ANALYSIS OF THE PREVAILING PRACTICE OF FGM IN THE UPPER WEST REGION OF GHANA: ARE INTERNATIONAL LAWS AND DOMESTIC POLICY EFFECTIVE IN ERADICATING FGM WITHIN THE STATE?

A thesis submitted to the Kent State University Honors College in partial fulfillment of the requirements for University Departmental Honors

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# TABLE OF CONTENTS

LIST OF FIGURES.............................................................................................. vi

LIST OF TABLES ................................................................................................... vii

ACKNOWLEDGMENTS ........................................................................................ viii

CHAPTER

I. INTRODUCTION. .......................................................................................... 1

   How to Refer to the Practice................................................................. 1

   Types of FGM.......................................................................................... 4

   Health Consequences .............................................................................. 9

      a. Physical Effects ............................................................................... 9

      b. Psychological Effects ...................................................................... 12

   Policy Trial and Error .............................................................................. 13

   What We Know of the Origins of FGM .................................................. 15

   Tools and Practitioners ........................................................................... 16

   Scope of the Practice .............................................................................. 18

   Research Design: Multi-method Approach .......................................... 20

      a. Survey Purpose and Methodology .............................................. 20

      b. In-Person Interviews ................................................................. 23

   Dilemmas in Data Collection ............................................................... 27

II. THE PRACTICE OF FGM, REASONING AND LEGAL
   CONSEQUENCES ...................................................................................... 32
Social, Spiritual, and Cultural Justifications…………………32
Religious Justifications………………………………………..37
International Laws and Treaties against FGM………………39
The Blurry Line of Cultural Relativism and where it Stops……43

III. GHANAIAN POLITICAL STRUCTURE OVERVIEW………………47
       General Information and Context…………………………..47
       The Chieftaincy…………………………………………………..47
       Ghanaian Domestic Policies against the Practice………….48
       The Constitution………………………………………………….49
       Criminal Law……………………………………………………52
       Upper West Statistical Overview…………………………..54
       Survey Data………………………………………………………57
            a. Male vs Female Survey Results…………58
            b. Regional Survey Results…………………..62
            c. Open-Ended Response Findings…………….67
       Discoveries during Field Research…………………………70
       Conclusion………………………………………………………79

BIBLIOGRAPHY……………………………………………………...82
APPENDIX A…………………………………………………………86
       IRB Informed Consent Form…………………………………87
APPENDIX B. ........................................................................................................ 89

Survey Questions. ............................................................................................. 90

APPENDIX C. ..................................................................................................... 94

Interview Questions. .......................................................................................... 95
LIST OF FIGURES

Figure 1 .........................................................................................................................10
Figure 2 .........................................................................................................................12
Figure 3 .........................................................................................................................56
LIST OF TABLES

Table 1. Male Response to Questions on a Scale from 1 to 5 ..........................58
Table 2. Female Response to Questions on a Scale from 1 to 5 ..........................59
Table 3. Ashanti Region Responses on a Scale of 1 to 5 ...............................62
Table 4. Volta Region Responses on a Scale of 1 to 5 ...............................62
Table 5. Western Region Responses on a Scale of 1 to 5 ..........................63
Table 6. Greater Accra Region Responses on a Scale of 1 to 5 ......................63
Table 7. Brong-Ahafo Region Responses on a Scale of 1 to 5 ......................64
Table 8. Central Region Responses on a Scale of 1 to 5 ..........................64
Table 9. Eastern Region Responses on a Scale of 1 to 5 ..........................65
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I: Introduction

Female genital mutilation (FGM) is a cultural tradition involving the cutting, pricking or burning of healthy genital tissues of a female. There are four types of FGM that range in severity, which will be discussed in further detail shortly. It is practiced throughout populations around the world, but more concentrated within the continent of Africa with 29 countries there continuing the practice. The genesis of the practice is unclear, but it has been traced back over one thousand years to ancient Egyptian and Roman societies. Reasoning for the practice varies across communities around the world, including justification such as prescription in religious doctrine, aiding in the child delivery process, cosmetic preference, a range of mystical beliefs, and the association with a female’s rite of passage into womanhood. Despite these purposes, FGM has proven to have detrimental health consequences to both the female that has undergone the process, and her unborn child if she is pregnant.

How to Refer to This Practice?

Due to the health consequences and sensitivity surrounding the topic, multiple names have been used in reference to the practice including female genital cutting (FGC), female circumcision, excision, and female genital surgeries. Using the term “FGM” within this thesis is purposeful and was chosen in recognition of its link to human rights advocacy. The word “circumcision” creates a false analogy that insinuates FGM is equivalent or even relatable to male circumcision. In order to avoid this, I chose to
remove the term from the general repertoire of this thesis. The term “FG surgery” was never even considered due to the implication that such a practice is equal to that of a typical procedure carried out in a medical facility.

The term “mutilation” has been contested by those who believe the term to indicate intentional infliction of pain and harm to the female, when in reality, many parents who insist upon the performance of FGM believe they are doing it for the benefit of the child and/or community. Another reason for opposition to the term is the offensiveness of thinking that one’s body, especially genitalia, is disfigured and/or “mutilated.” As further support for my word choice, although I am not opposed to referring to the practice as female genital cutting/FC, I believe that it does not properly address the wide-spread aspect of the practice, nor the dangerous consequences of physical and psychological damage that can occur post-cutting.

For the purposes of this text, the term “female genital mutilation/FGM” will be used to refer to the practice under study. The reasoning behind the decision to utilize FGM in lieu of any of the alternatives is summarized well by Kathleen Sheldon. “‘Mutilation’ is clearly political, ‘circumcision’ inaccurate, FG ‘surgeries’ makes it sound medical…” (Skaine 7). Another reason for my usage of this term is that most variants of FGM entail damage to or removal of healthy tissues or organs that do not need intervention (Skaine 3). Furthermore, due to the political nature of this thesis, I decided that using the term supported by United National Population Fund (UNFPA), as well as numerous other political and human rights organizations, would be the best route to take
for this subject. More importantly to this context, as of 2007 with the enactment of Act 741 to the Ghana Criminal Code, the phrasing used within the law against FGM has been changed from “female circumcision” to “female genital mutilation” to reflect the lawless nature of the act (“Sexual and Reproductive Health and Rights in Ghana: The role of Parliament”). This terminology is in no way meant to inflict any further harm on those who have undergone the practice.

I made the decision to refer to the practice as “female circumcision” during my interviews at the recommendation of Dr. Ebenezer Ayesu, a Senior Research Fellow within the Institute of African Studies at the University of Ghana, Legon. I had worked closely with Dr. Ayesu in preparation for my trip to the Upper West region during both visits to Ghana. This decision was made in order to keep from causing offense or inflicting any emotional harm upon participants.

Additionally, it is important to note while on the topic of positionality and bias, that something that proved to be a struggle throughout my field research was approaching this topic with a feminist ideology. As perfectly put by Gruenbaum, I would never want to contribute to the “pedagogy of missionizing, telling others what they ought to do differently for reasons justified only by the “enlightened” outsiders’ beliefs” (Gruenbaum 35). This has been a difficult sort of grey area that has proved to be a near-constant struggle throughout the writing process, attempting to present my research findings, advocate against the practice within a historical and legal context, all the while trying to show the recognition of my place on the sidelines of this issue. I wanted my stance and
acknowledgement of bias to be known from the beginning as this thesis is framed from within that context.

Types of FGM

There are four types of FGM, the first being the least severe on the spectrum, and type three causing the most potential damage. According to the World Health Organization (WHO), the categories of FGM are defined as follows:

**Type I:** Also called a *clitoridectomy*, this is the partial or total removal of the clitoris and/or the prepuce. The WHO provides a further division of Type I circumcision into two subcategories, *Type Ia* being the removal of only the clitoral hood, and *Type Ib* being the removal of both the clitoral hood and the clitoris itself.

**Type II:** Also referred to as *excision*, this is the partial or total removal of the clitoris and the labia minora. Excision may or may not include removal of the labia majora. WHO has proposed three different subcategories for excision: *Type IIa* is the removal of solely the labia minora. *Type IIb* is the partial or total removal of the clitoris and labia majora. And finally, *Type IIc* is the partial or total or total removal of the clitoris, the labia majora, and the labia minora.

**Type III:** Also known as *infibulation*, this is the category of FGM known to cause the most long-term health risks due to the extent of the tissue taken and/or altered from
the vagina. This involves the narrowing of the vaginal orifice by cutting and sewing together the labia minora and labia majora, which may or may not involve the removal of the clitoris. WHO has also proposed two further subcategories for infibulation: Type IIIa is the removal and apposition of the labia minora, and Type IIIb is the removal and apposition of the labia majora (WHO Sexual and Reproductive Health). Infibulation has also been known as pharaonic circumcision due to the documented usage of this type of female circumcision in Egypt at the time of the pharaohs. Additional terminology used within this category is the distinction between angurya cuts, scraping of the vaginal orifice, and gishiri cuts, cutting of the vagina. Different mixtures of harsh herbs and other substances may be mixed together and placed inside the vagina with the goal of corroding the area, thus tightening the opening (Toubia 17).

**Type IV:** This category was made in order to provide distinction for all of the other miscellaneous types of unnecessary alterations to the female genital area that do not serve a legitimate medical purpose. These actions could include those such as the pricking, piercing, incising, scraping, and cauterization of the genital area.

In Ghana, Type III is seldom if ever practiced, but Types I and especially II have been documented at high frequencies throughout practicing communities (Rahman and Toubia 164). Additionally, while conducting interviews, none of the female participants elaborated on a more complex procedure being performed upon them or within their communities while giving their personal accounts. A majority simply referenced the removal of the clitoris, or the “dirt.”
There will be two primary research questions addressed in this text: are domestic policies implemented in Ghana effective in the eradication of FGM? And if the practice still exists, why would communities wish to continue despite the threat of imprisonment? Although this study is not capable of speaking to the broad, global context, the importance of the answers to these questions cannot be understated due to their direct link to a practice that impacts the health and livelihoods of millions of women and girls around the world each year. For Ghanaians, data produced through a 2015 United Nations Children’s Fund (UNICEF) statistical bulletin shows that the infant mortality rate in Ghana was thirty-two in one-thousand deaths, and increased to thirty-five per one-thousand in the Northern regions of the country (REALLY SIMPLE STATS). A study done by the World Health Organization (WHO) highlighted the grave results in regards to infant mortality, stating that:

The death rate among babies during and immediately after birth is also much higher for those born to mothers with FGM: 15% higher in those with FGM I, 32% higher in those with FGM II, and 55% higher in those with FGM III. It is estimated that in the African context an additional 10 to 20 babies die per 1000 deliveries as a result of the practice (WHO Media Centre).

With the most prevalent cases of FGM being Type I, and much rarer cases of Type II and III, the importance of the termination of the practice could not be clearer. These totals also fail to account for the women who die as a result of obstructed labor or other medical complications relating to FGM. If these factors were considered, FGM may be treated like more of a public health crisis. It has become exponentially more difficult to combat FGM after the practice became criminalized with the imposition of
Article 69(a) of Ghana’s Criminal Code in 1994. With strict punishments now outlined for those who disobey the law, there is suspicion that the practice has been driven underground in order to evade legal persecution and scrutiny from those who oppose the practice.

**Literature Review**

When addressing the issues of policy implementation in developing countries, scholars have produced a myriad of suggestions in an attempt to solve underlying issues. It has been found that the internal assessment of organizations is just as important as the organizations themselves. A study undertaken by the Program for Appropriate Technology in Health (PATH) assessed FGM activities in Kenya (MYWO), Egypt (CEOSS), and Senegal (TOSTAN) (“FGM: What Works and What Doesn’t”). The reports given by these programs found that when engaging in community-based discussion, the population was able to self-identify the areas in need of addressing, as well as formulate concrete solutions. Almost more importantly than drafting solutions, these internal assessments were able to reveal areas of weakness within the organizations that needed further examination. They found that too many institutions, specifically those working within FGM advocacy, were weakened by the fact that a majority of the staff were volunteers, and that their educational programs hadn’t yet reached many of the communities known to continue the practice (“FGM: What Works and What Doesn’t”). These reports also showed that when a country takes advantage of the momentum created
from powerful initiatives and if acting in a timely manner so as not to lose support of the goal at hand, that policy changes can create more of a lasting effect long-term. Utilizing this momentum could come in the form of additional policies being implemented if necessary, or resources being presented by the government in the form of financial or physical resources.

When looking at the instance of Ghana, research has shown that all of the aforementioned weakness are relevant in this context, and additionally, that there has been an issue with aligning international standards with local realities. In a 2002 article written by Rev. Dr. Kpieta B. Alfred and Laari B. Prosper, the authors explored the failed implementation of child protection laws in Ghana. They make the important point in the broader aim of their analysis that in order to understand why policy isn’t effective in Ghana, it is essential to respond and intervene appropriately based on the context of the country’s situation. The authors point out that in these situations, although education is important, with much of the population in poverty, it is necessary for the good of the child and family as a whole that the child work to help the family sustain itself. Brashly insisting that a child go to school regardless of the situation without aiding in provisions to relieve the economic strain could cause more harm than good. In the case of FGM, especially when the prevalence rate for the country has dropped to 3.8% (“FGC is a Crime”), a nuanced approach needs to be introduced, particularly in areas where police officers are undertrained or not trained at all in gendered issues, do not have adequate resources to combat FGM, and may have more immediate problems to handle.
Health Consequences

Physical Effects

There are a wide range of health consequences due to the variety of ways in which the practice of FGM is carried out. The more tissue that is removed, the more damage done, so usually Type I is considered the least harmful of the four types. Resulting health consequences may include infection, keloids, and difficulty giving birth due to the tightness of the resulting scar tissue. Type III is strongly associated with more severe health consequences such as obstructed birth and fistulas. It is important to note that no matter which type performed, hemorrhage and death may still occur if cut improperly.

A more comprehensive list of physical ailments resulting from FGM include vulvar ulcers, dermoid cysts, keloids, neuroma (when a clitoral nerve is relocated to the exterior of the body, trapped within the scar tissues left behind from the procedure), incontinence, vaginal obstruction, various degrees of infection, urinary and vaginal stones, and menstrual disorders (Toubia 33-37). The World Health Organization recognizes these complications in addition to severe pain, genital tissue swelling, shock, urination problems, impaired wound healing, and obstetric fistula as other possible risk factors (WHO Media Centre). Unsanitary conditions surrounding the practice, i.e. sharing of the cutting instrument when groups of girls would be collectively circumcised, carries the potential of spreading HIV infection or other diseases. Lack of proper medical equipment and training may also lead to the most ultimate consequence of this practice:
death. Many interview participants in the Upper West claimed to have abandoned the practice after one or several deaths resulted from uncontrollable hemorrhaging. These instances show that these concerns remain relevant in the Ghanaian context.

In order to give a better visual of the medical repercussions women and children may face, Figure 1 is an image taken from a guide for medical professionals on the proper way to cut and re-stitch the available tissue when removing a dermoid cyst. Anywhere from the size of a pea to that of a grapefruit, these cysts can result from a skin fold being embedded within the scar tissue left behind post-FGM, or blockage of the sebaceous gland duct (Toubia 33). Similar to this bubble-like appearance, keloids are more difficult to treat since they may multiply if interfered with when aggravating the area of scar tissue. Plastic surgery, radiation treatments, or a topical steroid may be the only truly effective ways to quell the effects of a case of keloids (Toubia 34).

Defibulation, or the reopening of the stitched area of the vagina, is usually reserved for Type III FGM, but may even occur in the lesser practices in order to ensure safe child delivery. A doctor working at Nyaho Hospital in the Greater Accra region who...
preferred his identity be kept confidential, stated the following when asked if Type I was the most commonly practiced FGM type in Ghana:

More or less, not the severe one, Type II I think, where the labia minora and a bit of the clitoris is removed. So what you do is, we do what they call defibulation. So that’s when you infiltrate with xylocaine and then cut so that they don’t – when there’s an instance they can have lacerations and make it worse, so we normally do the defibulation and then someone goes to deliver the baby.

Defibulation may cause additional harm when reopening the scar tissues, causing further trauma to the area, or even pose another risk of hemorrhage if done improperly. In many cases of Type III FGM, a woman might be defibulated in order to give birth and reinfibulated after the baby successfully passes through the birth canal. In some cases this is still not possible, and a cesarean birth is the only remaining option. During my brief stay as a patient at 3M&C hospital in East Legon while receiving treatments for malaria, I was reading Rosemarie Skaine’s book entitled *FEMALE GENITAL MUTILATION*, and upon inquiry by a nurse, began a conversation about the practice. She relayed that although she had never seen a case of FGM at 3M&C since the practice is not performed in Accra, (unless maybe by an immigrant from a different region), during her nursing training she had seen the most severe case (infibulation) when aiding a birth attendant in the maternity ward at a hospital in Kumasi. She described how the shape of the baby’s head was pushing against the skin of the mother’s birth canal, but the child was blocked from exiting. With the life of the mother and child both hanging in the balance, the medical staff was unable to perform a C-section until they had been able to reach the
father of her husband for permission. Below is another image from Toubia’s book in order to provide a better visual of the medical complications that can ensue.

Figure 2

This image shows a mother attempting to give birth. The bulge is the baby’s head that is unable to exit the birth canal due to the narrow passage as a direct result of Type III FGM. The scar tissue present once infibulated and sewn closed does not allow for the expansion of tissues needed to deliver a child. As seen in the photo, the skin is stretched tightly as the child tries to exit, but there is no viable passage to continue through. The child in this case did not survive.

Psychological Effects

Depending on the age of the child, mental trauma may result from instances where FGM is performed on a child old enough to be aware of their surroundings and harbor memories of the experience. Although in Ghana specifically, eighty-three percent of females circumcised had the procedure performed before the age of five (Statistical Profile of Female Genital Mutilation/Cutting), if the procedure happens to be performed later in life, she may need to be held down by multiple people in the community in order to complete the procedure. These kinds of painful instances may be associated with the
community or family for the female and cause social withdrawal and/or issues of trust. An article published by 28 Too Many, a human rights organization dedicated to FGM education and eradication, lists psychological consequences of the practice to include Post Traumatic Stress Disorder (PTSD) at the same level as people who have been subjected to early childhood abuse, and that up to 80% of women suffer from affective mood and anxiety disorders (Chung). The World Health Organization reiterates these points, adding that the meaningful nature of the practice to the participant will not ensure that they are immune from psychological complications (WHO Sexual and Reproductive Health).

**Policy Trial and Error**

The matter of FGM in Ghana is not solely an issue impacting women’s health, but also one affecting the livelihoods and rights of Ghanaian women. With the establishment of the Ministry of Gender, Children and Social Protection in 2013, concrete steps were made towards improving the well-being of women and girls in Ghana. When steps are taken to end FGM, there are also steps being taken towards the broader goal of gender equality. The cessation of FGM promotes the agencies of women who are then able to choose their own paths. This can be seen as one small step in the larger potential domino effect of establishing gender equality, as it may be connected to fewer child and adolescent marriages, additional years gained in education, and fewer cases of domestic violence and gender-based violence.

One of the most obvious methods of designing policies that could be used to
combat a social problem is trial and error. But when it comes to a governmental, country-wide scale where human rights violations are the issue at hand, the stakes become quite high, and the consequences of the ‘error’ phase can be dire. A prime example of this can be seen in Kenya’s efforts to combat FGM. Attempts at one culture trying to enforce widespread homogeneity have proven time and time again to fail, and in many instances lead to backlash. This example can be seen on Mt. Kenya in the mid-1950’s when laws against FGM were first enforced. Out of retaliation in feeling as if their cultural values were being suppressed, groups of girls fled to the outskirts of town, and within one day, an entire village of females had been circumcised on their own accord in an act of defiance to preserve the practice they held to be sacred. They became known within surrounding communities as Ngaitana, meaning “I will circumcision myself”, because in order to avoid the prosecution of those who had aided and abetted, these same women proclaimed, “I circumcision myself” before the court. Over two-thousand women were arrested in the coming years (Shell-Duncan and Hernlund 130). Although the push to stop FGM had been somewhat influenced by Christian missionaries residing in the area, the decision to end FGM in the Meru community was made through its local hierarchy, the Njuri Ncheke, a council of male leaders with legitimate establishment (Shell-Duncan and Hernlund 129). Seeking to further their reach and insert themselves into the dilemma, the Methodist Church of Meru instituted a loyalty pledge at this same time to members of the congregation, saying that the renunciation of the practice would be their way of affirming their loyalty to the church and Christian values. Nevertheless, adding insult to injury, they watched their membership sharply drop in the following weeks from seventy people to
only six (Shell-Duncan and Hernlund 129-131). This example shows that if a community wishes to create legal change in complex situations such as FGM, especially in communities where it has been supported rather than criminalized for centuries, making too sudden of a change could lead to the opposite of the desired outcome.

When looking at the data available for the twenty-nine African countries still practicing FGM, some rates are as alarmingly high as ninety-eight percent. Local government’s efforts to decrease incidents of FGM have been thwarted in certain cases where circumcisers cross borders in order to evade persecution. It is well-known that circumcisers tend to cross the borders from Burkina Faso and Ivory Coast in order to aid the continuation of the practice in Ghana. If bilateral agreements or mutually agreed upon grounds of prosecution can be set in place with bordering nations, this combined effort to stop the practice would not only raise awareness within those countries on these issues and promote advocacy work that has already been started, but further aid the efforts of Ghanaians with their mission as well.

**What We Know of the Origins of FGM**

In a seemingly impossible quest for the original justification of FGM, scholars and historians have thus far failed. The oldest record to date of the practice was written by Herodotus, a Greek historian who travelled to Egypt and wrote about the practice in the fifth century B.C.E. There were also accounts by Herodotus that Phoenicians, the Hittites, and Ethiopians practiced FGM. A few centuries later, documentation of the practice was discovered in Memphis from papyrus dating back to the year 163 B.C.E.
detailing incidences of FGM being performed on girls at the time they received their dowries (qtd. in Kouba and Muasher). A Greek geographer named Strabo wrote of the practice in 25 B.C.E. Several other European travelers of various occupations also wrote about their findings throughout the centuries in Egypt. So far, it appears that this country may be an option for the origin of FGM, but there is still no certifiable proof. Today Egypt remains subject to some of the highest recorded incidents of FGM. A study in 2003 by the WHO reported a prevalence rate of 94.6% for married women, and 41% of those in primary school (Bulletin of the WHO).

It is also important to note that industrialized countries have also had to address the issue of FGM within their borders. There is evidence that shows FGM being conducted in the United States and Great Britain with the claim that it would ‘‘treat hysteria, lesbianism, masturbation and other so-called ‘female deviations,’’’ lasting as late as the 1950’s (Skaine 46). The ideology displayed here that a woman’s sexuality needs to be harnessed and contained is one of the most prominent factors for conducting FGM all across the globe and will be discussed in depth.

**Tools and Practitioners**

The types of tools used to conduct FGM vary from place to place. Commonly used instruments include knives, razors, pieces of glass, sharp stones, and other miscellaneous objects. In Ethiopia the practice sometimes includes cauterizing (burning) the clitoris in order to successfully remove it from the body (Skaine 11). In the Upper
West region, only knives were documented as having been used for the practice. In Kperisi, they used the Wale word for knife, baraa, and described the instrument and process as:

They usually used baraa [knife], very stylish. It’s a small blade packed into a wooden handle with a sheath, and it could be folded. It was sharpened by rubbing it against his [the wanzam’s] palm. So as you waited for the wanzam, you could hear the sound. They would cut the person raw, without anesthetic. There was a particular tree where the bark would be removed and then ground into a pulp. But soon after that, it would be solidified like a cube of sugar. After the procedure, the wanzam would rub it against a clay pot into a powder, and the drop it onto the wound. This would cause further excruciating pain, but it would stop the bleeding. Then you would take some home and apply it with cotton to the wound. – (Group discussion of three women in Kperisi)

Practitioners are generally not medically trained due to the controversial and fairly recent illegality of the practice, and there has been a push to prevent it from ever becoming acceptable in medical institutions. During an interview with a male wanzam (term used in Ghana for a circumciser) in Sing, I asked why he had started the practice. He admitted that he had no medical knowledge. The prominent male elders of his village had always done it, so he had adopted the trade from watching their skills throughout the years. He had even circumcised his future wife when she was a child.

The sex of the practitioner varies from community to community. In the Upper West region of Ghana, some communities had a female circumciser and some had males, showing that even within one region there is variance. In other communities, the women laughed when I asked if a male or female performed the practice, with one woman from
Dornye remarking, “Of course it is the women! The men don’t know which one is the clitoris!”

**Scope of the Practice**

As previously noted, a recent report released by UNFPA in February of 2018 shows that FGM is still practiced in twenty-nine African countries: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Ivory Coast, Democratic Republic of Congo, Djibouti, Egypt, Eritrea, Gambia, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somali, Sudan, Tanzania, Togo, Uganda and Zambia. Additionally, UNFPA lists communities in India, Indonesia, Malaysia, Pakistan, Sri Lanka, Oman, the United Arab Emirates, Yemen, Iraq, Iran, Israel, the Occupied Palestinian Territories, Georgia, and the Russian Federation among those continuing the practice. It is also found with significantly lower frequency in specific communities in Colombia, Ecuador, Panama, and Peru (“FGM frequently asked questions”). It cannot be overlooked that the practice has persisted in Western countries as well due to the immigration of diaspora populations including the United States, New Zealand, the United Kingdom, and Australia, to name a few (28 Too Many).

Legislation has been passed over the last few decades in many of the aforementioned countries with various stipulations, the US passing their FGM law after the groundbreaking case of Fauziya Kassindja in 1996 (Center for Gender and Refugee Studies). Although this landmark case was a success for providing legal protections to
those seeking to escape the practice, and therefore recognizing its harm, whether or not US regulations prohibiting the practice are actually successful is another story. The first prosecution of FGM in the US took place in April of 2017 when a married couple, Fakhruddin Attar and Dr. Jumana Nagarwala, were charged with “conspiracy to commit female genital mutilation” and “aiding and abetting female genital mutilation” at their medical clinic located in a Detroit suburb (“4th Person Charged in Detroit Genital Mutilation Case”). Even though the issue of FGM had been identified as a problem in the US during the 1990’s, the fact that there had been no prosecutions until decades later attests to the difficulties faced in trying to catch those who still perform the practice, whether located in a developing country or not.

In Ghana, the scope of the practice is not entirely clear. According to the US Department of State archives, studies conducted 1986-1987 revealed that the ethnic groups that are commonly known to practice FGM in Ghana were the Kussasi, Frafra, Kassena, Nankanee, Bussauri, Moshie, Manprusie, Kantansi, Walas, Sissala, Grunshie, Dargati and the Lobi (Ghana: Report on FGM/FGC). The archives also documented that there were an estimated 30% of women continuing the practice as of the late 1990s; these numbers are now estimated to be below 5%. In a recent statement made on February 28, 2018, which is International Zero Tolerance Day for FGM, Honorable Djaba, Minister of the Ministry of Gender, Children and Social Protection, observed that “although the current national prevalence stands at about 3.8%, prevalence in the Upper East stands at 27.8% which is far higher than the national prevalence” (“FGC is a Crime”). This sharp decrease isn’t as encouraging after viewing a report released by the United Nations
Division for the Advancement of Women stating that according to Ghana’s 2005 Demographic and Health Survey, there was a 3.8% prevalence rate among women aged 15-49 with all three types found (Ras-Work 9). This shows a long plateau period where a remaining 3-4% of the population have not been swayed in over a decade.

**Research Design: Multi-method Approach**

I utilized both quantitative and qualitative approaches to collecting data for this study using two primary methods: in-depth interviews (some individual and some in small groups), and through a survey given to students at the University of Ghana. Data collection took place over the course of two trips to the country: the first took place over the course of four months beginning in January of 2017 while completing a semester exchange program at the University of Ghana, and the second lasted thirteen days in January of 2018.

**Survey Purpose and Methodology**

In order to ascertain whether or not the youth population was aware of the legislation passed in regards to FGM, I conducted a survey of 61 students at the University of Ghana. The survey was also an attempt to gauge the viewpoint of this topic from the stance of the younger generations growing up in a society far less saturated with the practice than their parents and grandparents. Respondents of this study were comprised of 31 males and 30 females across seven of the ten regions of Ghana, with zero participants from the Northern, Upper West, and Upper East regions. Due to the
small scale of this survey, the results should be interpreted with caution as they do not represent the entirety of Ghana’s youth population.

The survey was conducted with IRB approval (of which the informed consent form given to participants is listed under Appendix A) along with two requirements: the participant had to be enrolled at the University of Ghana and be a Ghanaian national. The survey was given to the students I was able to access during the week of finals on campus, and included only those who were willing to participate. This therefore does not constitute a random sample.

As mentioned above, it was a bit difficult to access survey participants since my approval for this venture came during finals week, meaning the campus was not nearly as lively, and students were not easily accessible. I began handing out surveys throughout the different wings of the library on campus, thinking I was likely to find potential participants there.

In order to ensure participants that they were taking part in an anonymous survey, I reviewed the opening page containing the informed consent form with them as needed, being sure to highlight the portion stating that the survey was completely voluntary and that I could be contacted at any time in the future for questions or concerns. I would then stand in the corner of the room, retrieving the packets one by one as participants signaled to me their completion, immediately stowing the surveys in an envelope in order to provide any extra comfort to the participant that I would not be able to match their face to any particular questionnaire result.
The second location(s) that produced a majority of my questionnaire feedback were the dorms. Luckily, due to exams week, many students were in their rooms diligently studying, giving me a more substantial pool to work with. I first went around the four stories of my building, ISH1, handing out as many surveys as I could. At the University of Ghana, you need to have a contact living in a dorm building to be able to gain access to the area, verifying this by the resident signing you in at the front desk. There is a very strict system for this. Knowing someone at a nearby dorm, ISH2, I was able to then go throughout that building as well for participants. Unfortunately, with most of the close acquaintances I’d made in Ghana living between these two dorm buildings, this was the extent of the spans of my dorm participants. Remaining participants were those stopped on sidewalks or approached on benches throughout campus while going from building to building. This in turn restricted the selection of participants able to participate in the study.

The data attained through the survey included biographical data such as the age and sex of the participant, what university level they were currently at (100-400, 100 being freshman status, and 400 denoting a senior), along with the region from which they originated. The course of study and department of the degree-seeking student was not of interest for this study as FGM is a cultural tradition across Ghana. The second section of the survey included eleven statements with a rating on a scale of one to five, one being “absolutely true” and five being “absolutely false”. These were meant to assess the participant’s knowledge on the topic of FGM and feelings regarding regional disparities on matters of police enforcement, policy implementation, and the different treatment of
males and females in Ghana. The data that is analyzed from these questions in a later section was constructed from following survey questions:

1) Men and women are treated equally in Ghana.
2) If I am having a problem, I am confident the police will handle it.
3) I feel that there are currently enough females representing constituencies in Parliament.
4) I am aware of the practice of female circumcision.
5) I believe that female circumcision is a harmful practice.
6) I believe that this practice still continues in Ghana.
7) Female circumcision is outlawed in Ghana.
8) Policy implementation happens quickly in Ghana.
9) Men and women are regarded with equal seriousness when reporting problem to police.
10) Rural and urban regions have equal police protection.
11) Rural and urban regions are equally knowledgeable of the laws passed in Parliament.

The final section of the survey was included on a separate page, leaving half a page for each of the two open-ended questions: “Do you think women’s rights are important? Why or why not?” and “Do you think there needs to be more advocacy for females in Ghana? Why or why not?”

In-Person Interviews

Interviews took place throughout both the Greater Accra and Upper West regions of Ghana. Those that took place in the Greater Accra region included personnel from two hospitals, a professor of women’s studies at the University of Ghana, a Parliamentarian, the Deputy Minister of the Ministry of Gender, Children and Social Protection, and the Municipal Director of the Commission on Human Rights and Administrative Justice (CHRAJ.) Interviews that took place in the Upper West region included personnel at Wa
Regional Hospital, the police chief of the Domestic Violence and Victim Support Unit (DOVVSU), and women throughout seven different communities: Kperisi, Sing, Busa, Bunkye, Dorny, Yuonur, and Dompeio. These Upper West communities were chosen in an attempt to represent three of the major ethnic groups of the region: the Birfuor, the Dagara, and the Wala. The first three communities visited during this study (Kperisi, Sing, and Busa) are predominantly Wala. Yuonur, Dorny, and Bunkye are known to be Birfuor peoples, while Dompeio is a mixture Birfour and Dagara. All group and individual interviews conducted with female community members in the Upper West were conducted in the local languages (Wale and Birfuor) and translated by a PhD student from the region. All other interviews were conducted in English.

The purpose of these interviews was to explore the narratives of the women living within communities in the Upper West region who have been known to engage in the practice of FGM. Through their stories, a better picture was painted of the timeline of the practice from within the communities, as well as the various reasons for its significance. These details aided in understanding why FGM is still important enough to continue today despite the issue of its legality. Interviews throughout both regions also sought to explore whether or not implementation of the laws prohibiting FGM have been effective in its eradication in the Upper West.

Although difficulties presented themselves during interviews such as with language barriers, having the flexibility to adapt at an instant to ask unscripted questions throughout conversations led to discoveries that would not have transpired had it not been
for a community-based interview setting. For example, I learned from one woman that even though she was very outspoken against the practice, she had ended up circumcising her children because it was the will of her husband to have it done. Though the topic had not been planned out in the initial questioning stage, our conversation aided greatly in forming a better idea about the power dynamics in the household and how this has resulting effects on the issue of FGM.

In order to prepare for these interviews, I would meet periodically with Dr. Ebenezer Ayesu on campus at the University of Ghana in order to review my interview questions, drafting samples for critique in order design appropriate questions for various types of participants and what knowledge they may have to share. An important aspect we addressed early on in this preparation process was how to identify social cues, whether verbal or nonverbal, that would signify a participant either not wanting to answer a question due to discomfort of the subject, not wanting to reveal sensitive information, or even moments of distrust due to me being an outsider. My primary goal for the future interview process was to show respect and keep discomfort minimal, so these instructions provided comfort in knowing I would have a rudimentary grasp on the feelings of my participants. Examining the behavior of participants enabled me to draw more from the interviews than what was given at face value, and gave me the ability to provide meaningful interpretations of the information given.

I also obtained my introductory letter from Dr. Ayesu, as is customary to bring along when conducting an interview in Ghana; in fact, it is a necessity. Similar to that of
a letter of recommendation in the United States, this letter must be written and signed by a person either supporting or encouraging your course of work, meaning someone working for a school, government body, or business with their official logo or watermark on the page. The letter briefly explains the reason for the interviewer’s arrival and includes a few encouraging words to urge the interviewee to comply. It is also addressed to the specific person or organization, dated, and signed. Having one of these letters readily available, usually with a copy on hand for the interviewee to keep, is essential.

When I came back to Ghana at the beginning of 2018, Dr. Ayesu and I had already discussed a plan for how and with who I would conduct my interviews. Originally, the plan had been that I would be coordinating with a chief in the Wa area, Issa Bonask, and that he would be guiding me to different villages in the area where I would be able to speak to midwives on the topic of FGM. Because English is not the primary language spoken in the region, Dr. Ayesu also mentioned that his PhD student, Samson Kpen-nyine Ninfaazu, would be available for assistance should I need additional translation. My methodology was rapidly forced to adapt when this changed upon my arrival. Only meeting with Bonask three brief times throughout my work in Wa, I was partnered with Samson as my translator and driver for a majority of the time I spent in the Upper West.

With very little time, and few resources or contacts during my field research stage in the Upper West, I became reliant on Samson’s knowledge of his home area and suggestions for village choices in order to effectively conduct my interviews to the scope
that I had intended. Not realizing a vast majority of my participants would be from the
general community at large and not attuned in the profession of midwifery as I had
anticipated, I found myself quickly adapting my questions as we went along. For the rest
of my time collecting data in the Upper West, Samson and I rode from village to village
by means of a motorbike, averaging two communities per day. After Samson and I had
parted ways at the end of four days, I spent my remaining day in Wa interviewing the
police chief of the local DOVVSU unit and paying a visit the Wa Regional Hospital by
myself.

In the end, I would consider a major shortcoming of my interviews in the Upper
West to be the limited number of communities addressed, and the fact that the study was
only able to be conducted in the Upper West region rather than perhaps the bordering
region of the Upper East where the prevalence of FGM is known to be significantly
higher and more overt. Another issue with this study would be that although interviews
gave personal insight into the motivations and thoughts of the participants in a given
community on the topic of FGM, such data cannot be expanded to represent Ghana or
even the entirety of the region considering results varied so drastically even between
communities within a minimal spatial range of one another.

**Dilemmas in Data Collection**

There were numerous dilemmas encountered when collecting the qualitative data
needed to complete this research study. The following section will discuss the difficulties
encountered throughout the second period of time spent in Ghana from January 1 through January 13th, 2018 while conducting field research in the Upper West region.

The language barrier proved to be one of the greatest challenges when conducting interviews. I did not enter the region under the assumption that English would be the predominantly spoken language, and therefore did not expect it to be used during all of the anticipated interviews, but as it turned out, there were very few participants that were capable and comfortable speaking English at all, and reliance on my translator, Samson, became essential. I remembered the director of our program at the University of Ghana urging us all to take Twi due to his strong belief that “language is the strongest, most immediate link connecting two individuals.” This statement proved to be extremely relevant as I watched a sense of apprehension develop among participants when my translator would introduce the reason for our visit to the community. Had there not been the issue of language barriers, I believe some of this apprehension would have been quelled.

Given this, one of the major dilemmas encountered was establishing a sense of trust with the interview participants. The topic of FGM is no longer necessarily taboo, but due to the nature of the subject, it is still not an issue openly discussed, especially in communities where it has been known to persist the longest. Being a foreigner that was unable to establish this foundation of trust first-hand due to language barriers did not aid in the situation either. There was a very distinct difference in the comfort level displayed by participants depending on how far we had ventured from Wa. The more rural the
community, the greater the apprehension expressed by the participant before beginning the interview. This would become apparent in a variety of ways, some of which included hard stares in my direction, as I suspect the interviewee worked to assess any ulterior motives while my translator introduced the reason for our arrival in the community. Others would ask several questions first in order to get me to elaborate on the kind of information we wanted. In the rural communities where we interviewed, it seemed that the women I spoke to were not entirely confident with the motivation behind my questions. They were more determined to ensure that there was no poor reflection upon their communities when giving their responses. As a stark contrast to this, as we awaited permission from the chief of Sing to interview women in his community, we spoke with his wife outside on the matter. She became very animated at one point in their discussion, and when I asked my translator why that had both erupted into laughter, he explained that she had just proclaimed, “Oh! I am circumcised too! You should just interview me!” Her blunt and ready response was one I seldom saw expressed in any of the other participants.

After FGM became viewed as detrimental to the women and girls as well as communities that took part in the procedure, certain communities would frown upon others for continuing it, and the denunciation from outsiders only added to this mounting internal pressure. Even from within their own communities, a woman interviewed from the rural community of Dompieo said that after the law was passed, “at that time if they asked you to stop and the child died when you did it in secret, the whole community would see you as disobedient.” From this known dynamic of condemnation came interview responses that I could not be certain were always truthful. I claim this for two
reasons: first, from time to time during an interview, a story would suddenly change. Second, several of the communities that claimed to have stopped performing the practice asserted that it had been stopped, even in private, around seventy-five years ago. This claim seemed highly improbable due to the fact that the law had finally been passed only three decades prior. Evidence from other in-person interviews to support my assessment will also be included in a later section.

I had had a discussion with the director of the regional hospital in Wa where I went to try and obtain permission to interview midwives, and there appeared to be apprehension at the professional level as well. From what I had been told, there may have been incidences in the past involving foreign students and media organizations coming to paint a poor image of the general community based on their personal feelings about FGM. He even mentioned the legal action that could follow if I did not go through the proper paperwork process mandated by the hospital to secure these interviews.

Minor difficulties that occurred with the collection of data also included logistical struggles. Our method of transportation was a motorbike, and this presented its own challenges as my translator and I made our way in and around Wa collecting data. On days where we visited distant communities up to a three-hour ride away from our base in Wa, we had to keep time constraints in mind due to the fact that the headlight on the motorbike we were using was broken, and it would be rather dangerous attempting to venture all the way back without a light source. Without lamp posts along the road for a majority of the journey in addition to most of the roads being unpaved, ensuring our
departure from these distant communities well before dusk was imperative to our safety and caused the premature end to some of the interviews.

Another logistical issue that came about while riding deeper into the more rural areas of the region was locating the communities we were in search of. Because Samson lived in the Upper West, he was able to easily navigate us from town to town with few instances of confusion that couldn’t be righted by having a quick word with someone walking along the side of the road. The final day of interviews presented us with additional obstacles in that we could not seem to find the community of Dompieo. The roads for a majority of our journey were unpaved, and the further we went, the more difficult it was to use the motorbike. After discussing the matter with one of Samson’s local contacts and attempting to discern which road would be the most viable for our needs and ability, we eventually chose a road. The road faded out after a time and became no more than a footpath. We continued our pursuit regardless and eventually reached Dompieo, but the challenges of limited transportation options and the community’s location not being visible on a map did present additional obstacles in obtaining data.
“The first problem for all of us, men and women, is not to learn, but to unlearn.” – Gloria Steinem

Social, Spiritual, and Cultural Justifications

The justification behind the practice of FGM varies widely from location to location. The most common reasoning for FGM is that a woman cannot be chaste, and is therefore not fit for marriage, unless the practice is performed. The value placed on a girl’s virginity has led to females being ostracized by their communities or even murdered in honor killings if they are “devalued” through premarital sex. The clitoris being the equivalent of the nerve endings at the tip of a man’s penis, its removal also generally removes the sex drive from females, and much, if not all, of the satisfaction experienced when reaching an orgasm. Depending on the extent of the damage and resulting scarification after FGM, urinating and menstruating may become painful, let alone sex, so this unintended result is useful in ensuring the virginity of a girl or the loyalty of a woman to her husband. A woman I interviewed who was from Yuonuur stated that you would be considered “like a dog woman” if you hadn’t been circumcised due to the belief that not undergoing FGM equated infidelity.
This perspective was not isolated, and was something I heard repeatedly from interview participants. During an interview in Busa, while the courtyard cleared out in order for me and the interviewees to have a more private setting, some women lingered on the outskirts chattering amongst themselves while looking in our direction. When I asked Samson what they were discussing, he said they were complaining that the practice had stopped. They said that, “the girls used to go climb trees and never think about boys. Now they sneak away against our orders to go play with the boys all hours of the day.” This exasperated sentiment resonated with other women in different interviews as well, all reminiscing days where women never once considered the topic of sex before getting married.

Taking a mystical approach to FGM, another fairly common belief among different communities that have practiced or continue to practice FGM, is that clitoris has somewhat of an instant death effect. For example, the Bambara of Mali believe that the clitoris will kill a man if it comes in contact with the penis during intercourse (qtd. Mackie 1009). A more wide-spread belief is that death will fall upon a child if their head is to touch the clitoris when exiting the birth canal. This belief is held in Nigeria (Cloward 73), Burkina Faso, Mali and Ghana. During an interview in Kperisi, a woman claimed:

If the child’s head touched the clitoris, the child would die. So even at pregnancies it would be done. If not then, then within a week’s time of the birth it would be done. But if the mother didn’t know anyone that could do it then, even if the child grew up to be a woman, they would bring strong men to put her down to do it. – (Group discussion of three women in Kperisi)
There is also the common belief in excessive clitoral growth. This would not only result in mocking and social ridicule for taking the risk of developing what is believed to be an unsightly body part, but there was also a medical concern that the clitoris would grow so long that it would cover the birth canal and cause the death of the fetus and possibly the mother if not cut before giving birth. There are some practicing FGM in Somalia who believe that the clitoris can extend even farther than this, touching the ground if not cut at a young age (Cloward 73). A woman in Dornye gave the following explanation for the practice:

One reason was that it was fashionable that all the girls should do it. If one girl did not do it, she became a ridicule. They would say, ‘You long clitoris!’ and that was an insult. If we would be at a social gathering, we would know who had done it and who had not, and she was always isolated. – (Woman in Dornye)

Relating to the belief that this growth could cause death by blocking the birth canal, two communities interviewed supported this belief as well saying:

When they cut it, anytime a child being delivered, the way was clear and they could see the child and everything. But if they couldn’t see the child, there was another issue of a mystical problem. In present times, women go to the hospital. The woman there even complained that the clitoris covered the hole. The doctors then said it [circumcision] was very good and aided delivery. – (Group discussion of five women in Dompieo)

Our grandmother told us that the clitoris was very long and could close the birth passage. – (Woman in Bunkye)

Other justifications of FGM have included the belief in both males and females containing components of the other sex in their genitals before circumcision. Two notable instances of this have been documented in Egypt and Mali. In Egypt during the times of
the Pharaohs, there was the belief in the bisexuality of the gods. There existed masculine and feminine “souls,” the masculine soul dwelling in the clitoris, and the feminine soul residing in the prepuce. In order to become wholly man or wholly woman, one would need to extract the masculine or feminine soul that did not belong by means of circumcision (Gruenbaum 43). Slightly different, this same belief appears in Mali among the Bambara people. In addition to the belief in the bisexuality of the child, it is also said that an evil power called the Wanzo inhabits these organs, and that this evil entity must be removed (Mirzoeff 167). An oddly similar concept appeared during one of my interviews with three women in Dornye. Heavily steeped in mysticism, the midwife among the group told us her explanation for the necessity of FGM included curses. She related the ability of the clitoris to grow long enough to cover the birth canal, and then used a term I could find in no documented source outside of this interview: the belief in nyir.

According to the midwife, the belief was that the nyir was a type of vaginal overgrowth that resembled the clitoris, but existed in addition to it. Similarly to the bisexual theories of the clitoris held by the pharaohs and Malians, nyir also can be either the male or female sex. She described what it would look like for both: the female version of this growth would resemble the clitoris, and she described it as being like a singular finger. In contrast, the male version of this extra growth would be easily identifiable due to multiple pieces, resembling something like an octopus.

Another quality of this growth was that if a woman had one of them present, it may cause infertility. The midwife explains this phenomenon as such:
Apart from the clitoris there is another thing like a sickness, an overgrowth. If a woman has it, she cannot deliver. If they found that the child had the clitoris and that thing, they would have to pay 100 cowries. If you had the two, you were supposed to cut the two. The name of the thing is nyir. The nyir is either female or male in gender if it’s in your body. If it is female and you cut it, you can still deliver. But if it is male, the woman cannot deliver because it covers the place. If it is male, whether they cut it or not, a woman still cannot deliver. They know it is male because the woman cannot deliver. – (Midwife in Dornyé)

She attributed her credibility on this subject to her first-hand experience with nyir and its abilities; her grandmother had been a twin, and while her grandmother had been able to bear children due to a lack of the nyir, her grandmother’s sister died in 2013 without ever bearing children due to having had the male nyir. Unlike the instances in Egypt and Mali though, there was no mention of this bisexual component being present in males to justify male circumcision, but rather either of the sexes could be present on the female genitalia in this extra growth.

Aside from mystical beliefs, coming from more of a medical standpoint, surprisingly, many of the women I had interviewed in the Upper West region claimed with strong conviction that after a girl had been cut, giving birth was made easier for her.

We were being foolish, ignorant in the days of old. Now there is some light. There’s the belief of easy birth and mockery among peers. There is also the issue of infidelity. You were considered like a dog woman if you didn’t have it done.” – (Woman in Yuonuur)

It was easy [giving birth] because it was performed upon me. I only felt labor pains which is normal. The pain was not because of circumcision. – (Woman in Bunkye)

We are not very comfortable with this topic, but we’ve come to understand that some of the children are mythical children, and when they are cut, they can bleed to death. In some rare cases if a child is born, even
now, and they feel that they are able to determine that the child is not a cursed one, they call the circumciser to do the work. But the circumcisers are no longer interested in doing the work. – (Group discussion of three women in Dornye)

As a midwife, in my experience, if a woman has gone through the circumcision, the delivery is very easy for her unless there is a curse upon the woman. But generally, the circumcision allows free passage. If your head is not sweet [if you’re an unlucky person] you will suffer labor and may not survive. – (Midwife in Dornye)

**Religious Justification**

Though commonly associated with Islam, the fact is that Muslims, Christians and Jews across the world have all participated in forms of FGM at one point or another throughout history. There is no viable evidence that suggests the practice is encouraged let alone obligatory for Muslims. For instance, FGM has been a common practice amongst Coptic Christians in Egypt for centuries (Gruenbaum 60), as well as the Jewish population of the Felasha in Ethiopia (*Country Profile: FGM in Ethiopia*). FGM predates Christianity and Islam. Despite the gap between theological facts and performing the practice, this does not prevent those who continue FGM in certain Muslim communities from claiming it is commanded by the Prophet Muhammed.

In Islam, principles are often drawn from the Hadith, which is the verbal translation of the messages given in the Qur’an into pragmatic terms, as exemplified by the Prophet Muhammad. As discussed by Gruenbaum on her account of FGM when conducting her research in Sudan, she asserts that the general sentiment surrounding followers of the Islamic faith is that, “Islam is not just a religion, but a way of life.’ With
that view, virtually any customary act, particularly with those of moral weight and symbolic significance, must be redefined by Muslims in relation to religious belief” (Gruenbaum 62). She adds:

In Sudan, pharaonic circumcision, along with other pre-Islamic or non-Islamic beliefs and practices, was successfully syncretized into the Sudanese Islamic belief system. These practices were incorporated in such a way that they acquired meaning that was consonant with Islamic beliefs.

Female circumcision is in fact mentioned in the Hadith. There has been much controversy over the interpretation and legitimacy of this portion of the sacred text, however. There are a couple of key lines in different areas of the Hadith that lead to speculation of if these verses associated with FGM are legitimate. The first is from Al-Nahl verse 123 which says, “Then We revealed to you: “Follow the way of Abrahim with exclusive devotion to Allah. He was not one of those who associated others with Allah in His Divinity” (Munir 3). Author Muhammad Munir does a phenomenal job in breaking down each piece of contested passages relating to FGM in the Hadith. He debunks this first assertion by stating that there was not meant to be a literal interpretation of “following Abrahim” meaning mimicking all that he is and has done (including being circumcised), but rather that this was merely meant to establish that monotheism should be preached and continued as was done by Abrahim.

Moving on to the second Hadith used in support of FGM by some, there is one allegedly written by a female companion of the Prophet, Umme Atiyah, saying that the Prophet said to her, “do not cut off too much as it is a source of pleasure for the woman
and more liked by the husband.” Continuing into this thought, there is another line stating that, “circumcision is a Sunnah for men and a source of respect and power for women” (Munir 4). It is no coincidence that the term for female genital mutilation in some areas, particularly Sudan, is Sunnah (Skaine 8). Addressing this first quote, Munir dismisses this Hadith, saying that the origins of its writing are da’ef or weak, since the author is uncertain. There is also rumor that the potential writer of that line was a man crucified for fabricating ahadith. As for the second line, Munir asserts once again that the writer of these lines ends up being da’ef, and that the report cannot be considered Islamic law due to the fact that the man associated with the writing, Imam Ahmad b. Hanbal, was linked to Hajaj b. Artat, another fabricator of ahadith, and therefore exempt from legitimate claims within Islamic teachings. Munir finishes these explanations saying, “The supporters of FGM could only take refuge in custom or culture, but not religion, especially the two primary sources of Islamic law, i.e. the Qur’an and the Sunnah of the Prophet Muhammad” (Munir 5). This analysis eliminates the Qur’an as a justification for FGM, or at the very least proves that those claiming FGM as a religious right have a weak argument at best.

**International Laws and Treaties against FGM**

Universal standards of human rights norms are a fairly recent global phenomenon. With human rights organizations rapidly sprouting up in the post-World War II era, isolationism was officially over, and a fresh start into a modern and globalized standard
with regard to rights had begun. While the establishment of universal, fundamental rights of any given individual has progressed, the process has been riddled with debates and issues on implementation. Though not relating specifically to the issue of FGM, interest has been shown by Ghana in the past on the topic of strengthening the relations between international and domestic policies. A former Ghanaian Chairperson of the African Commission, EVO Dankwa requested in 1991 that the nine international treaties ratified by Ghana at the time be adopted as part of Ghanaian domestic law. He argued this case because the effects of these documents that were meant to take place in the country were unable to hold up in the Ghanaian court system (Viljoen 546). His motion was not accepted, but this shows a certain level of government initiative in closing the gap between agreeing with the basis of an international agreement by signing it, and actually taking the steps necessary to make lawful change on the ground.

The following section addresses international documents recognized if not ratified by the Ghanaian government and the country’s acceptance of international human rights standards. The portions highlighted are those relevant to protection against the practice of FGM, whether that be pertaining to rights of the child, women’s rights and gender equality, or bodily autonomy:

**Universal Declaration of Human Rights. Article 2:** Everyone is entitled to all of the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex.

**Article 3:** Everyone has the right to life, liberty and security of person.
African Charter on the Rights and Welfare of the Child, Article 14(1): Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.

Article 21(1): States Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular:

(a) those customs and practices prejudicial to the health or life of the child; and

(b) those customs and practices discriminatory to the child on the grounds of sex or other status.

- *Ratified by Ghana on January 24th 1989 and signed on July 3, 2004* ("Ratification Table: ACHPR").

Women’s Convention, Article I: The term “discrimination against women” shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on the basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

Banjul Charter, Article I 6: Every individual shall have the right to enjoy the best attainable stat of physical or mental health.
Article 8(3): The State shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.

Children’s Rights Convention, Article 6(2): States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 19(1): States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical and mental violence.

Article 24(1): State Parties recognize the right of the child to the enjoyment of the highest attainable standard of health.

Article 24(3): States Parties [are to] take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

Declaration on the Elimination of Violence against Women, Article I: [T]he term “violence against women” means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women.

Platform for Action of the Fourth World Conference in Women, Paragraph 89: Women have the right to the enjoyment of the highest attainable standard of physical and mental health…. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
International Day of Zero Tolerance to Female Genital Mutilation: Though not legislation itself, Resolution A/RES/67/146 was adopted by the UN General Assembly in 2012 where it “Calls upon States, the United Nations system, civil society and all stakeholders to continue to observe 6 February as the International Day of Zero Tolerance for Female Genital Mutilation and to use the day to enhance awareness-raising campaigns and to take concrete actions against female genital mutilations” (UN Events).

These international laws and initiatives have succeeded in laying the groundwork for countries to enact their own provisions against FGM. Many of the organizations that participated in the construction of these agreements, such as the United Nations, have also developed programs to further aid governments and humanitarian efforts to end the practice with resources anywhere from funding to media coverage. If support continues to progress at the international level, its effects can then trickle down to domestic institutions where action can occur on the ground.

The Blurry Line of Cultural Relativism and where it Stops

Cultural relativism is the view that moral or ethical systems, which vary from culture to culture, are all equally valid and no one system is really “better” than any other (“Cultural Relativism: All Truth is Local”). This is the basis for the assertion that there is no universal standard of judging what is “good” and what is “bad”, meaning there is also no singular ethnic group, nationality, sex or person with the authority to serve as judge and jury to determine such claims of morality. All moral claims are therefore reduced to
one’s positionality in the world, or their perspective of the ways in which a society should function based on their role and place in it. I will argue here though, as many advocates against FGM have in that past, that there are certain universal rights that should be respected for all humans, such as the right to one’s bodily autonomy. Acknowledging fully that the following statement is a perception constructed through my positionality in the world, my stance remains that although there are certain instances where it is difficult to discern the blurry line of cultural relativism, when regarding matters such as FGM, there is a limit where this defense falls flat.

The rationale of cultural relativism has been used to protect misunderstood cultural practices in nations across the globe. Powerful nations have engaged in colonial projects for centuries, demonizing and forcing the mass assimilation of entire populations based upon the assumption of having attained a moral and cultural superiority over those they ruled. Thus the stance of cultural relativism has legitimate importance. Gruenbaum argues that cultural relativism may in fact offer positive perspective when considering the topic of FGM. She challenges her readers in asking, “Will external condemnation serve as a deterrent to future such incidents? Or will changing economic, educational, nutritional, and other social opportunities be a more effective route to change?” (Gruenbaum 28). She follows this by stating, “With issues like female circumcision, utilizing relativism is often more fruitful because it requires contextualization and inhibits crude ethnocentric prejudices that interfere with effective dialogue” (Gruenbaum 28).
Addressing this more specific issue of cultural relativism and effective policy, Catherine Warrick speaks of the subtle political nature of all laws and how they are a direct representation of the cultural identities and general morality of the society. She asserts that “those who advocate changing the laws to redress inequality must counter the assertion that they are promoting individual (political) preferences over the society’s morality and cultural authenticity” (Warrick 317). Especially in the case of FGM where it has long been a community tradition, when those from within a culture seek alternative means to a morally-based issue, they must present the benefits that will elevate the totality of the group. Warrick also describes the dual purpose of laws in situations where cultural relativism is argued: "law reflects dominant social values and at the same time helps shape these values. Thus, law indicates what interests in a society are most powerful" (Warrick 316). This suggests that the fight against FGM has become a topic of public interest, and reaffirms the notion that cultural norms can be fluid.

Though there is no notable documentation depicting any kind of popular resistance to the law prohibiting the practice in Ghana when it came into effect, the opposition can be seen in the fact that the practice has not yet stopped. It did not appear that people were surprised that laws were being passed against the practice, especially if my interview participants were truthful in their statements about FGM coming to an end in communities on their own accord decades prior to the passage of the law due to their own opposition to the harmful practice. Five years earlier in 1989, the governmental stance for the residing administration at the time made it clear that FGM was not an acceptable practice when President Rawlings issued a formal declaration to the public
condemning the practice and any other traditional practice considered harmful to society (“Ghana: Report on FGM/FGC”). When shifting to the international context, it can be argued that Gruenbaum has a valid point in asserting that cultural relativism has an important place in the discussion of human rights, although her thoughts on the ineffective nature of international condemnation producing change within domestic governments will be debated later in this thesis. Due to the complex nature and historical tradition of FGM, the approach in its eradication must be multifaceted. Engaging in programs to eliminate some of the structures that support the practice, such as through easing economic dependency of females on their husbands or male elders, or promoting education and career development of females so that they are presented with options to marriage, are likely crucial in effective, lasting policy implementation.
Chapter III: Ghanaian Political Structure Overview

General Information and Context

The Ghanaian governmental system has endured many changes over time, and these existing structures are relevant in our understanding of FGM policy implementation today. Beginning with the Parliamentary structure, this system of government was set in place during British colonial rule. After Ghana gained independence from the British in March of 1957, there were four different Republics with four different Parliaments from 1960 until 1992, three of these Republics interrupted by military coups. In 1992, Ghana became a unitary republic, consisting of an executive presidency and multiparty political system. The national legislature in Ghana is a unicameral Parliament (*The Commonwealth*). These political institutions along with the chieftaincy are responsible for all governmental action taken against the practice of FGM.

The Chieftaincy

The Ghanaian political system contains a chieftaincy, or a system of chiefs which constitute regional networks of governance. A chief is defined as “a person, who, hailing from appropriate family and lineage, has been validly nominated, elected and selected and en-stooled, en-skinned or installed as chief or queenmother in accordance with the relevant customary law and usage” (*Chieftaincy*). A very foreign concept to Westerners, there are two primary bodies of the chieftaincy: the National House of Chiefs and the
Regional House of Chiefs. With five paramount chiefs (traditional rulers) selected by the National House in each region, they maintain authority over the sub-chiefs (can be compared to the mayor of a town) of each region. The Regional House has original jurisdiction over the stool or skin (referring to the chief and/or the area he owns) depending upon the region, and is responsible for the election, selection, and installation of chiefs to the National House. The Parliament is able to determine the members residing in the Regional House but are now prohibited from enacting laws that would withdraw authority from the chiefs. The National House may also undertake the progressive study, interpretation, and codification of customary law. Customary law was considered the collection of laws that each tribe used to govern their people before the British colonized Ghana and other West African territories. These laws had a specific communal focus, and the customary laws of other tribes were considered like foreign law to others (Davies and Dagbanja 305). Customary law can now still take effect in communities as long as it does not interfere with the Constitution or laws set in place by Parliament. The topic of FGM falls under this category, and thus the National House had the power to make rulings on this matter before FGM was made illegal in Ghana’s Criminal Code.

**Ghanaian Domestic Policies against the Practice**

“Never doubt that a small group of thoughtful committed citizens can change the world. Indeed, it is the only thing that ever has.”
- Margaret Mead
International laws have been criticized for a lack of concrete compliance when it comes to human rights abuses. Because many of these international declarations and treaties have no legally-binding authority, it is up to the states to take the lead on matters of human rights and ensure these globally-adopted standards are taken seriously, and that local agents are provided the resources necessary for enforcement and impactful change. The following section reviews the policy in Ghana that has been set in place via the Constitution and Criminal Code with its relation to FGM. The later portion of this section will review the current state of implementation, as discovered via survey data and in-person interviews on the topic.

The Constitution

Chapter 5 of Ghana’s Constitution specifically addresses the rights of civilians based upon human rights principles. The following list of article sections and subsections exemplify the legal doctrine set in place by the government from the very beginning which afford protections to civilians against the practice of FGM:

*Article 15(1)*: “the dignity of all persons is inviolable.”

*Article 17(2)* and (3) provide for basic clauses against gender discrimination and mention instances of Parliamentary interference in the following:

*Article 17(2)*: “a person shall not be discriminated against based on grounds of gender, race, color, ethnic origin, religion, creed or social or economic status.”
Article 17(4): nothing in this article shall prevent Parliament from enacting laws that are reasonably necessary to provide –

(a) for the implementation of policies or programmes aimed at redressing social, economic or educational imbalance in the Ghanaian society;

(b) for matters relating to adoption, marriage, divorce, burial, and devolution of property or death or other matters of personal law;

These first two provisions of Article 17(4) can be applicable to cases of FGM in that they give Parliament the power to legally insert themselves if necessary in redressing social imbalance, such as when the occurrence of cutting healthy female organs is presented.

Article 19(11): No person shall be convicted of a criminal offense unless the offense is defined and the penalty for it is prescribed in a written law.

Article 26(1): Every person is entitled to enjoy, practice, profess, maintain and promote any culture, language, tradition or religion subject to the provisions of this Constitution.

(2): All customary practices which dehumanize or are injurious to the physical and mental wellbeing of a person are prohibited.

Article 28(1) (d): Children and young persons receive special protection against exposure to physical and moral hazards;

Article 28(5): For the purposes of this article, “child” means a person below the age of eighteen years.
Chapter 6:

Article 39(2): The State shall ensure the appropriate customary and cultural values are adapted and developed as an integral part of the growing needs of the society as a whole; and in particular that traditional practices which are injurious the health and well-being of the person are abolished.

Article 39(2) states that a governmental policy objective is to ensure that “traditional practices which are injurious to the health and well-being of the person are abolished.”

Article 37(2)(b): the protection and promotion of all other basic human rights and freedoms, including the rights of the disabled, the aged, children and other vulnerable groups in the development process.

Chapter 22:

Article 272(c) states that the National House of Chiefs should “undertake an evaluation of traditional customs and usages with a view to eliminating those customs and usages that are outmoded and socially harmful;”

These articles have given human rights advocates the much-needed foundation for officially contesting the practice, and getting FGM included in the Criminal Code (which will be discussed shortly below.) Not only do these statements give legal rights to citizens to abandon harmful traditional practices while affirming that the government has a duty to intervene in such cases (which effectively aids in discrediting the cultural relativism
argument within the Ghanaian context), it also provides several clauses specifying the protection of the child. Due to the majority of those who undergo FGM in Ghana being children, as discussed prior, these protections are the critical base components necessary for those who do not want the practice performed upon themselves, their children, a community member, etc. to now have a better chance at successfully seeking legal counsel on this issue.

**Criminal Law**

In 1994, the Parliament of Ghana amended the Criminal Code of 1960 to make FGM a criminal offense. In Article 69(a), it provides that:

1. Whoever excises, infibulates or otherwise mutilates the whole or any part of the labia minora, labia majora and the clitoris of another person commits an offense and shall be guilty of a second degree felony and liable on conviction to imprisonment of no less than three years.

2. For the purposes of this section, “excise” means to remove the prepuce, the clitoris and all or part of the labia minora; “infibulate” includes excision and the additional removal of the labia majora.

Article 69(a) of the Criminal Code was later updated in 2007 when Parliament passed an amendment stating, “Whoever carries out female genital mutilation and excises, infibulates or otherwise mutilates the whole or any part of the labia minora, labia majora and the clitoris of another person commits an offense, and is liable on summary conviction to imprisonment for a term of not less than five years and not more than ten years” (*Global Database on Violence against Women*). This amendment is crucial for
two reasons: first, it increases the minimum sentence from three years to five years. Second, it now addresses the practice as “female genital mutilation” rather than “excision.” Although there has been great progress with the prevalence rate decreasing from 30% to around 4% since the passing of the law, communities holding onto the belief in this practice as part of a valuable cultural tradition in need of preservation has forced the practice underground.

With much of this illegal activity occurring within communities in a manner where it may be more difficult to identify, community watchdogs are needed in order to aid the police in the successful eradication of FGM. If these watchdogs were to work alongside of the chieftaincy, the effects could be much more pronounced. As I was familiar with the significant roles and esteemed status of the chiefs before conducting my field research, a question I asked many of my interview participants was, “if the chief of your village were to tell those practicing FGM that they could no longer practice, do you think that this would make them take the law more seriously?” The results to this question were a mixed bag. When interviewing a group of three women in Bunkye, when asked this question they responded:

If a chief disallowed the practice, they would go by that. But the chief themselves knew the significance and would not speak against it. Sometimes even they, the chiefs supported it, especially when the wanzam was invited to a particular community. The chief would also invite the other surrounding villages to bring their children to that particular spot.

As for a woman from Yuonuur:
It does not necessarily make a difference to the people still practicing today if the government passed the law or if a the chief of the village or tendaana [the first who settled in the village that owns it while the chief is away] makes no differences because the wind of change has blown over everyone around here. So whether the chief or government that passed the law, changes were needed. For this particular village, for now it has stopped secretly. But remote villages probably still practice, though I have not seen it with my own eyes.

When asking a federal legislator about the matter, Honorable Augustine Tawiah stated:

To some extent, when they are explained in their own local languages the consequences, the impact they feel that is explained, part of the people will have a change of mind, and the less they will participate.

The pronounced opinion of Dr. Cyrelene Amoah-Boampong reflected a different sentiment:

It’s, you see, the power of the traditional authority to me is irrelevant in this particular instance because it is a criminal act, period. Plain and simple, the state has ruled on it. The chiefs do not supersede the state, and it’s a criminal act whether the chief gives his blessing or not. So for me, the role of the chief is irrelevant. You can only think about the chiefs or bringing in the chiefs in the implementation phase when you’re trying to win their support and say, “Go advocate against this”. Of course you’re trying to do this hoping this chief himself hasn’t got a set of wives who are all circumcised and daughters that are all circumcised. If he sees nothing wrong with it, you’re never going to get him to go out in the community and tell them anything. He probably will do advocacy, but tell you to do it safely. So for me the chiefs are inconsequential; if it’s a crime, it’s a crime.

**Upper West Statistical Overview**

The region and groups chosen for this study were a direct result of the limited resources I had at my disposal at the time: one contact in the Northern end of the country
living in an area rumored to continue the practice, and six available days’ worth of time and funding to gather interviews while in the Upper West. Wa is also a major city in this rural region, so travel accessibility from the opposite end of the country in Accra was also possible. Had I had contacts in the Upper East region, the study would have been conducted there as the rates of FGM are significantly higher. The focus instead was around the Walas, who constitute 16.3% of the regional population. Interviews were conducted in and around Wa, where 40% of the Walas reside. Other ethnic groups include the Sissala at 16%, minor indigenous ethnic groups at 5%, and various groupings of the Akan at 3.2% (“Upper West: Government of Ghana”). In this study, the other two ethnic groups interviewed were the Birfuor and the Dagara due to their proximity to Wa and my translator’s knowledge of the nearby villages and languages. There are two dominant ethnic groups regionally, the Grusi (18.4%) and the Mole Dagbon (75.7%) (“Upper West: Government of Ghana”). Neither of these larger ethnic groups were interviewed throughout the course of this study resulting from issues of accessibility. Due to the complex nature of FGM and the differing accounts that were given for each community, these interviews should not be used as representation of every ethnic group in the Upper West region. The following information is comprised of statistical data on the demographics of the Upper West region of Ghana. The goal of this section is to provide knowledge of the region and people in order to better understand the history and persistence of FGM in the area.
The most up-to-date Population and Housing Census records that there is a slightly higher population of females than males in the region, at 51.6% of the population. It does not appear that the Population and Housing Census has been carried out in the Upper West region since 2010. It documents the main source of income for many families is through the agricultural sector. With 72% of the region relying on agriculture to earn their livelihoods, a startling portion of the population within the region is at risk of being negatively impacted should natural disaster strike. Production and transportation equipment work come in next at 12.1% of the industry, sales work at 5.2%,
and service work and professional, technical work both being ranked at a mere 4% (“Upper West: Government of Ghana”).

For those age fifteen years or older, 73.4% are not literate in any language. With the national average only being at about 42.1%, this larger figure is a bit alarming. It is also not entirely surprising considering the extremely high rate of agricultural jobs in the region. In other words, many Ghanaians living in these districts may not find it necessary to spend the time or money on getting to the nearest school when they know their path will be in the agricultural sector (“Upper West: Government of Ghana”).

Religious affiliation is fairly balanced throughout the Upper West region, 35.5% being Christian, 32.2% practicing Islam, and 29.3% classified as “traditional.” Though not important to the practice of FGM as described previously, it may be of interest as a general background to note that 44.4% of those living in Wa are of the Islamic faith (“Upper West: Government of Ghana”).

Survey Data

“People should be aware of the clear distinction between misandry and feminism! A lot of angry women make it seem like an attack on the male species. We are not looking for bitterness towards men. We are not looking for power over men. All we are asking for, is EQUAL RIGHTS.”

-- Female survey participant open-ended response
Male vs Female Survey Results

The survey data indicates that while males and females both seem to agree on their feelings towards policing in Ghana and effective governance as a whole, there is a divide in their opinions on issues of gender disparity. This divide continued over into questions relating to FGM and the participants’ knowledge of the current laws against it.

Table 1

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N = 31
The x-axis shows the results of each question asked within the second section of the survey, the colors representing one to five translating over to the rating of a scale of one to five for the questions. The y-axis shows how many participants responded to what degree on this scale for the eleven questions.

My initial analysis of the data focused on the areas with high response frequencies. Beginning with the data collected from surveys filled

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<th>Survey Questions</th>
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<td>4) I am aware of the practice of female circumcision</td>
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<td>5) I believe that female circumcision is a harmful practice</td>
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<td>6) I believe that this practice still continues in Ghana</td>
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<td>7) Female circumcision is outlawed in Ghana</td>
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<td>9) Policy implementation happens quickly in Ghana</td>
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<td>10) Rural and urban regions have equal police protections</td>
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<td>11) Rural and urban regions are equally knowledgeable of the laws passed in Parliament</td>
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out by females, high spikes were seen on questions four, five, six, seven, nine, ten, and eleven. Curiously enough, women were much more likely to choose a three on the scale for these questions, signifying they were “neutral” in their response. This neutrality/uncertainty was not anticipated due to the pre-conceived assumption that the issue of FGM and the rights of Ghanaian women in general would invoke data more pointedly asserting their opinions on the matter.

Another high-frequency response was among female respondents who indicated they were certain or near-certain of the existence of the practice of female circumcision (86.7%) when answering question four, in contrast to only 63.7% of men. In the question five, an exceptionally high rate of women (93.3%) found FGM to be a harmful practice, with 84.8% of males sharing this sentiment. These results are interesting in that more people claimed that the practice was harmful than those who responded that they were aware of the practice at all. This could possibly be due to a misunderstanding that [“in Ghana”] was implied at the end of question four, or it could be an overall sentiment that the circumcision of females would be harmful.

When addressing the legality of FGM in Ghana in question seven, “female circumcision is outlawed in Ghana,” 46.7% of females responded “absolutely true.” This means that fewer than half of the female sample felt confident in the laws surrounding FGM, with 16.7% indicating that this statement was false. This result gives reasonable doubt of the female participants’ knowledge of the legislation in place to prevent the practice. The fact that young women do not seem to be aware of the law against FGM is a cause for concern. Usually FGM is conducted before a female is at the age where she can
attend a university, but this is not always the case. Some females are circumcised as adult women before getting married or giving birth, therefore women at this age are still susceptible to FGM and should be made more aware of its illegality. Meanwhile, there was a startlingly higher number of males responding that “female circumcision is outlawed in Ghana” is “absolutely true” (60.6%), with an only slightly higher percentage than the females (21.3%) indicating it to be false.

The final key question relating to legal issues in Ghana was number eight: “Policy implementation happens quickly in Ghana.” Here, 54% of women and 60.6% men felt that this statement was false, indicating that over half of the participants from each group have little to no faith that policies will be implemented efficiently. This question’s results are highly important due to the suspicion that the continued practice of FGM may be strongly linked to a lack of enforcement in the country after a law is passed.

Questions ten and eleven addressed the issue of law enforcement: “rural and urban regions have equal police protection” and “rural and urban regions are equally knowledgeable of the laws passed in Parliament.” It can be concluded from the results of these questions that males do not have quite as much faith in the law enforcement structures existing within the rural regions as females. A full 70% of women and 69.7% of men indicated that they felt question ten was false, “rural and urban regions have equal police protections.” And similar results appeared in question eleven, “rural and urban regions are equally knowledgeable of the laws passed in Parliament”, with 63.4% of females and 78.8% of males considering this to be a false statement.
Regional Survey Results

The following charts show survey results based on the region of the respondent:

Table 3

Ashanti Region Responses on a Scale of 1 to 5

N = 11

Table 4

Volta Region Responses on a Scale of 1 to 5

N = 14
Table 5

Western Region Responses on a Scale of 1 to 5

N= 4

Table 6

Greater Accra Responses on a Scale of 1 to 5

N= 7
Table 7

Brong-Ahafo Region Responses on a Scale of 1 to 5

N = 3

Table 8

Central Region Responses on a Scale of 1 to 5

N = 7
Of the 61 participants, fifteen were from the Eastern region, fourteen from the Volta region, eleven from the Ashanti region, seven from both the Central and Greater Accra regions, four from the Western region, three from the Brong-Ahafo region, and zero participants from any of the northern regions (the Northern region, Upper East and Upper West regions.) This lack of regional representation could simply be a matter of chance due to the limited scope of the survey, or potentially due to the distance of these Northern-most regions from campus, making attendance difficult. The high cost of attending the University of Ghana may also be a factor.

The regional breakdown indicates similar response frequencies as those seen in the gendered responses. Every region shows almost paralleled responses when asked about the existence of the practice of female circumcision, and similarly for whether or not...
not FGM is harmful. This lack of variance shows that, within the survey sample, the region of Ghana does not seem to effect the outcome of if a person is more or less likely to know of the practice of FGM or feel that it is harmful or not. It is imperative here to keep in mind that the regions known to practice FGM in larger numbers despite the law are the Northern, Upper West, and Upper East regions, none of which were included in the survey. Had their data been present in the survey findings, it is possible that more of a regional disparity in responses could have been evident.

There did appear to be slight differences in response relating to regional dynamics when it came to questions about efficient law enforcement. When asked if the practice is illegal in question seven, almost all regions had high rates in responding “absolutely true” (Volta 57.1%, Western 50%, Greater Accra 71.4%, Brong-Ahafo 66.7%, and Eastern 73.3%) save for the Ashanti region (27.3%) and the Central region (28.6%). This shows that a majority of the regions may, at the very least, be aware that the practice is forbidden, whether or not they know the stipulations of the law with its specific consequences.

When asked about whether they have confidence that the police can be relied upon in question two, respondents from all of the regions appeared to lean more towards a negative response, except for the Greater Accra region, which notably is also the most urbanized region of the country, containing the capital. It is therefore no surprise that later, when asked if rural and urban regions receive equal police protection in question ten, respondents in Accra agreed more with this statement (28.6%) than was indicated in results from the other regions. This may perhaps be due to the relative comforts of having
more concentrated police bodies available in urban areas, leading to an assumption that other regions may fare about the same. For the rest of the regions, as seen in the division of male/female survey results, a majority of the regions responded that statements given in questions ten and eleven about policing efforts were false, with only three regions indicating “absolutely true” (the Ashanti, Brong-Ahafo and Central regions.)

**Open-Ended Response Findings**

I didn’t anticipate the length of the open-ended responses when I originally added the questions into the end of the survey. Almost as a last minute additive, it was more curiosity than anything that compelled me to place two final questions there. The open-ended questions asked were:

1) Do you think women’s rights are important? Why or why not?
2) Do you think there needs to be more advocacy for females in Ghana? Why or why not?

After reading through all sixty-one responses, a majority of them containing what I would consider (normatively) as positive, very feminist-oriented responses, I found there were several answers in this section that contradicted the rest of the person’s survey, meaning perhaps either the person had misunderstood the questions on a scale from one to five, or they simply have conflicting and contradictory views on women in Ghanaian society. The first example of this went as follows:

Answer to open-ended question #2: “Yes, I think there needs to be more advocacy for females in Ghana. This is because there have been a sort of stigmatization on the females
which has prevented them from holding various roles in the economy.” --Female participant, age 18-22, level 400, from the Eastern region

This well-formulated response would appear to indicate a pronounced opinion of the gender disparities in the country as well as the reasons for their existence. However, when looking back to the questions rating on a scale from one to five, this participant marked a one or two for every question, indicating she found the statements to be true or absolutely true. This included agreeing with question one, “men and women are treated equally in Ghana”, and question three, “I feel that there are currently enough females representing constituencies in Parliament.”

Another example of this could be seen with a male survey participant, age range 23-26, level 400 from the Greater Accra region. The participant responded to the second open-ended question by saying, “Not really. I think there is enough advocacy for females in Ghana.” Oddly enough though, the participant seemed to indicate otherwise in his scale of one to five questions, writing in a five for question one, “Men and women are treated equally in Ghana,”, indicating he found this statement “absolutely false”, entering the neutral indication of the number three to question three, “I feel there are currently enough females representing constituencies in Parliament”, and another five to question nine, “Men and women are regarded with equal seriousness when reporting a problem to the police”, once again indicating the statement to be “absolutely false.” It must be noted though that it is possible he thinks all of these things, and that women don’t need more advocacy, seeing as this critique comes from more of a feminist perspective.
With a few additional questionnaires ending with similar results, the disconnect between an understanding of gender issues and the importance of equal representation is puzzling. There also appeared to be a lot of back-handed compliments and encouragement of women, so-to-speak, in that respondents sometimes acknowledged the agency and potential of females, but made a sexist remark and doubled down on the comment in some form or other. Four responses exemplified this:

Question two: “Yes, because women are unique and sensitive to issues which are emotional, and they are also productive when involved in decision-making.” – Female participant, age range 18-22, level 400, from the Central region

Question one: “Women need to be protected because they carry lots of potential.” – Female participant, age range 23-26, level 400, from the Eastern region

Question one: “Yh! Cos everyone’s right must be protected.” Question two for the same participant: “No! Cos it’s already all over the place.” – Male participant, age range 23-26, level 400, from the Volta region

Question one: “Yes. Women need protection and care and must be treated how men are treated.” Question two for the same participant: “Yes. Women are fragile and need to be listened to, and advice should be accepted.” – Male participant, age range 23-26, level 400, from the Ashanti region

Question one: “Yes. Basically because women have a major role to play and can bring a lot to the table. They just need to be given an equal opportunity to do so and
freely be creative about it. Every development project deserves a feminine touch of
detail.” – Male participant, age range 23-26, level 400, from the Eastern region

I find these responses to be rather revealing in terms of the current gender
dynamics and stereotypes operating in Ghana, even among the youth population. The
word “protect” was used in three out of the four above responses, indicating the
perception of the lack of a female’s ability to defend themselves, whether that be
physically or in their ability to forge a path in the public sphere based on self-reliance.
This concept corresponds with the word “fragile” being used twice within the statements,
as well as the final statement adding that a “feminine touch of detail” would go far in
development project. Going back through the other quotations written down for their
discrepancies or sexist undertones, of the fifteen quotes pulled from the questionnaire
results, seven of the responses came from the Eastern region, three from the Volta region,
two from the Central region, two from the Greater Accra region and one from the Ashanti
region. These responses reveal some of the sexist perspectives that FGM is grounded in.
In order to really eliminate such a practice, these perceptions about a female’s role in
society must also be reshaped.

Discoveries during Field Research

The survey data shows that although males and females are both in agreement that
the practice of FGM itself is harmful, males seemed to be much more aware of the law
that made FGM illegal than the females. Considering this survey was distributed among
well-resourced students at the best university in Ghana, it was curious that the women in this sample were the ones with a lesser knowledge on this issue. The survey results also support the assumption that rural areas may have less police protection than urban areas, and that their law enforcement agents may not be as knowledgeable of policies produced in the capital as they are passed into law. Furthermore, the survey results suggest that as policies are acknowledged throughout the regions of Ghana, implementation of these policies may not be quick to take effect.

These findings were reinforced by many of the interview participants who were selected because of their professional occupations. From these interviewees, I heard many times that citizens knew of the laws, but they were just not willing to abide by them. Furthermore, implementation was the hindrance to eradication most consistently mentioned. There was the belief that cultural practices could be swayed and abandoned over time, if the issue were to be policed properly. Several interviewees offered valuable points on the topic of implementation:

> A friend of mine always says the problem here is not about lack of laws and policies, but about the implementation and people being held accountable for their wrongdoing. This is not being carried out. Enforcement goes beyond the police just arresting people; but if they arrest, how to help people move away from these negative tendencies. And that means you have to do whatever to the resources. To equip the policy, equip those with social means. There’s the economic aspect of it: how much resources have to be invested in the fight against FGM?  
> (Doctor wishing to remain confidential, Nyaho Hospital)

Where the doctor at Nyaho saw benefit in government resources being utilized in order to carry out the issue of implementation, when speaking to Honorable Tawiah, a legislator,
he had a different take on this issue. In response to the same question, he stated, “It’s strange how government will handle this. Government should be the regulator, but the implementer should be the civil society, organizations, the media, and watchdog groups.” This remark suggests that effective policy implementation will take place outside of the governmental realm, and be better completed by the people themselves. The sharp decrease in FGM that took place across the country after threat of the persecution was initially presented to the general public indicates that he may be incorrect. This is not to say that community participation would go without positive outcomes. On the contrary, if more community members were directly involved there would be an increase in intervention, reporting, and accountability on this issue. This initiative could also gain much more traction if supported or even led by women who have undergone the procedure themselves and are able to lend their experiences while remaining empathetic to the community. Elaborating on that is the statement from Dr. Cyrelene Amoah-Boampong:

Well, laws are good, the issue is about enforcement and implementation of the law, so uh, the laws are excellent in terms of what is in the books, it has been banned since, I believe, 1994, but does that ban apply in reality in the day to day experience of places where FGM is perpetrated? So the laws itself are okay. Implement it, then we can see some progress.

If all illegal actions were presented with the appropriate consequences, and if the scope of police abilities and training were on par, then why would anyone feel as if they could get away with practicing FGM? Perhaps if police presence were to be taken more seriously on a consistent basis on criminal matters, then there would be progress here. If the daily
actions of the police do not create an environment where their presence is associated with negative outcomes for negative behavior, or with taking a hard stance on crime, then the crimes will continue.

But is implementation failure the only reason the practice persists? The evidence in this study would deem such a statement false. It is more that the preservation of culture and tradition are considered a duty to the people, and the obligation they feel to continue outweigh the potential consequences. Honorable Tawiah’s opinion was that there is no link between the legality and the actual practice: “In fact, the people feel that it is their sacred duty and not a legal issue, and approaching it as a legal issue, you’ve already lost the battle. So you are not going to make any headway, therefore it should be a social transformation effect and not trying to enforce a law.” Dr. Amoah-Boampong added that there is the important relating factor of supply and demand to take into consideration. If the demand is high enough, society will be more inclined to feel as if their desires are reflective of that of the general population, and thus validated: “Yes. They are very much aware of the laws against the practice, but they are very much aware that societal demands are much more important than some law that can be revised with a change in the political administration.” This statement frames tradition like a rock unable to be eroded by the continuously flowing changes in the political realm. Though it is important that tradition be preserved and stand the test of time, it is also important for a community to be able to recognize when traditions need to be released for the betterment of society.
When asked the “why,” many answered that stopping FGM had been better for the community as a whole due to the deaths that had resulted from the practice. When looking closely at interview responses though, there were a variety of different reasons offered:

Sometimes even the way the girl lost blood and the way the canal was opened several times, or if the places was sealed at birth, sometimes they would have to create their own canals. Or by the time the fetus came out, it would be a stillbirth.” (Group discussion of three women in Kperisi)

When the circumcision was done, it was the wanzams, someone a little bit callous. If you feared blood or were soft-hearted, you could not do it. Now all the callous women are too old to perform.” (Group discussion with five women, Dompieo)

There was a threat that if you did it, you would be arrested. So out of fear of facing the law, it is done in private. (Woman in Yuonuur)

It was until such a time that the child bled to death, then it was not a good thing. It is no longer a public affair, it is an individual affair. If someone wants the wanzam, they call him. (Woman in Dorny)

These responses show that the life of the child, the law, and the availability of wanzams have all played roles in the end of the practice. The last quote cited reveals too that sometimes when one of these factors come into play, the way FGM is carried out may just be adapted rather than eradicated. This can also be seen when there is a shortage of wanzams, since it is common for circumcisers to cross over from bordering countries to perform the practice if needed, for example.

Even with the information given from the female interviewees of the Upper West region, I found it quite difficult to establish an accurate timeline as to when (and if) communities abandoned FGM. All of the communities I visited were located within an
approximate range of thirty kilometers from one another, and all had varying accounts of the time period that the practice ended in the area. Of all of the individuals I interviewed, only one claimed that FGM had ceased in the area less than ten years prior, and this same participant later recanted her statement. The interview was conducted with a woman from Yuonuur outside of the children’s school she taught at. The interview went as follows:

1) Where are you from, and when did the practice stop there?
“It has been four years since the law was passed in this community.”

2) What was the reason for the practice?
“We were being foolish, ignorant in the days of old. Now there is some light. There’s the belief of easy birth and mockery among peers. There is also the issue of infidelity. You were considered like a “dog woman” if you didn’t have it done.”

3) Do you think it’s possible that people still practice in secret here?
“Yes. I do not do it, but people are stealing the act [meaning doing something secretly] under the cover of darkness and probate spheres.”

4) Do you think they fear the law then since they still practice?
“There was a threat that if you did it, you would be arrested. So out of fear of facing the law, it is done in private.”

5) Why do you think these people feel it is worth it despite the consequences?
“I don’t think there is anything good about it. So for others still doing it, I don’t think there is an advantage to it. Today it offers no good. It is still for the same purpose.”

6) Do you feel it would make a difference to the people still practicing today if a community leader like a chief or religious leader said it was wrong?

It does not necessarily make a difference to the people still practicing today if the government passed the law or if a the chief of the village or tendaana [the first who settled the village that owns it while the chief is away] makes no differences because the wind of change has blown over everyone around here. So whether the chief or government that passed the law, changes were needed. For this particular village, for now it has stopped secretly. But remote villages probably still practice, though I have not seen it with my own eyes.
7) Are there any specific places you can think where it would still be practiced?

“Universally nobody still practices. Are you asking a legal question?”

I felt that the full dialogue of this conversation was necessary to display due to the very evident and sudden change in the participant’s claims of the discontinuation of the practice by the end of the seventh and final question. Though I did not detect it from the body language or tone of voice of the woman, responses such as the one given to question number five as well as the end of the response to question number six where she assures “though I have not seen it with my own eyes”, takes on an almost defensive choice of words, asserting throughout that she herself has had no involvement in it. Her apprehension becomes even more clear at the end of the final question before the arrival of the next woman when she asks “are you asking a legal question?” and states the rather wild “fact” that “universally nobody still practices.” These claims that eradication had taken place as far back as over fifty years prior were a bit difficult to believe. Once I returned to Accra after completing my interviews in the Upper West, I inserted an additional question into all of my interviews addressing this timeline. I received a range of reactions to the claim that the practice was part of a much-distant past.

Coming from a bit of a more optimistic standpoint, the Deputy Minister Ampofo supported the idea that communities could have stopped on their own accord as distant as seventy-five years prior if it meant lives hanging in the balance: “No, it could be! All those who admitted that after a girl was circumcised and some complications arose so the
whole village agreed that we can’t continue this, those ones could bring an end to this.”

When consulting with a doctor who wishes their identity to remain confidential about his experiences within the Wa Regional Hospital and asked this same question, he had a slightly less optimistic tone than the Deputy Minister, but seemed to feel that the law was effective in stating:

“It’s actually about 25-30 years ago. This was when government to up the matter to parliament and got the laws passed. There was however fight on smaller scales across the country and the globe against FGM far before governments put it to a national discourse.”

Freeman Ndar from CHRAJ was not as easily convinced on this point, and insisted quite the contrary. He responded to these claims in the Upper West saying, “Seventy-five years? It’s not true. No. That’s too long. Maybe twenty-five…even that would seem impractical, but maybe. Seventy-five is not realistic. No, no, no.” When asked the follow-up question of why these communities would therefore makes such claims, he responded, “They themselves know what they are doing is wrong, so for them to protect their image they must lie to protect it. So I think they are just trying to be smart and protect their credibility.”

With these differing claims combined with the statistical data showing prevalence still persisting in the country at the same rate as it had one decade prior, interview participants changing their claims, and taking into consideration all of the aforementioned citations from interview participants in Accra, I think it is realistic to say that FGM still continues in very small pockets throughout the Upper West region.
Despite all of the previously mentioned interviewees stating that implementation was one of the greatest barriers to effective eradication of FGM, I found there is a firm belief that change is occurring regardless of this, and that there is wide-spread optimism for continued progress. In fact, all of these same participants seemed almost certain that eradication of FGM could be successful within the next decade if not much sooner. The Deputy Minister stated that “if you picked a handful of women aged 75-60, you’d find almost all mutilated. When you go to 25 you find much less. When you go up until 18 you see it has gone down very drastically even in those [rural] places,” and attributes this success to the country-wide education efforts pushed into every region by the government for the past five years and counting. Similarly, Ndor agreed that the education of communities was and is paramount to the practice ending. On a slightly different path, he attributed the education and encouragement of the chiefs to aiding in creating a future without FGM. Giving recognition to the position of the chiefs, he claimed:

> You see, chiefs are seen as key players in the society, and then everything they [the people] do is channeled through their chiefs. When you do any kind of public education, the first step is the chief’s palace to let the chiefs know and to let them get involved. Some of them have been educated now and have been so much enlightened and know the practice is not the best.

The doctor interviewed from the Wa Regional Hospital attributed the success of the decreased prevalence ratings to not only the government-sponsored initiative, but to the grassroots organizations, listing Ghana Education Service, the Ministry of Health, DOVVSU, Ministry of Gender, Children and Social Protection, social groupings, and the media as all deserving of recognition for their efforts.
The need for a combined effort of addressing social, economic, educational and
gendered issues is a must in order to facilitate this change. Until the societal belief in the
necessity of the chastity of a female, the singular usage of the female genitals, and the
sacred nature of her (not his) virginity is expelled, gender-based issues such as FGM that
harm the agency and capabilities of women will continue to arise.

**Conclusion**

Drawing from the information obtained during the interviews conducted between
both the original spans of four months in the Greater Accra region at the University of
Ghana beginning in January 2017, combined with two weeks of field research the
following year between the Greater Accra region and the Upper West region, I feel
confident in claiming that the practice has not in fact ceased entirely within the Upper
West region. I began this research with the hypothesis that the rate of FGM persisting
within the Upper West region would be much higher than the reality of the situation that I
discovered during my in-person interviews. The reason as to why the practice has not
stopped entirely despite threat of imprisonment I had originally speculated to be due to
the strength of cultural beliefs. The result of this ended up proving to be partially true,
save for the crucial component of police resources needing strengthened, in addition to
government programs needing to achieve a wider reach in order to successfully tackle the
small remaining population.
When acknowledging the timeline of the cessation of FGM in the region as told by some of the female interview participants, although it seems wholly possible that the practice of FGM did perhaps fade from existence in certain communities as long as seventy-five years ago due to traumatic incidents involving loss of life, conflicting statements from several interview groups have led to a cause for reasonable doubt. This uncertainty stems from statements within several groups changing halfway through an interview session from commentary affirmatively acknowledging the practice continuing in modern times, to then later insisting the practice had ended decades prior, or even in private, for the whole community.

The combination of these results along with interview responses from the regional DOVVSU unit, indicating supporting evidence of occasional occurrences of FGM in the Upper West, only proved to solidify this assumption further. Prevalence rates have rapidly dropped within the last few decades. The claim that this steep decline is a resulting from the domestic policies against the practice are also supported. There is little to no evidence of international treaties having had an effect other than a symbolic gesture in the case of FGM decline in Ghana. Though there could be a potential connection made between the international condemnation of the practice in spurring government action in regards to the issue, the criminal code was not amended until almost a decade after several prominent international treaties were ratified by the state. With existing evidence of the domestic law being disobeyed to this day throughout Ghana despite the severe consequences that would follow if discovered and prosecuted, and even the authority of local chiefs being blatantly ignored in these instances, it is highly unlikely that those still
practicing would take any seriousness into an arbitrary international agreement (assuming all citizens are even aware of such agreements.)

Additionally, it appears that although the practice may still be continued secretly in small numbers of people not yet willing to abandon this traditional practice, educational initiatives put forth from within the community by means of grassroots organizations and governmental powers have proved themselves effective in the eradication of FGM. With many of the elderly interview participants referring to the new generation as “enlightened”, and community outreach groups educating the chiefs as well as the general public on this public health issue, there does not seem to be evidence of any communal retaliation towards these programs. This successful community-based, government-supported approach does in fact seem to align with the claims from various interview subjects that Ghana will be capable of eradicating FGM for good within the next decade.
Bibliography


“Cultural Relativism.”


APPENDIX A
IRB INFORMED CONSENT FORM
Informed Consent to Participate in Research Study

Study Title: Analysis of Prevailing Practice of Female Genital Mutilation (FGM) in Ghana: Are domestic laws and international treaties effective in the eradication of FGM within the state?

Principal Investigator: Julie Mazzei and Megan Swoger

Purpose: The research project focuses on to what effect international treaties and domestic policies have on the effect of the continuing practice of FGM in Ghana, and if the policies do more harm than good (i.e. driving the practice underground, etc.)

Procedures: Participants will hold an informal interview with the researcher, which may last between 30-45 minutes. This is an “open-ended,” informal interview, meaning there are no structured, required questions, and the interview will proceed more like a conversation. You may withdraw from participation at any time.

Audio Recording: If you will allow, the researcher will digitally record this conversation. The recording will be destroyed immediately after transcription, which should take place within one month. The audio recording will not have any identifying information attached to the file in order to protect your confidentiality.

Benefits/Compensation: While there are no benefits for participants in this study directly, the potential benefit of the research project is that it may give valuable insight into whether or not policies have been adequately enforced in Ghana. There is no compensation for participation.

Risks/Discomforts: Some of these questions may probe issues that are not easy to discuss. You are free to skip any question you wish, and terminate the discussion whenever you choose. In addition, because of potential risks, including stress and discomfort, your confidentiality will be protected within the limits of the law, unless you waive this confidentiality protection (see below). If you experience distress or these topics upset you, you may want to talk to your chief or sub-chief or visit ghanahospital.org for information counseling services that may be available. Your identity will not be recorded in any materials coming from this conversation, audio or written.

Privacy and Confidentiality: Your identity will be protected throughout the entirely of the research project, unless you waive this right.

1. If you wish to have your identifying information entirely protected with strictest confidentiality: All of the interview materials will be coded with an alphanumeric code rather than with any identifying information. There will be no documentation associating
identities with codes. Your information will not be reported to any institution, reporting agency nor in study results (where “unnamed” sources may be quoted) within the limits of the law. In addition, I am not asking you to sign nor return this form, in order to ensure that the ONLY record of your identity will never be with the data at any point in time, including now. You may retain a copy of this consent form.

2. **SHOULD YOU CHOOSE to permit me to use your identifying information:**
Notes and/ or recordings may contain identifying information. Your information may be used in published or publicly presented materials. You must signify your decision to waive the right to confidentiality and by signing this consent form and returning it to me. **In doing so, you acknowledge that you understand that your name/identifying information will be used in published or publicly presented materials.** You may retain a copy of this consent form. You may revoke permission granted for a period of ten days following the interview.

**Voluntary Participation:** Taking part in the study is entirely up to you. You may choose not to participate or to discontinue the conversation at any time.

**Compensation:** If giving up time from their work to be interviewed, participants will be given ten Ghana cedi per one hour of their time being interviewed for this study as means of compensation for the time that they could have spent working.

**Contact Information:** If you have any questions or concerns about this research, you may contact me, Megan Swoger, at +1(724) 513-1598 or mswoger@kent.edu or Julie Mazzei at Jmazzei@kent.edu. This project has been approved by the Kent State University Institutional Review Board (IRB). If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at (330) 672-2704.

_____ I have chosen to allow the researcher to use my name in published materials and in maintained written notes/transcription of this interview. I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. I have maintained a copy of this consent form.
Participant Signature: ________________________________

Date: ________________________________
APPENDIX B

SURVEY QUESTIONS
Female Genital Mutilation/Circumcision (FGM/C) Honors Dissertation Consent Form

You are being asked to take part in a research study of how college students studying in Ghana feel about female circumcision and policy implementation in Ghana. Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

What the study is about: The purpose of this study is to learn how effective policy implementation is in Ghana when it comes to the issue of FGM/C.

What we will ask you to do: If you agree to be in this study, you will complete the following survey questions. The questions will include those based on demographics (e.g. age, gender, etc.) as well as a section of questions rated on a scale of 1 to 5 and two open-ended responses. The questions should take no more than approximately ten minutes to complete.

Risks and benefits:

I do not anticipate any risks to you participating in this study other than those encountered in day-to-day life.

There are no benefits to you.

Your answers will be confidential. The records of this study will be kept private. In any sort of report we make public we will not include any information that will make it possible to identify you. Research records will be kept in a locked room or suitcase at all times; only the researcher will have access to the records. At the end of this study, all signature forms and survey responses will be shredded.

Taking part is voluntary: Taking part in this study is completely voluntary. You may skip any questions that you do not want to answer. If you decide not to take part or to skip some of the questions, it will not affect your current or future relationship with the researcher. If you decide to take part, you are free to withdraw at any time.

If you have questions: The researcher conducting this study is Megan Swoger. Please ask any questions you have now. If you have questions later, you may contact Megan Swoger at mswoger@kent.edu.

Statement of Consent: I have read the above information, and have received answers to any questions I asked. I consent to take part in the study.

Your Signature __________________________________ Date ____________________

Your Name (printed) __________________________________________________________
Please circle your responses to the following:

What is your age?
   a) 18-22  b) 23-26  c) 27+

Gender:
   Male         Female

What university level are you?  
   100  200  300  400

Which region of Ghana are you from?  
   Central  Brong-Ahafo  Northern  Eastern  Western  Volta  
   Upper West  Upper East  Ashanti  Greater Accra

Other: ...........................................
Please rate the following questions on a scale of 1 to 5.
1 being absolutely true and 5 being absolutely false:

1) Men and women are treated equally in Ghana

2) If I am having a problem, I am confident that the police will handle it

3) I feel that there are currently enough females representing constituencies in Parliament

4) I am aware of the practice of female circumcision

5) I believe that female circumcision is a harmful practice

6) I believe that this practice still continues in Ghana

7) Female circumcision is outlawed in Ghana

8) Policy implementation happens quickly in Ghana

9) Men and women are regarded with equal seriousness when reporting a problem to police

10) Rural and urban regions have equal police protection

11) Rural and urban regions are equally knowledgeable of the laws passed in Parliament
Open-Ended Response:

- Do you think women’s rights are important? Why or why not?

- Do you think there needs to be more advocacy for females in Ghana? Why or why not?
APPENDIX C

INTERVIEW QUESTIONS
Interview Questions:

**General Participant Questions:**

1) Do you have any knowledge of female circumcision in your community?
2) Is this a part of your cultural practice?
3) How long has it been practiced here?
4) How has this practice been important to your community?

**Questions for Circumcised Women:**

1) At what age were you circumcised?
2) Whose decision was it? Parents/Grandparents/Yourself?
3) Do you feel that circumcision has changed your life in some way?
4) Would you want to also be circumcised? Why or why not?
5) Are you aware of the law against female circumcision? If so, how do you feel about it?
6) What important role does this practice play for your community and for you personally?
7) If your chief did not like the practice, would that change the opinion of others? Religious leaders?

**Questions for Organizations:**

1) Do you think people are aware of the laws against FGM?
2) Do you think they are fearful of these laws? Why or why not?
3) Do you think the current penalties are strict enough?
4) Why do you think this practice persists in the North of Ghana specifically?
5) Do you think that religion or spirituality are reasons behind why people practice?
6) Do you think the involvement/opinions of chiefs strongly impacts advocacy work surrounding FGM?

7) How big of an impact do you think education would have on this issue?

8) Do you think that extra-territorial legislation will be put into place in the near future in order to enhance protection from circumcisers crossing borders?

9) Where do you see the issue of FGM in Ghana 5 years from now?

**Questions for Law Enforcement:**

1) How many cases of female circumcision do you have reported to your station each year?

2) Do you think the general community is aware of the law passed in 1994?

3) Do you think that the laws are effective in stopping the practice of female circumcision? Why or why not?

4) What would be the procedure for you if you had someone report a case?

5) Do you think the legal consequences are taken seriously? Why or why not?

6) Do you think that those that perform the surgery are aware of the law?

7) Who do you think could sway the public opinion more? The Parliament or the chiefs? Why?

**Questions for Upper West DOVVSU Unit:**

1) Do you respond to many cases of female circumcision within your jurisdiction? How many?

2) When was the last time one was reported that you can recall?

3) What is your protocol to respond to a case if you were to get one?
4) Do you feel that all the officers here are well-acquainted with the law passed in 1994 against female circumcision?

5) Was there anything your department did with the passage of the law to inform the more rural communities of it?

6) Do you think the passage of the law was effective in eradicating the practice?

Questions for the Ministry of Gender, Children, and Social Protections:

1) Do you think people are aware of the laws against FGM in Ghana? What about in the Upper West region?

2) Do you think that people are fearful of these laws? Why or why not?

3) Why do you think that this practice persists in the North specifically?

4) In what ways does the Ministry advocate for the cessation of FGM in the regions such as the Upper West that are more rural?

5) Do you think that laws passed in Parliament or the decisions of chiefs have more of an effect on people stopping the practice?

6) Do you think that extra-territorial legislation, or laws passed bilaterally between bordering countries will be implemented in order to have a better chance at catching circumcisers that cross borders?

7) When I was in Wa, I visited several communities, some very remote. I was told by maybe three of these communities that FGM had stopped as long as 75 years ago due to a death or two that occurred. Do you find this timeline to be realistic?

8) What do you think the situation is really like currently in the Upper West region?