www.alhaq.org/
Al Mezan Center for Human Rights http://www.mezan.org/en/
ANERA http://www.anera.org/index.php
The Arab Association for Human Rights http://www.arabhra.org/HRA/Pages/Index.aspx?Language=2
Arab Commission for Human Rights http://home.swipnet.se/~w-79939/
Badil Resource Center www.badil.org
BTSELEM

http://www.btselem.org/English/index.asp
Bunian http://www.bunian.org.jo/bunian/english/projects/www.htm
Euro-Mediterranean Human Rights Network http://www.euromedrights.net/
Global Justice links http://www.globaljusticecenter.net/research-links/womens-rights.html
Health Link (HL) http://www.healthlink.org.uk?partners/a-z.html
Human Rights Link http://www.derechos.net/links/ngo/regional/mena.html
International AIDS Society (IAS) www.iasociety.org
International Humanist and Ethical Union World Population Foundation http://www.arabcanconf.org/index.asp
Iraqi Al-Amal Association http://www.iraqi-alamal.org/english/index.htm
Mossawa Center http://www.mossawacenter.org/
Palestinian Centre for Human Rights (PCHR) http://www.pchrgaza.org/portal/en/
Peace Building Portal (PB) http://www.peacebuildingportal.org/index.asp
Physicians for Human Rights - Israel (PHR - Israel) http://www.phr.org.il/default.asp?PageID=145
Regional Human Rights Organizations - Middle East http://www.law.emory.edu/ihr/mideast.html
TARGEThttp://www.target-human-rights.com/HP-02_target/u12_ueberTarget/index.php?lang=en&

APPENDIX E. NON-GOVERNMENTAL ORGANIZATION QUESTIONNAIRE

My name is Nazia Naeem and I am doing my Master's Thesis on Female Genital Cutting (FGC) in the Middle East and Africa with the support of my mentors Dr. Karen Polonko, Dr. Lucien Lombardo and Dr. Elizabeth Monk-Turner at Old Dominion University, Norfolk, Virginia, USA. This research intends to develop estimates of FGC for countries currently lacking data and to increase our understanding of this practice by gathering information from Non Governmental Organizations (NGOs). With your cooperation I hope to be able to develop an estimate of FGC for your country.

Please know that your responses will be kept completely ANONYMOUS. Please use a secure or private connection/computer. Thank you very much for your time and cooperation.

1. Please provide the following information:
   Name of NGO:_____
   Country:_____

2. Have you ever heard of any case of FGC performed in your country?
   __Yes
   __No

   If respondent said, "NO" to question 2, then they skip questions 3-7.

   If respondent said, "YES to question 2, then they skip questions 8-9.

3. Overall what do you think is the total percent of females in your country that have undergone FGC?
   __01 to 10%: Not Prevalent
   __11 to 25%: Slightly Prevalent
   __26 to 50%: Somewhat Prevalent
   __51 to 75%: Prevalent
   __76 to 100%: Very Prevalent

4. Based on your best knowledge, please put a check mark next to any group more likely to have higher rates of FGC in your country compared to others in the category:

A. Place of Residence
__Urban
__Rural
__No difference

B. Woman's Education
__No Education
__Primary
__Secondary
__No difference

C. Household Wealth
__Poorest
__Middle
__Upper
__No difference

D. Religion
__Muslim
__Protestant
__Catholic
__No difference
__Other (please specify): _____

E. Region
__North
__South
__East
__West
__No difference

F. Are there certain ETHNIC GROUPS in your country, which are more likely to have undergone FGC than other groups? (For example nomadic tribes, such as Kurds in Iraq and Bedouins in Jordan)_____
_____

G. Are there ANY OTHER IDENTIFIABLE GROUPS in your country which are more likely to have undergone FGC than other groups? (For example, Immigrants or Refugees)_____
_____

5. Overall, which of the following is the most common type of FGC in your country? Check MOST COMMON TYPE in your country.

__Type I: Clitoridectomy- Part or total clitoris is cut off (clitoridectomy)
__Type II: Part or total removal of both the clitoris and inner lips (labia minora)
__Type III: Infibulation or Pharaonic circumcision- Clitoris is removed, some or all of inner and outer vulval lips (labia minora and labia majora) are cut off and the vaginal opening is partially closed after excision.

6. What do you think is the most important reason why FGC continues in your country? Rank from 1 to 5: 1 being the least important and 5 being the most important.

   A. __Community/Tradition: Social acceptance in community; Uphold tradition

   B. __Religion: Religion requires it

   C. __Marriage: Better marriage prospects; Ability to marry upward

   D. __Control Female Sexuality: Preserve female virginity; Prevent premarital sex

   E. __Female Genitals: To make female genitals clean and hygienic

   F. __Other (please specify):_____

7. Do you think any of these would help reduce or prevent FGC in your country? (Mark Y for Yes and N for No)

   A. __Increased primary and secondary education of girls

   B. __Education of girls on FGC

   C. __Education of mothers on FGC

   D. __Education of fathers on FGC

   E. __Religious leaders speaking out against practice

   F. __Political leaders speaking out against practice

G. __Community leaders speaking out against this practice

H. __Laws against this practice

I. __NGO activities

J. __Other (please specify):_____

8. What do you think is the most important reason why FGC does not exist in your country? Rank from 1 to 5: 1 being the least important and 5 being the most important.

A. __Community/Tradition: No social acceptance in community; Not supported by tradition

B. __Religion: Religion does not require it

C. __Marriage: Does not increase marriage prospects

D. __Control Female Sexuality: Female virginity and sexuality can be controlled through other factors

E. __Female Genitals: Female genitals become unclean and unhygienic

F. __Other (please specify):_____

9. Do you think FGC does not exist in your country due to ANY of these factors? (Mark Y for Yes and N for No)

A. __Increased primary and secondary education of girls

B. __Education of girls on FGC

C. __Education of mothers on FGC

D. __Education of fathers on FGC

E. __Religious leaders speaking out against practice

F. __Political leaders speaking out against practice

G. __Community leaders speaking out against this practice

H. __Laws against this practice

I. __NGO activities

J. __Other (please specify):_____

10. Are there any persons, NGOs, and/or studies that might have information or help us get information on the prevalence of FGC?
__Yes
__No
If yes: Names of persons, NGOs, and/or studies and where to find them:_____
_____

11. Could students at our University help your NGO to stop FGC?_____
_____

12. Please feel free to share any other thoughts in regards to FGC._____
_____

APPENDIX F. NON-GOVERNMENTAL ORGANIZATION QUESTIONNAIRE CODED

	Variable	Code
Q1	Name of NGO and Country	Open ended
Q2	Have you ever heard of any case of FGC performed in your country?	0= No 1= Yes
Q3	Overall what do you think is the total percent of females in your country that have undergone FGC?	1= 1 to 10% Not Prevalent, 2= 11 to 25% Slightly Prevalent, 3= 26 to 50% Somewhat Prevalent, 4= 51 to 75% Prevalent, 5= 76 to 100% Very Prevalent
Q4	Based on your best knowledge, please put a check mark next to any group more likely to have higher rates of FGC in your country compared to others in the category:	
Q4A	Place of Residence	1= Urban, 2= Rural, 3= No difference
Q4B	Women's Education	1= No education, 2= Primary, 3= Secondary, 4= No difference
Q4C	Household Wealth	1= Poorest, 2= Middle, 3= Upper, 4= No difference
Q4D	Religion	1= Muslim, 2= Protestant, 3= Catholic, 4= No difference
Q4E	Region	1= North, 2= South, 3= East, 4= West, 5= No difference
Q4F	Are there certain ETHNIC GROUPS in your country, which are more likely to have undergone FGC than other groups?	Open ended
Q4G	Are there ANY OTHER IDENTIFIABLE GROUPS in your country, which are more likely to have undergone FGC than other groups? (For example, Immigrants or Refugees)	Open ended
Q5	Overall, which of the following is the most common type of FGC	1= Type I: Clitoridectomy- Part or

	in your country?	total clitoris is cut off (clitoridectomy) 2= Type II: Part or total removal of both the clitoris and inner lips (labia minora) 3= Type III: Infibulation or Pharaonic circumcision- Clitoris is removed, some or all of inner and outer vulval lips (labia minora and labia majora) are cut off and the vaginal opening is partially closed after excision.
Q6	What do you think is the most important reason why FGC continues in your country?	
Q6A	Community/Tradition: Social acceptance in community; Uphold tradition	1= Least important, 2= Slightly important, 3= Somewhat important, 4= Important, 5= Most important
Q6B	Religion: Religion requires it	1= Least important, 2= Slightly important, 3= Somewhat important, 4= Important, 5= Most important
Q6C	Marriage: Better marriage prospects; Ability to marry upward	1= Least important, 2= Slightly important, 3= Somewhat important, 4= Important, 5= Most important
Q6D	Control Female Sexuality: Preserve female virginity; Prevent premarital sex	1= Least important, 2= Slightly important, 3= Somewhat important, 4= Important, 5= Most important
Q6E	Female Genitals: To make female genitals clean and hygienic	1= Least important, 2= Slightly important, 3= Somewhat important, 4= Important, 5= Most important
Q6F	Other (please specify)	Open ended
Q7	Do you think any of these would help reduce or prevent FGC in your country?	
Q7A	Increased primary and secondary education of girls	0= No, 1= Yes

Q7B	Education of girls on FGC	0= No, 1= Yes
Q7C	Education of mothers on FGC	0= No, 1= Yes
Q7D	Education of fathers on FGC	0= No, 1= Yes
Q7E	Religious leaders speaking out against practice	0= No, 1= Yes
Q7F	Political leaders speaking out against practice	0= No, 1= Yes
Q7G	Community leaders speaking out against this practice	0= No, 1= Yes
Q7H	Laws against this practice	0= No, 1= Yes
Q7I	NGO activities	0= No, 1= Yes
Q7J	Other (please specify)	Open ended
Q8	What do you think is the most important reason why FGC does not exist in your country? Rank from 1 to 5: 1 being the least important and 5 being the most important.	
Q8A	Community/Tradition: No social acceptance in community; Not supported by tradition	1= Least important, 2= Slightly important, 3= Somewhat important, 4= Important, 5= Most important
Q8B	Religion: Religion does not require it	1= Least important, 2= Slightly important, 3= Somewhat important, 4= Important, 5= Most important
Q8C	Marriage: Does not increase marriage prospects	1= Least important, 2= Slightly important, 3= Somewhat important, 4= Important, 5= Most important
Q8D	Control Female Sexuality: Female virginity and sexuality can be controlled through other factors	1= Least important, 2= Slightly important, 3= Somewhat important, 4= Important, 5= Most important
Q8E	Female Genitals: female genitals become unclean and unhygienic	1= Least important, 2= Slightly important, 3= Somewhat important, 4= Important, 5= Most important
Q8F	Other (please specify)	Open ended
Q9	Do you think FGC does not exist in your country due to ANY of these factors?	
Q9A	Increased primary and secondary education of girls	0= No, 1= Yes
Q9B	Education of girls on FGC	0= No, 1= Yes
Q9C	Education of mothers on FGC	0= No, 1= Yes

Q9D	Education of fathers on FGC	1= Yes, 2= No
Q9E	Religious leaders speaking out against practice	0= No, 1= Yes
Q9F	Political leaders speaking out against practice	0= No, 1= Yes
Q9G	Community leaders speaking out against this practice	0= No, 1= Yes
Q9H	Laws against this practice	0= No, 1= Yes
Q9I	NGO activities	0= No, 1= Yes
Q9J	Other (please specify)	Open ended
Q10	Are there any persons, NGOs, and/or studies that might have information or help us get information on the prevalence of FGC?	0= No, 1= Yes
Q10A	If yes: Names of persons, NGOs, and/or studies and where to find them:	Open ended
Q11	Could students at our University help your NGO to stop FGC?	Open ended
Q12	Please feel free to share any other thoughts in regards to FGC.	Open ended

VITA

NAZIA ROSE NAEEM
Old Dominion University, Department of Sociology and Criminal Justice, Norfolk, Virginia 23529 (757)683-3791

EDUCATION

Master of Arts, Applied Sociology and Criminal Justice
Old Dominion University, Norfolk, Virginia, August 2011

Bachelor of Science, Political Science and Criminal Justice
Old Dominion University, Norfolk, Virginia, May 2009

PRESENTATIONS

Polonko, Karen, Adams, Nicholas, Naeem, Nazia, and Adinolfi, Ava. "Prevalence of Child Sexual Abuse in Africa and the Middle East: A Review of the Research" Presented at the 4th Annual International Conference on Sociology, 10-13 May 2010, Athens, Greece.

Polonko, Karen, Naeem, Nazia, Adams, Nicholas, and Adinolfi, Ava. "Child Sexual Abuse in Africa and the Middle East: Prevalence and Relationship to Other Forms of Sexual Violence" Presented at the 18th Annual International Congress on Child Abuse and Neglect, 26-29 September 2010, Honolulu, Hawaii.

FORTHCOMING PUBLICATION

Polonko, Karen, Adams, Nicholas, Naeem, Nazia, and Adinolfi, Ava. "Prevalence of Child Sexual Abuse in Africa and the Middle East: A Review of the Research" forthcoming. ATINER.

SKILLS

Microsoft Word/Excel/Access/PowerPoint, WordPerfect, Survey Monkey, Lexis Nexis, Accurint, Statistical Package for the Social Sciences, and familiarity with STATA.

LANGUAGES

Fluently speak English, Hindi, and Urdu. Basic understanding of Arabic, Punjabi, and Spanish.

AWARDS AND ASSOCIATIONS

Criminal Justice Honor Society, Golden Key International Honor Society, National Honor Society, Political Science Honor Society, and Sociological Honor Society.