

A close-up portrait of a woman with dark skin and eyes, wearing traditional Ugandan beaded jewelry. She has a headband with blue beads and cowrie shells, and a large, colorful beaded necklace with red, yellow, and white beads. The background is blurred, showing more of the necklace.

COUNTRY PROFILE:
FGM IN UGANDA

JULY 2013

 **28 TOOMANY**
FGM...
let's end it.



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FOREWORD

In an increasingly results and outcome orientated culture, donors in development are expecting greater demonstration of monitoring and evaluation mechanisms to show good use of their partnership investment. Similarly, in the female genital mutilation (FGM) sector, governments, NGOs, academics and the media are seeking more robust research data to show current trends and analysis of a benchmarked and mapped situation at any given time.

This Country Profile on Uganda shows that the overall prevalence of FGM in Uganda is low compared to other countries in Africa. Although FGM appears to be decreasing in one of the main regions where it is practised and much positive action is being undertaken to combat FGM, the rate is increasing in other areas. FGM has affected over 140 million women and girls worldwide, 102 million of whom are in Africa. It continues to affect three million girls a year, which equates to one every ten seconds. UNICEF estimates that, given present trends, as many as 30 million girls under the age of 15 may be at risk (UNICEF, 2013).

The procedure has no known health benefits and is harmful to women and girls in terms of immediate pain and trauma, interfering with natural bodily functioning and producing immediate and long-term health consequences. Babies born to women who have undergone FGM suffer higher rates of neonatal death.

The reasons for FGM are as varied as the places and communities practising it. From a human rights perspective, the practice reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination on minors. It also violates the rights of the child, breaching rights to health, security, physical integrity, freedom from degrading treatment and possibly resulting in death.

FGM connects with other social issues such as girls not completing education and growing into

women who have poor literacy; pressure to accept early or child marriage; poor access to physical and psychological health care, and a risk of HIV/AIDS transmission.

I worked in a medical clinic in rural Northern Uganda in 2004-5, helping support the physical and psychological needs of children in Internally Displaced Children's (IDC) Camps, fleeing from the Lord's Resistance Army. I will never forget the women I saw die in childbirth or the children killed needlessly. Since then I have watched with interest as Uganda has experienced some progress in many development indicators, such as the re-establishment of functioning medical care which has reduced the need for emergency care programmes such as the ones in which I worked. It was a few months later in 2005 that I first came across FGM whilst working in North Sudan, and then worked in Internally Displaced People's (IDP) Camps in Dadaab, North East Kenya in 2008, with over 250,000 Somali IDPs. This led to my research on FGM that was published in March 2012 (Wilson, 2012/2013).

Since first experiencing personal stories of FGM, which we receive daily, we are pleased 28 Too Many has been able to undertake this research and see progress. The photograph below shows a ten year old girl, with a baby, in North Uganda. She is the same age as the girl I met in North Sudan in an IPD camp who had experienced FGM at five and had a baby born of rape at ten years old, nearly dying during labour due to complications caused by both her young age and FGM.

During our research we heard this story from Muthoni: 'I had a polygamous father, so I came from a family of 18 children. I was the only girl not to be cut because I was educated at church of the harm it does. When it came to my time, I decided not to do it. Many years later I desired to help others girls receive the same knowledge and opportunities as I did. This was how Sisters of the Heart began. We started meeting to help women to help empower each other' (Muthoni, one of six original founders of FBO Sisters of the Heart). This

experience helps me see how far we have come, yet how much further change is needed.

We are seeking partners, FGM advocates, research volunteers and donors to help us end FGM across Africa and the diaspora. Our dream is that a woman does not cut her daughter, then as a mother that daughter does not cut her own daughter; and as a grandmother, that she will not cut her granddaughter/others in the community, and over three generations (36 years) major change will happen; over five generations (60 years) FGM could be eradicated across Africa. Meanwhile, 28 Too Many plans to create Country Profiles on each of the 28 countries in Africa as a resource tool to the FGM and development sector, government, media and academia. With your partnership, we can make these useful and often accessed reports which share good practice. We are pleased to launch this report on Uganda, to complement our earlier Country Profile on Kenya, and thank all who contributed to it.

Dr Ann-Marie Wilson
28 Too Many Executive Director

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BACKGROUND

28 Too Many is an anti-FGM charity, created to end FGM in the 28 African countries where it is practised and in other countries across the world where members of those communities have migrated. Founded in 2010, and registered as a charity in 2012, 28 Too Many aims to provide a strategic framework, where knowledge and tools enable in-country anti-FGM campaigners and organisations to be successful and make a sustainable change to end FGM. We hope to build an information base including providing detailed Country Profiles for each country practising FGM in Africa and the diaspora, and develop a network of anti-FGM organisations to share knowledge, skills and resources. We also campaign and advocate locally and internationally to bring change and support community programmes to end FGM.

PURPOSE

The prime purpose of this Country Profile is to provide improved understanding of the issues relating to FGM in the wider framework of gender equality and social change. By providing a country profile, collating the research to date, this Country Profile can act as a benchmark to profile the current situation. As organisations send us their findings, reports, tools and models of change, we can update these reports and show where progress is being made. Whilst there are numerous challenges to overcome before FGM is eradicated in Uganda, many programmes are making positive active change and government legislation offers a useful base platform for deterring FGM practice.

USE OF THIS COUNTRY PROFILE

Extracts from this publication may be freely reproduced, provided the due acknowledgement is given to the source and 28 Too Many. 28 Too Many invites comments on the content, suggestions on how it could be improved as an information tool, and seeks updates on the data and contacts details.

ACKNOWLEDGEMENTS

28 Too Many is extremely grateful to all the FGM practising communities, local NGOs, CBOs, FBOs, international organisations, multilateral agencies, members of government and media in Uganda, who have assisted us in accessing information to produce this Country Profile. We thank you, as it would not have been possible without your assistance and collaboration. 28 Too Many carried out all its work as a result of donations, and is an independent objective voice not being affiliated to any government or large organisation. That said, we are grateful to the many organisations that have supported us so far on our journey and the donations that enabled this Country Profile to be produced. Please contact us on info@28toomany.org.

THE TEAM

Producing a Country Profile such as this is a collaborative process. We are very grateful to the following key contributors:

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Johanna Waritay is Research Coordinator for 28 Too Many. Prior to this, she worked for 13 years as a lawyer at a leading international law firm in London. She has carried out research in three countries in which FGM is practised in the last year.

Ann-Marie Wilson founded 28 Too Many and is its Executive Director who worked in Uganda in 2004-5. She published her paper this year on 'Can lessons be learnt from eradicating footbinding in China and applied to abandoning female genital mutilation in Somalia? A critical evaluation of the possibilities offered for developing strategies to expand current promising practice' in the *Journal of Gender Studies*.

Rooted Support Ltd for donating their time through its Director Nich Bull in the design and layout of this Country Profile, www.rootedsupport.co.uk.

We are grateful to the rest of the 28 Too Many Team who have helped in many ways.

Photograph on front cover: *Pokot Woman*, © www.lafforgue.com

LIST OF ABBREVIATIONS

AIDS - Acquired Immunodeficiency Syndrome

ABEK - Alternative Basic Education for Karamoja

ARP - Alternative Rites of Passage

ASB - Arbeiter-Samariter-Bund

CBO - Community-Based Organisation

CEDAW - Convention on the Elimination of Discrimination Against Women

CPJ - Committee to Protect Journalists

CRC - Convention on the Rights of the Child

CSW - Commission on the Status of Women

DHS - Demographic Health Survey

EAC - East African Community

EALA - East African Legislative Assembly

FBO - Faith-Based Organisation

FGM - Female Genital Mutilation

FPAU - Family Planning Association of Uganda

GBV - Gender-Based Violence

HIV - Human Immunodeficiency Virus

KACSOA - Kapchorwa Civil Society Organizations Alliance

KTR - Kapchorwa Trinity Radio

IAC - Inter-African Committee on Traditional Practices

ICESR - International Covenant on Economic, Social and Cultural Rights

LGBT - Lesbian Gay Bisexual and Transgender

LRA - The Lord's Resistance Army

MAZIDEP - Matheniko Zonal Integrated Development Programme

MCIS/-3 - Multiple Indicator Cluster Survey /round 3

MDG - Millennium Development Goal

MoH - Ministry of Health

MP - Member of Parliament

NGO - Non-Governmental Organisation

NRM - National Resistance Movement

OECD - Organisation for Economic Co-operation and Development

PATH - Programmes for Appropriate Technology in Health

POZIDEP - Pokot Zonal Integrated Development Programme

PTSD - Post Traumatic Stress Disorder

REACH - Reproductive, Educative and Community Health Project

RHU - Reproductive Health Uganda

RWB - Reporters Without Borders, also Reporters Sans Frontières

SEA - Sabiny Elders' Association

SIGI - Social Institutions and Gender Index

SSF - State Security Forces

TBA - Traditional Birth Attendant

TPO Uganda - Transcultural Psychosocial Organisation

UN - United Nations

UNFPA - United Nations Population Fund

UNGEI - UN Girls Education Initiative

UNICEF - United Nations Children's Fund

VHT - Village Health Teams

WHO - World Health Organisation

EXECUTIVE SUMMARY

In Uganda, according to the most recent Demographic Health Survey (DHS), the estimated prevalence of FGM in girls and women (aged 15-49 years) is 1.4% (DHS, 2011). In comparison to many of the other countries in Africa in which FGM is practised, Uganda has a very low rate. There are regional variations in prevalence with the highest rates occurring in Karamoja (4.5%) and the Eastern Region (2.3%) (DHS, 2011). All other regions in Uganda have prevalence rates of below 2%.

The ethnic groups that practise FGM are mostly located in the North East of Uganda in the Eastern and Karamoja regions. They are the Sabiny (also called the Sebei) (in the Eastern Region), and the Pokot, Tepeth and Kadama (Karamoja Region). These ethnic groups are all part of the larger Kalenjin ethnic group and are related to the Maasai in Kenya and Tanzania who also practise FGM. Among the Pokot, FGM is near universal at 95% and the practice is estimated at approximately 50% among the Sabiny (UNFPA, 2011). FGM among these ethnic groups is largely practised as a rite of passage and to ensure marriageability. It is closely associated with early marriage and bride price. It is also a way of distinguishing such ethnic groups from their neighbours (the Karamojong who do not practise FGM) with whom they sometimes have a hostile relationship. Although there is little available data, FGM may also be practised by the Nubi and Somali communities.

The Sabiny practise Type I or II, whereas the Pokot practise Type III infibulation. The age at which FGM is carried out varies between ethnic groups. Among the Pokot, girls are cut aged 9-14 every year between July and December. Sabiny girls aged 10-15 are at risk, with the normal cutting age being 15. Their ceremonies usually take place in the December of even numbered years, although there are reports that cutting now takes place at any time. The Tepeth cut their girls between the ages of 11-14. There is also the practice of genital elongation that is carried out by the Baganda. This is sometimes referred to as female genital modification (FGMo) and there is some debate about its inclusion into the WHO category of Type IV.

Dr Baryomunsi, the Member of Parliament (MP) who tabled the anti-FGM bill in the Ugandan parliament, asserted that by 2015, FGM would be no more in Uganda (Tebajjukira, 2009). The DHS, however, shows that overall in Uganda, the rate of FGM has in fact increased from 0.6% in 2006 to 1.4% in 2011 (DHS 2006 and 2011). In the Eastern Region, where there has been a longer history of intervention against FGM in comparison to Karamoja, the rate has decreased from 2.4% in 2006 to 2.3% in 2011 (DHS 2006 and 2011) and other statistics also suggest a long-term decline in the

practice in this region.

Since the 2010 anti-FGM Act, the practice has gone underground. There are also anecdotal reports of increases in cases of FGM following the coming into force of the law, with communities reportedly continuing to cut in defiance of the law. It should, however, be noted that gathering reliable data on FGM in Uganda is challenging due to the fact that the practice is often now carried out in secret or over the border in Kenya for fear of prosecution, and regions where FGM is practised are remote.

Under the political and economic stability of recent years, Uganda has made progress towards the Millennium Development Goals according to a 2010 report. In particular, Uganda has made good progress towards providing access to schooling, evidenced by the massive increase in enrolment after the introduction of universal primary and secondary education. Rates of literacy and school enrolment, however, remain low in the regions where FGM is practised (the literacy rate in Karamoja is 12% for men, 6% for women, compared to the national rate of 76.8% for men and 57.5% for women and 50.3% of girls and 49.7% of boys of school going age in Karamoja have never accessed education). This may be partly attributable to the resistance to education among the pastoralist Pokot (and Karamojon), where historically education has been used as a political tool to sedentarise (i.e. to change the community from a nomadic one to one where they remain permanently in one place) and integrate them. One report highlights the lack of education in Moroto District, with some sub-counties not having a primary school (Weber, 2012). Improving access to education is vital because if girls complete their education they are less likely to undergo FGM and early marriage.

There are many local NGOs, CBOs, FBOs, international organisations and multilateral agencies working in Uganda to eradicate FGM. Moreover, the Ugandan government has been strongly supportive of the anti-FGM movement. A broad range of initiatives and strategies has been used. Among these are: health risk/harmful traditional FGM practices approach; addressing the health complications of FGM; providing alternative income generation activities to excisors; alternative rites of passage (ARPs) and Culture Days; religious-orientated approach; legal approach; human rights approach; intergenerational dialogue; promotion of girls' education to oppose FGM and supporting girls escaping from FGM/child marriage.

The role of education is particularly important with this region of Uganda which has a history of resistance to education and suffers from very low literacy rates and school attendance. One study on the Pokot (in Kenya, but relevant to the Pokot in Uganda) found the most significant decrease in the practice of FGM is observed in areas that

have had schools for a long time and where the Church is well established compared to marginalised sections of the larger Pokot district where communities are yet to embrace girl child education and Christianity. The Church is seen by the community as a 'unique platform in influencing at stopping this practice' (Kristensen and Nairesiae, 2009). This highlights the importance of both education and the potential of the Church to contribute to the fight against FGM. It is particularly important to tailor education to the pastoralist lifestyle in relation to the Pokot (as the district education authorities in collaboration with Save the Children did in relation to the Alternative Basic Education for Karamoja (ABEK) scheme). Culture Days have had some reported success although some report that they had not yet provided the excitement, enthusiasm and values equivalent to those associated with FGM (Kiirya and Kibombo, 2000).

Due to the particular ethnic and cultural traditions and beliefs that underpin FGM, organisations need to tailor anti-FGM initiatives and strategies accordingly. There are still many challenges to overcome before FGM is eradicated in Uganda, but with increased awareness of the FGM law and active anti-FGM programmes progress continues in a positive direction. We propose the measures relating to:

- Recognising cultural significance of FGM
- Incorporating other ethnic groups and internal migrants within FGM strategies
- Sustainable funding
- Considering FGM within the Millennium Development Goals and post-MDG framework
- Facilitating education on health and FGM and advocating for girls' education
- Improvements in managing health complications of FGM, and more resources for sexual and reproductive health education
- Increased advocacy and lobbying
- Increased law enforcement
- Maintain effective media campaigns
- Encouraging faith-based organisations to act as agents of change and be proactive in ending FGM
- Increased collaborative projects and networking

- Recognising role of faith-based organisations
- Greater use of partnerships and collaborative research

INTRODUCTION

‘FGM/C is a social norm that can only be changed through collective agreement - the creation of a new social norm - rather than individual decisions. This is because FGM/C is fundamentally linked to girls’ and woman’s identity, their full acceptance by society and their marriageability. Individual families deciding alone not to cut their daughters, simply risk condemning them to a life of ostracism and stigma’ (DfID,2013)

Female genital mutilation (sometimes called female genital cutting or female genital mutilation/cutting) is defined by the WHO as referring to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. FGM is a form of gender-based violence and has been recognised as a harmful practice and a violation of the human rights of girls and women. Between 100 and 140 million girls and women in the world are estimated to have undergone such procedures, and 3 million girls are estimated to be at risk of undergoing the procedures every year.

FGM has been reported in 28 countries in Africa, affecting 102 million girls and women, and occurs mainly in countries along a belt stretching from Senegal in West Africa, to Egypt in North Africa, to Somalia in East Africa and the Democratic Republic of Congo (DRC) in Central Africa. It also occurs in some countries in Asia and the Middle East and among diaspora communities in North America, Australasia, Middle East and Europe. As with many ancient practices, FGM is carried out by communities as a heritage of the past and is often associated with cultural identity. Communities may not even question the practice or may have long forgotten the original reasons for it occurring.

The WHO classifies FGM into four types:

| | |
|-----------------|---|
| Type I | Partial or total removal of the clitoris and/or the prepuce (clitoridectomy). |
| Type II | Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Note also that the term ‘excision’ is sometimes used as a general term covering all types of FGM. |
| Type III | Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). (The term ‘appositioning’ is used in preference to ‘stitching’ because stitches (with thorns or sutures) is only one way to create adhesion. Other common techniques are tying legs together or using herbal pastes). |
| Type IV | All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation. |

FGM is often motivated by beliefs about what is considered appropriate sexual behaviour, with some communities considering that it ensures and preserves virginity, marital faithfulness and prevents promiscuity/prostitution. There is a strong link between FGM and marriageability with FGM often being a prerequisite to marriage. FGM is sometimes a rite of passage into womanhood, and necessary for a girl to go through in order to become a responsible adult member of society. FGM is also considered to make girls ‘clean’ and aesthetically beautiful. Although no religious scripts require the practice, excisors often believe the practice has religious support. Girls and women will often be under strong social pressure, including pressure from their peers and risk victimisation and stigma if they refuse to be cut.

FGM is always traumatic (UNICEF, 2005). Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections;

cysts; infertility; an increased risk of childbirth complications and newborn deaths, and the need for later surgeries. For example, a Type III infibulation needs to be cut open later to allow for sexual intercourse and childbirth (WHO, 2013).

The eradication of FGM is pertinent to the achievement of six millennium development goals (MDGs): MDG 1 - eradicating extreme poverty and hunger; MDG 2 - achieving universal primary education; MDG 3 - promote gender equality and empower women; MDG 4 - reduce child mortality, MDG 5 - reduce maternal mortality and MDG 6 - combat HIV/AIDS, malaria and other diseases.

In Uganda, the estimated prevalence of FGM in girls and women (15-49 years) is 1.4% (DHS, 2011). The DHS shows that overall in Uganda, the rate of FGM has in fact increased from 0.6% in 2006 to 1.4% in 2011 (DHS 2006 and 2011). In the Eastern Region, where there has been a longer history of intervention against FGM in comparison to Karamoja, the rate has decreased from 2.4% in 2006 to 2.3% in 2011 (DHS 2006 and 2011) and other statistics also suggest a long-term decline in the practice in this region. FGM is only practised by a minority of ethnic groups. Among the Pokot, FGM is near universal at 95% and the practice is estimated at approximately 50% among the Sabiny (UNFPA, 2011). There are no clear statistics on the prevalence among the Tepeth or among minority migrant groups. Since the 2010 anti-FGM Act, the practice has gone underground and this makes it challenging to collect accurate data on the practice, as well as enforce the law. FGM is a deeply rooted cultural practice, although the reasons vary between ethnic groups. Among the Sabiny, Pokot and Tepeth it is an important rite of passage and is closely tied to marriageability. As will be discussed in this Country Profile, there are many local NGOs, CBOs, FBOs, international organisations and multilateral agencies working in Uganda to eradicate FGM using a broad range of approaches.

The vision of 28 Too Many is a world where every woman is safe, healthy and lives free from FGM.

A key strategic objective is to provide detailed, comprehensive Country Profiles for each of the 28 countries in Africa where FGM is practised. The Country Profiles provide research on the situation regarding FGM in each country, as well as providing more general information relating to the political, anthropological and sociological environments in the country to provide a contextual background within which FGM occurs. It also offers some analysis of the current situation and will enable all those with a commitment to ending FGM to shape their own policies and practice to create conditions for positive, enduring change in communities that practice FGM. We recognise that each community is different in its drivers for FGM and bespoke, sensitive solutions are essential to offer girls, women and communities a way forward in ending this practice. This Country Profile provides a sound knowledge base from which to determine the models of sustainable change necessary to shift attitude and behaviour and bring about a world free of FGM.

INTRODUCTION TO FGM

See Introduction above for details of types of FGM.

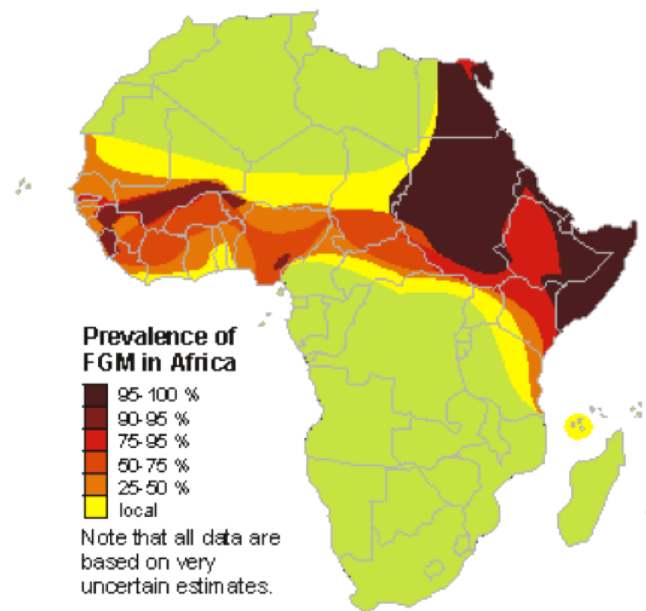
HISTORY OF FGM

FGM has been practised for over 2000 years (Slack, 1988). Although it has obscure origins, there has been anthropological and historical research on how FGM came about. It is found in traditional group or community cultures that have patriarchal structures. Although FGM is practised in some communities in the belief that it is a religious requirement, research shows that FGM pre-dates Islam and Christianity. Some anthropologists trace the practice to 5th century BC Egypt, with infibulations being referred to as 'Pharaonic circumcision' (Slack, 1988). Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young female herders; as a custom amongst stone-age people in Equatorial Africa; or as 'an outgrowth of human sacrificial practices, or some early attempt at population control' (Lightfoot-Klein, 1983).

There were also reports in the early 1600s of the practice in Somalia as a means of extracting higher prices for female slaves, and in the late 1700s in Egypt to prevent pregnancy in women and slaves. FGM is practised across a wide range of cultures and it is likely that the practice arose independently amongst different peoples (Lightfoot-Klein, 1983), aided by Egyptian slave raids from Sudan for concubines and maids, and traded through the Red Sea to the Persian Gulf (Mackie, 1996) (Sources referred to by Wilson, 2012/2013).

FGM – GLOBAL PREVALENCE

FGM has been reported in 28 countries in Africa, as well as in some countries in Asia and the Middle East and among certain migrant communities in North America, Australasia, Middle East and Europe.



Prevalence of FGM in Africa (Afrol News)

NATIONAL STATISTICS

GENERAL STATISTICS

POPULATION

33,640,833 (2012 est.)

Median age: 15.1 years

Growth rate: 3.58% (2012 est.) (World Factbook)

HUMAN DEVELOPMENT INDEX

Rank: 161 out of 186 in 2013 (UNDP)

HEALTH

Life expectancy at birth (years): 53.4 (World Factbook)

Infant mortality rate (per 1,000 live births): 61.22

Maternal mortality rate 310 deaths / 100,000 live births (2010); country comparison to the world: 36th

Fertility rate, total (births per women): 6.14 (2012 est.)

HIV/AIDS – adult prevalence rate: 6.5% (2009 est.)

HIV/AIDS – people living with HIV/AIDS: 1.2 million (2009 est.); country comparison to the world: 8th

HIV/AIDS – deaths: 64,000 per annum (World Factbook)

LITERACY (AGE 15 AND OVER WHO CAN READ AND WRITE)

Total population: 66.8%

Female: 57.7%; male: 76.8% (2002 est.) (World Factbook)

MARRIAGE

Girls aged 15 - 19 who are married, divorced, separated or widowed: 11.4% (DHS, 2011)

Married girls or women who share their husband with at least one other wife: 24.6% (DHS, 2011)

GDP

GDP (official exchange rate): US\$46.96 billion (2011 est.)

GDP per capita: US\$1,300 (2011 est.)

GDP (real growth rate): 6.7%

URBANISATION

Urban population: 13% of total population (2010)

Rate of urbanisation: 4.8% annual rate of change (2010-15 est.)

ETHNIC GROUPS

Baganda 16.9%, Banyakole 9.5%, Basoga 8.4%, Bakiga 6.9%, Iteso 6.4%, Langi 6.1%, Acholi 4.7%, Bagisu 4.6%, Lugbara 4.2%, Bunyoro 2.7%, other 29.6%.

RELIGIONS

Roman Catholic 41.9%, Protestant 42% (Anglican 35.9%, Pentecostal 4.6%, Seventh-Day Adventist 1.5%), Muslim 12.1%, other 3.1%, none 0.9%.

LANGUAGES

English (official), Ganda or Luganda (most widely used of the Niger-Congo languages, preferred for native language publications in the capital and may be taught in school), other Niger-Congo languages, Nilo-Saharan languages, Swahili, Arabic.

MILLENNIUM DEVELOPMENT GOALS

The eradication of FGM is pertinent to a number of the UN's eight Millennium Development Goals (MDGs).



GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

In Karamoja (including Moroto and Nakapiritpirit districts) there is a deteriorating food security situation, with an estimated 1.2 million people potentially affected (IRIN, 2013). This MDG is relevant given the correlation between food insecurity and education, and education and FGM respectively. Education (particularly primary education) for rural populations is a key factor in fighting food insecurity (Burchi and Muro, 2007). Education is also important in tackling FGM, as discussed below. This illustrates the links between MDGs and the key role education can play in combating not only FGM but also another pressing development issue for Karamoja, namely food insecurity.

GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

The aim of this MDG is to provide universal primary education with the target to ensure that by 2015 all boys and girls complete a full course of primary schooling. This is relevant in the context of FGM as the chances of girls undergoing FGM are reduced if they complete their schooling. See section on FGM and Education.

GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

The aim of this MDG is to eliminate all gender disparity in primary and secondary education no later than 2015. This is highly relevant given that FGM is a manifestation of deeply entrenched gender inequality and constitutes an extreme form of discrimination against women. Moreover there is a correlation between the level of a woman's education and her attitude towards FGM. See section on FGM and Education.

GOAL 4: REDUCE CHILD MORTALITY

FGM has a negative impact on child mortality. A WHO multi-country study, in which over 28,000 women participated, has shown that death rates among newborn babies are higher to mothers who have had FGM. See section on Women's Health and Infant Mortality.

GOAL 5: IMPROVE MATERNAL HEALTH

This MDG has the aim of reducing maternal mortality by three quarters between 1990 and 2015. In addition to the immediate health consequences arising from FGM, it is also associated with an increased risk of childbirth complications. See section on Women's Health and Infant Mortality.

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

Although the correlation between HIV/AIDS and FGM is not as direct as some research has previously claimed, there are a number of potential sources of HIV/AIDS transmission associated with

FGM and its consequences. See section on HIV/AIDS and FGM.

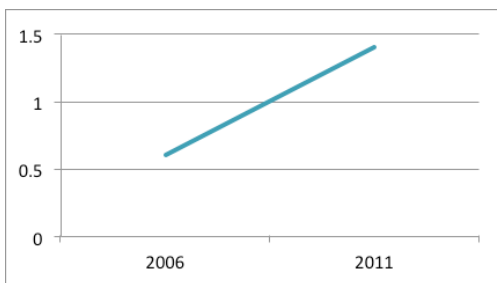
POST-MDG FRAMEWORK

As the MDGs are approaching their 2015 deadline, the UN is in the process of evaluating the current MDGs and exploring future goals. After 2015, the UN will continue its efforts to achieve a world of prosperity, equity, freedom, dignity and peace. Currently, the UN is working with its partners on an ambitious post-2015 development agenda, and striving for open and inclusive collaboration on this project (UN website). The focus of the UN CSW 58 is on the challenges and achievements in the implementation of the MDGs for women and girls, including the access and participation of women and girls to education. The UN is also conducting the MY World survey in which citizens across the globe can vote offline and online (including using mobile technologies) on which six development issues most impact their lives. These results will be collected up until 2015 and will influence the post-2015 agenda (Myworld2015.org).

Coinciding with this survey is 'The World We Want' platform, an online space where people can participate in discussions on the UN's sixteen areas of focus for development. On the issue of gender violence, there has been a growing call for the post-MDG agenda to include a distinct focus on ending violence against women (Harper, 2013). Though it is unlikely that FGM will be eliminated in Uganda by 2015, it is nonetheless encouraging that the MDGs have ensured a persistent focus on areas related to FGM (see above). The post-2015 agenda will undoubtedly provide renewed, if not stronger, efforts to improve women's lives. Additionally, the African Union's declaration of the years from 2010 to 2020 to be the decade for African women will certainly assist in promoting gender equality and the eradication of gender violence in Uganda.

NATIONAL STATISTICS RELATING TO FGM

Statistics on the prevalence of FGM are compiled through large scale household surveys in developing countries – the Demographic Health Survey (DHS) and the Multiple Indicator Cluster Survey (MICS). The estimated prevalence of FGM in girls and women (15-49 years) is 1.4% (DHS, 2011). This has increased since it was first reported at 0.6% in 2006 (DHS, 2006 and WHO, 2008). While this data appears to show that FGM is increasing overall in Uganda, there is reportedly a decline in the Eastern region (see Regional Statistics below). It is hard to assess the definitive numbers and statistics relating to FGM in Uganda. This is partly due to the fact that the practise is now often carried out secretly or even over the Kenyan border for fear of prosecution, and the regions where FGM is practised are remote making data collection challenging.



Prevalence of FGM in women and girls ages 15-49 (%) (DHS, 2006 and 2011)

The estimated prevalence of FGM in girls and women by age is set out below. See further FGM by Age.

PREVALENCE OF FGM IN UGANDA BY AGE %

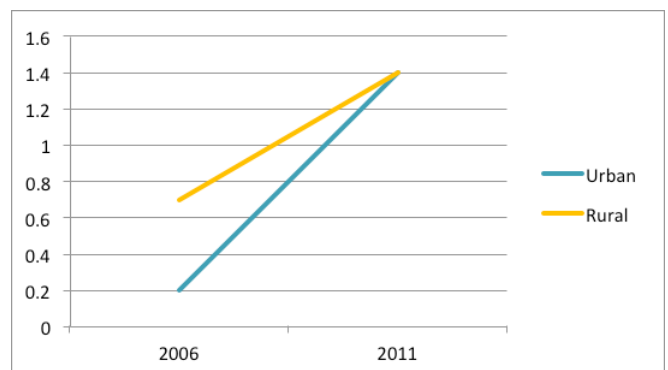
| | 2006 | 2011 |
|--------------|------|------|
| TOTAL | 0.6 | 1.4 |
| 15-19 | 0.5 | 1.0 |
| 20-24 | 0.8 | 0.8 |
| 25-29 | 0.3 | 1.9 |
| 30-34 | 0.8 | 2.1 |
| 35-39 | 0.8 | 1.3 |
| 40-44 | 1.0 | 1.7 |
| 45-49 | 0.4 | 1.9 |

Prevalence of FGM in women and girls by age (%) (DHS 2006 and 2011)

PREVALENCE OF FGM IN UGANDA BY PLACE OF RESIDENCE %

| | 2006 | 2011 |
|-----------------------|------|------|
| URBAN | 0.2 | 1.4 |
| RURAL | 0.7 | 1.4 |
| LOWEST REGION | 0.1 | 0.2 |
| HIGHEST REGION | 2.4 | 4.8 |

Prevalence of FGM by place of residence (%) (DHS 2006 and 2011)



Prevalence of FGM in Uganda by Place of Residence (%)

PREVALENCE OF FGM IN UGANDA BY HOUSEHOLD WEALTH %

The DHS breaks down the population into quintiles from the richest to the poorest, using information such as household ownership of certain consumer items and dwelling characteristics.

| WEALTH INDEX QUINTILE | 2006 | 2011 |
|-----------------------|------|------|
| POOREST | 0.9 | 2.2 |
| SECOND | 0.7 | 1.2 |
| MIDDLE | 0.9 | 1.2 |
| FOURTH | 0.4 | 1.0 |
| RICHEST | 0.4 | 1.5 |

REGIONAL STATISTICS

Uganda is a Group 3 country, according to the UNICEF classification, where only some ethnic groups practise FGM and the country overall has a low prevalence rate of between 1% and 24% (UNICEF, 2005).

FGM is not widely practised in Uganda and has comparatively low rates to other African countries,

however, the practice is highest in eastern regions of the country (DHS, 2011).

In the Eastern Districts of Kapchorwa, Kween and Bukwa, FGM is practised by the Sabiny (Sebei) ethnic group. The Sabiny people are the most studied in terms of FGM in Uganda. According to the DHS statistics, there appears to be decline in the rate of FGM in the areas inhabited by the Sabiny (Eastern District) from 2.4% in 2006 to 2.3% in 2011. Statistics by the NGO REACH also support this. There is, however, anecdotal evidence of an increase in prevalence as a result of defiance by the community to the new law. Please see section on FGM by Ethnicity below for further discussion.

FGM is also practised by the Pokot ethnic group living in the districts of Amudat and Nakapiripirit, and the Tepeth (also called the So) in the Moroto district of the Karamoja region. The Kadama ethnic group, who live on Mount Kadam in Nakapiripirit district, also practise FGM although there is very little data available on this group. The DHS figures show that FGM has increased in Karamoja from 1.8% in 2006 to 4.8% in 2011. Although the reasons for the increase are not completely clear, anecdotal evidence suggests that this may be attributable to the coming into force of the law against FGM. Please see section on FGM by Ethnicity below for further discussion.

The rate of FGM is also increasing in all other regions of Uganda.

FGM is also believed to be practised by the Somalis who are located in the Kisenyi zone in Kampala, and the Nubi ethnic group who reside in Bombo, north of Kampala, Arua and elsewhere (in the Western Nile region).

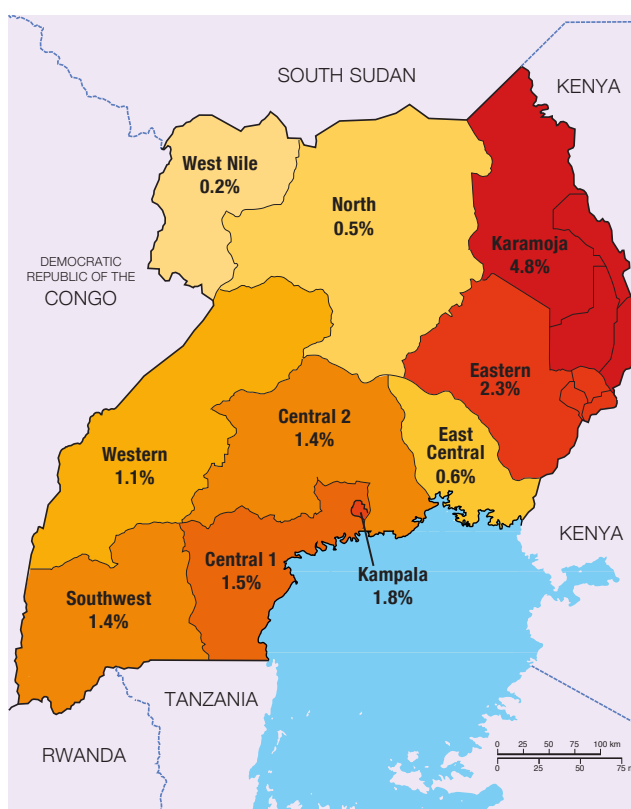
Additionally, FGM has been reported in the districts of Isingiro, Kamuli, Kamwenge and Bugiri (UNFPA, 2011).

Genital elongation – classed in the Type IV category – is practised mainly by the Baganda people in the Wakiso district (Pérez and

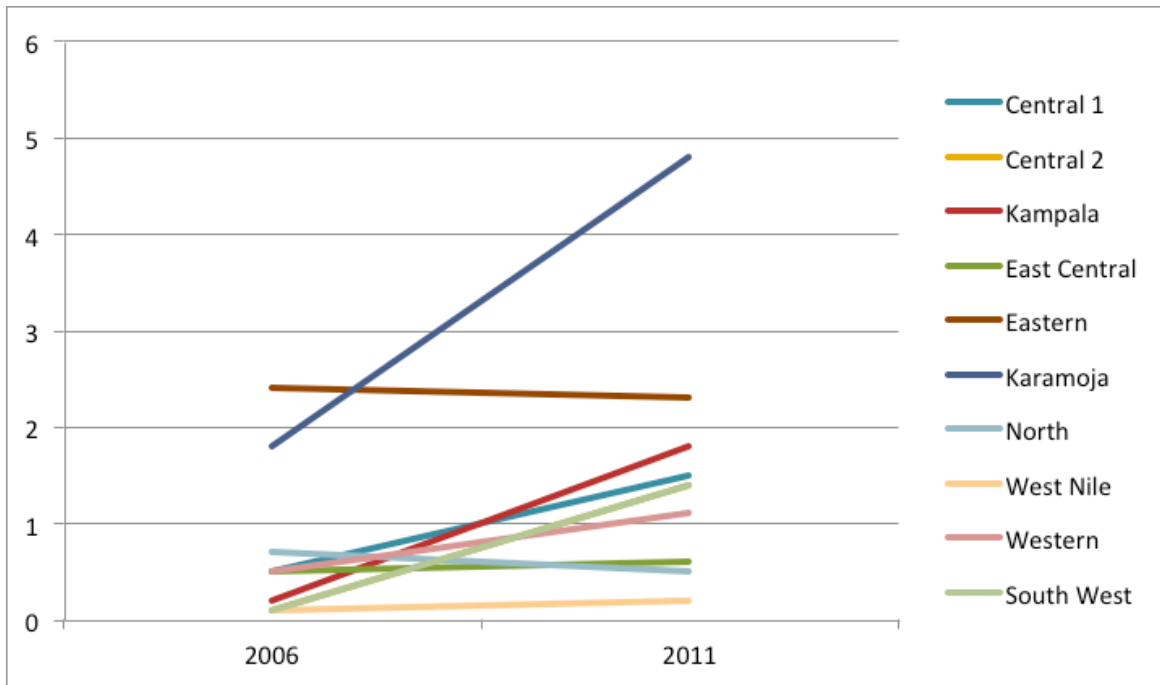
Namulondo, 2011).

| Region | % of women who have had FGM (2006) | % of women who have had FGM (2011) |
|--------------|------------------------------------|------------------------------------|
| Kampala | 0.2 | 1.8 |
| Central 1 | 0.5 | 1.5 |
| Central 2 | 0.1 | 1.4 |
| East Central | 0.5 | 0.6 |
| Eastern | 2.4 | 2.3 |
| Karamoja | 1.8 | 4.8 |
| North | 0.7 | 0.5 |
| West-Nile | 0.1 | 0.2 |
| Western | 0.5 | 1.1 |
| South West | 0.1 | 1.4 |
| IDP | 0.1 | - |

Regional variation for practising FGM showing trend (%) (DHS, 2006 and 2011)



Map showing regional variation of the practice of FGM in 2011 (%) (DHS, 2011)



Regional variation for practising FGM showing trend (%) (DHS, 2006 and 2011)

POLITICAL BACKGROUND

HISTORICAL

Uganda was first inhabited by hunter-gatherer peoples until 1,700 to 2,300 years ago when Bantu-speaking groups migrated to the southern parts of the region, establishing part of the Empire of Kitara (Chwezi) known as the kingdom of Buganda. Around AD 120 Nilotic people entered the area, introducing cattle herding and subsistence farming to the northern and eastern parts of the country. Arab traders then migrated to the region in the 1830s, followed by British explorers and missionaries in the late nineteenth century. The UK ruled Uganda as a protectorate from 1894 and this grouped together a wide range of ethnic groups with different political systems and cultures.

After Uganda achieved independence from the UK in 1962 and became a republic, differing views prevented the country from establishing a working political community. A power struggle between the government and King Muteesa led to the constitution being changed and Uganda was declared a republic in 1967, abolishing the traditional kingdom and making Milton Obote

President. Following a military coup, the dictatorial regime of Idi Amin from 1971-79 was responsible for over 300,000 deaths. Oboto was reinstated after the Uganda-Tanzania War in 1979, only to be deposed by Tito Okello during the 'Bush War', which was responsible for a number of human rights abuses.

CURRENT POLITICAL CONDITIONS

Since the late 1980s Uganda has stepped back from the abyss of civil war and economic catastrophe and has become a relatively peaceful, stable and prosperous nation (BBC, 2013). Yoweri Museveni, leader of the National Resistance Movement (NRM) party has been president since Okello was deposed by the National Resistance Army in 1986. Under Museveni's rule Uganda has experienced considerable stability and economic growth. Notably, he has been involved in the civil war against the Lord's Resistance Army, a group responsible for innumerable human rights violations including child slavery and mass murder.

In February 2011 Museveni was re-elected for another five year term with 68% of the votes. These elections were marred by irregularities including: 'diversion of government resources for partisan

gain, unfair access to media for NRM candidates, government intimidation, and disorganised polling stations (Human Rights Report, 2011). Ugandan government officials continue to engage freely in corrupt practices, and the World Bank's Worldwide Governance Indicators reflect this severe corruption problem, with an annual loss of 768.9 billion shillings (US\$286 million) to corruption (Human Rights Report, 2012).

ANTHROPOLOGICAL BACKGROUND

ETHNIC GROUPS

Uganda has great ethnic, cultural, religious and linguistic diversity with no one ethnic group as a majority. There are forty languages spoken in Uganda and they belong to four main groups: Bantu, Western Nilotic, Eastern Nilotic and Central Sudanic. The main ethnic groups are: Baganda, Banyakole, Basoga, Bakiga, Iteso, Langi, Acholi, Bagisu, Lugbara, and Bunyoro (see general statistics section above). There are isolated reports of violence between ethnic minorities, for example between the Pabwo and Lapyem clans (Human Rights Report, 2011). In January 2012, for example, there was a clash between the Bagisu and Sabinu over land, resulting in two fatalities, and 200 displaced persons (Human Rights Report, 2012).

Further tensions exist with the Batwa, an indigenous group who have been displaced and have limited access to education, health care, land and economic opportunities. Moreover, they have been prevented from continuing their traditional hunter-gatherer lifestyle, consequently suffering from food shortages (Human Rights Report, 2011). Conflicts between ethnic groups based on religion appear to be minimal. Other historical divides exist between the Nilotic speaking people of the north and Bantu-speaking peoples of the south, as well as an economic divide between pastoralists of the west and north, and agriculturalist in the highland and lakeside regions (Rowe, 1990). Conflicts between the Sebei, Karamojong and Pokot tribes on both sides of the Uganda-Kenya border have



Young Pokot Shepherds © Alessio Moiola | Dreamstime.com

continued since 2002. Raids, theft of cattle and other property and the killing of those who resist comprise these conflicts, and could be a factor in the continued presence of FGM. The Karamojong have been labelled as the aggressors and the Sebei as the target, though Sebei have also been accused of raiding, killing and arms trafficking. The Ugandan government has attempted to disarm the Karamojong and other groups with little success and has encountered violent resistance from the Karamojong (UNHCR, 2006).

COUNTRYWIDE TABOOS AND MORES

Uganda has a patriarchal society and there are moral and cultural restrictions on women and their behaviour. As in other African countries, sex and sexuality are taboo subjects in Ugandan culture. A woman who discusses sexuality openly could be labelled as 'immoral' or 'loose'. One article states, 'elderly women in Uganda prescribe to younger women as part of their initiation and socialisation processes that married women should be a Malaya (prostitute) for their husbands, and have to "package" their vaginas for the pleasure of their husbands. Their primary duty is to ensure their husband's sexual pleasure' (Mema, 2012). Cultural taboos on speaking about violence and sex also exist (Kraegel, 2007).

Unplanned pregnancies are extremely common in Uganda and young women are at particularly high risk. Premarital sex is common and many women/girls are sexually coerced or raped, making negotiating contraception impossible. As there is a taboo against premarital sex, young people are reluctant to use family planning services. Furthermore, premarital pregnancy is also stigmatised and can lead to shame and exile. Although abortions are permitted in life-saving situations, there is generally a stigma against the practice (Guttmacher Institute, 2013).

With respect to FGM, associated taboos exist within practising ethnic groups. For example, uncut women are not allowed to milk cows and it is believed that they will contaminate the milk if they do. (See further section on Sabiny below). Additional social stigmas include mental illness, and persons with disabilities face discrimination. There have been recent reports of abuse of children with disabilities in primary schools, and one indicated that 80% of health facilities lacked access ramps (Human Rights Report, 2012). Homosexuality is a taboo subject and LGBT persons face severe societal discrimination, including legal restrictions and the barring of NGOs associated with LGBT campaigns. Finally, there is a social stigma of HIV/AIDS and discrimination against persons with HIV/

AIDS is pervasive, preventing them from obtaining treatment and support, though the government and NGOs are working hard to improve this situation (Human Rights Report, 2011 and 2012).



Women carrying water in North Uganda © 28 Too Many

SOCIOLOGICAL BACKGROUND

ROLE OF WOMEN

Uganda was ranked 73 out of 86 in the 2012 OECD Social Institutions and Gender Index (SIGI). According to SIGI, women face equality challenges in the following areas:

DISCRIMINATORY FAMILY CODE:

Religious customary legal systems discriminate against women, although civil law takes precedence when the constitution has been violated. The Ugandan government proposed the Domestic Relations Bill in 2003, which was intended to reform laws relating to marriage, divorce and property rights. This bill was suspended as of April 2013 (Segawa, 2013). Child marriage is a problem in Uganda and the UN estimates that 32% of girls between the ages of 15 and 19 were married, divorced, separated or widowed. Polygamy is legal and falls under Islamic law. In the event of a divorce, men retain sole parental custody. Furthermore, women do not have the right to inherit and it is common for widows to lose their property.

RESTRICTED PHYSICAL INTEGRITY:

Domestic violence is common in Uganda with nearly 60% of women having experienced some form of violence, despite the Domestic Violence Act being enacted in 2010. Penalties for domestic violence ranges from fines to two years imprisonment, but many law enforcement officials view wife beating as ‘husband’s prerogative’ (Human Rights Report, 2012). Likewise sexual harassment is illegal, with penalties of up to fourteen years of imprisonment, but the law is not properly enforced. Incidents of sexual harassment occur frequently in schools, universities and workplaces.

Rape is also endemic and, although it is a criminal offence, the law is not effectively enforced and the majority of rapes go unreported. Rape is particularly associated with the ongoing violence of the LRA. In 2011 the police registered 520 rape cases and only 269 of those were tried. Part of this low prosecution and conviction rate is due to a lack of criminal forensic capacity to collect evidence (Human Rights Report, 2012). However, since 2009, rape victims have been able to access free medical examinations to assist investigations, with an estimated 10,000 examinations having been carried out at Mulago Hospital in Kampala (Human Rights Report, 2011).

Abortions are legal only in cases where the woman’s mental or physical health is in jeopardy. Contraception knowledge and use has improved in recent years due to the government’s efforts to combat HIV/AIDS. However, use of contraception by married women is low, despite the women’s desires to limit their family size. This is partly due to a low level of communication on contraception between husband and wife.

RESTRICTED RESOURCES AND ENTITLEMENTS:

Although the government has adopted the Land (Amendment) Act of 2004 to improve women’s access to land and property management, discriminatory customary practices are still prevalent. SIGI also states that women have

difficulties accessing bank loans and this is partly because in agricultural practices, women are the unpaid subsistence laborers. Eliminating gender inequality is a high priority for the government and in 2012 there were several workshops held on women’s rights in districts including: Amuru, Lira, Nebbi, Pallisa, Mubende, Kumi, Katakwi, Kween, and Kampala (Human Rights Report, 2012).

HEALTHCARE SYSTEM

The Ugandan Ministry of Health (MoH) is the main body for health governance and it shares responsibilities with other health development partners (public and private) at national and district levels. The MoH is decentralised, meaning that districts control healthcare at a local level. This results in many communities not having adequate funding and resources, including staff and medications. Moreover, the healthcare system continues to struggle since the government abolished patient fees a decade ago, causing a surge in poorer patients using facilities (Dugger, 2011).

It has been reported that 51% of the population does not have access to state-provided healthcare facilities (Human Rights Report, 2011). Furthermore, the MoH is struggling to cope with several health crises, including maternal mortality and HIV/AIDS, but is striving to meet the 2015 MDGs in this area. Although public health facilities are free, in reality healthcare workers are reported to extort money from patients. Clinics often do not have essential drugs, meaning that patients must purchase their medication from pharmacies or drug dealers (Kayuma, 2009).

The healthcare system has a hierarchical structure and is based on referrals. At the first contact level in rural areas, community medicine distributors and village health teams (VHT) volunteer their services. The next tier is a Health Centre II and is supposed to exist for each parish. These facilities are used to treat common diseases like malaria and are staffed by a nurse, midwife and assistants. Health Centre III is the next tier and

these exist in every sub-county. Each facility should have eighteen staff members and a managing officer and they run a general outpatient clinic, maternity ward and some have laboratories. The next level is a Health Centre IV, which services a whole county and operates like a small hospital. Hospitals are the top level (apart from the MoH headquarters) and these include consultants, and specialised clinics for fields such as mental health and dentistry. The national referral hospital is in Kampala. Uganda has some legislation related to mental health, but no comprehensive Mental Health Strategic Plan, or social insurance schemes that cover mental health. The small proportion of financing for mental health goes to referral hospitals with mental health units. Training for mental healthcare remains minimal (WHO, 2006).

There are particular challenges in the provision of healthcare services in the regions in the North East where FGM is practised. In Karamoja Region,

for example, one study found that the health indicators are the worst in the country (decidedly worse than LRA affected northern districts and the rest of the country) and that this was attributed to very low access and use of basic health services (averaging 24% compared to a national average of 72%, compounded by lack of local awareness (UNICEF, 2009). In relation to Kapchorwa district, one study referred to the health system as being 'dilapidated, and with limited drugs, equipment and trained service providers'. In addition, the inaccessibility, poor transportation and communication network, along with low population density make delivery of reproductive health care services to rural communities challenging (Kiirya and Kibombo, 2000).

Health clinic, North Uganda © 28 Too Many



EDUCATION



Schoolgirls in Uganda © Hel080808 | Dreamstime.com

Education in Uganda is provided by the state and the constitution of 1995 guarantees the equal right to education for all citizens (Equal Opportunities Commission Act, 2007). Education falls under the decentralised government scheme, with primary and secondary education being the responsibility of the local governments (Local Government Act, 1997). Higher education is governed by a national council. Pre-school is not compulsory and exists mainly in the private sector in urban areas. Primary education lasts for seven years and is compulsory from age six and tuition-free. According to the revised curriculum (2010), lower primary is from grades 1-3 where education is thematic, there is a transition year 4, and upper primary is from years 5-7, which is subject-based. In their final year, pupils sit the Primary Leaving Certificate examination. Secondary school is only free for the most underprivileged and has two cycles, lower secondary (which is four years and leads to the

Uganda Certificate of Education exam) and upper secondary (a two year cycle finishing with the Uganda Advanced Certificate of Education; a post-secondary education prerequisite) (World Data on Education, 2010/11).

Although there is still a gap in literacy rates (slightly higher rate for men at 90% than for women at 87% in the 15-25 year old age group), this gap has narrowed substantially in recent years (Millennium Development Goals Report for Uganda, 2010). The Ministry of Education and Sports acknowledges that there is a large enrolment gap between primary and secondary education, meaning that many Ugandans stop education after the primary level (Ministry of Education). Financing of education is through: fees, grants, donations, training levies, education tax, and other means deemed appropriate by the Government. In low income households, there is less value placed on educating girls, primarily due to the high costs of schooling (UNESCO, 2011). A further factor contributing to gender equality in primary schools is the lack of adequate sanitation facilities, including female-only toilets (UNESCO, 2011).

Gender inequality in education continues in Uganda, although the government is working towards achieving the 2015 MDG on gender equality and universal primary education (UN Dept. for Social and Economic Affairs, 2011). The government is currently focused on improving and guaranteeing education for marginalised groups, in particular orphans and other vulnerable children (who comprise 46% of the population). With respect to health education, in 1989 the curriculum was revised to include health, population and family life subjects. There are reported cases of corporal punishment being pervasive in primary schools in the greater Kampala area (Human Rights Report, 2012). Sexual harassment is a problem in schools and universities, and there are ongoing investigations on the sexual harassment of students by lecturers from Makerere and Kyambogo universities (Human Rights Report,

2012).

Uganda was fast-tracked by the UN's Education for All Initiative in 2000 under MDG 2 (Achieve Universal Primary Education). The UNGEI report states that although Uganda has made commendable progress in providing access to schooling, evidenced by the massive increase in enrolment after the introduction of universal primary education and universal secondary education, the quality of the education remains inadequate. Girls, particularly those in rural areas, continue to lag behind boys in nearly all access, quality and efficiency standards (UNGEI Uganda

Report, 2012).

There remain particular challenges in relation to education in those regions where FGM is practised. See Education and FGM section below.

Unless otherwise cited, this information is from (World Data on Education for Uganda, 2010-11).

The table below was taken from the 2010 MDG Report on the ratio of female to male at each level of education. Notably it is at 1:1 for primary education and is making significant progress towards equality for the 2015 goal.

| STATUS OF PROGRESS: SLOW | | | | | |
|---|--------|-----------|-----------|------|-------------|
| | 2000 | 2003**** | 2006 | 2009 | 2015 target |
| 2.1 Net enrolment ratio in primary education* | 86% | 101% | 92% | 93% | 100% |
| Boys | 89% | 101% | 94% | 96% | 100% |
| Girls | 82% | 100% | 90% | 90% | 100% |
| 2.2 Net enrolment ratio in primary education* | 63%*** | 56% | 48% | 52% | 100% |
| Boys | n/a | 66% | 55% | 55% | 100% |
| Girls | n/a | 47% | 42% | 48% | 100% |
| | 2000 | 2002/2003 | 2005/2006 | 2008 | |
| 2.3 Net enrolment ratio in primary education* | n/a | 81% | 83% | 88% | |
| Boys | n/a | 85% | 86% | 90% | |
| Girls | n/a | 77% | 79% | 87% | |

Source: ESSAPR (2008/2009); UNHS (2002/2003, 2005/2006) and NSDS (2008).

Notes: * Refers to the ratio of primary school children aged 6-12 years to the number of children of the same age range in the population. ** The primary completion rate is defined as the total number of pupils who registered for primary level education regardless of age, expressed as a percentage of the projected population at the official primary graduation age 12 for primary level 7. *** Year is 2001. **** Measurement errors are likely the cause of the net enrolment ratio exceeding 100% in 2003.

Primary Education Equality in Uganda (Millennium Development Goals Report for Uganda, 2010).

| | 2000 | 2003 | 2006 | 2009 | 2015 target |
|---|----------------|----------------|----------------|----------------|----------------|
| 3.1 Ratios of girls to boys in primary/secondary/tertiary education | 0.93/0.79/0.58 | 0.97/0.82/0.65 | 0.99/0.83/0.73 | 1.00/0.84/0.79 | 1.00/1.00/1.00 |

Secondary Education Equality in Uganda (Millennium Development Goals Report for Uganda, 2010).

RELIGION

Historically, indigenous religions existed in the Kingdom of Buganda but, when the region was opened up by Arabic trade networks in the mid-nineteenth century, Islam paved the way for religion as it offered ‘a “worldview”, a universal explanation of life with all its opportunities and problems’ (Ward, 1991). Christianity came to dominate the region during the late 1800s and subsequently became the dominant religion in Uganda over Islam. Only the regions of the West Nile, Kigezi and Karamoja were untouched by missionary work (Ward, 1991). It was these areas where the population lacked the large kingdoms and cultural cohesiveness that existed in Buganda. It is noteworthy here that it is the Karamoja district where FGM is still most prevalent.

During Amin’s rule Islam was the politically dominant religion, with Amin himself being a devout Muslim and head of the Religious Services. After his overthrow, Muslims became victims of the backlash against those who had supported Amin (Byrnes, 1990). Furthermore, tensions between the Acholi and Langi people in the north and the political centre in the south were heightened through religious tension relating to the acts of the LRA, who were driven by an ideology based on African mysticism, Christianity and Islam.

Freedom of religion is protected under Ugandan law and the government generally respects this freedom in practice. The 2011 Religious Freedom Report states: ‘There were no reports of societal abuses or discrimination based on religious affiliation, belief or practice, and prominent societal leaders took positive steps to promote religious freedom’. The government does, however, restrict religious groups perceived as ‘cults’. In 2012, there were also incidents of mobs attacking persons practising ritual sacrifices and witchcraft (Human Rights Report, 2012). Approximately 84% of Ugandans are Christian; 41.9% being Roman Catholic, and 42% Protestant (Anglican 35.9%, Pentecostal 4.6%, Seventh-Day Adventist 1.5%). Around 12% of the population is

Muslim, 3.1% are classified as ‘other’ (indigenous beliefs, Hinduism, Baha’i Faith or Judaism), and 0.9% are not religious (World Factbook). Religious studies are part of the primary and secondary school curriculum, with three hours of class per week (World Data on Education for Uganda, 2011). This instruction is optional in public schools and is common practice in private education (Religious Freedom Report, 2011).

MEDIA

PRESS FREEDOM

Media is governed by several statutes including The Constitution of 1995, the Press and Journalists Statute (1995), the Electronic Media Statute (1996) and the Uganda Communications Act (1997). It falls under Article 29(1) of the Constitution: ‘Every citizen has a right of access to freedom of speech and expression which shall include freedom of the press and other media.’ However, this freedom is restricted in Article 41(1): ‘Every citizen has a right of access to information in the possession of the State or any other organ or agency of the State except where the release of information is likely to prejudice the security or sovereignty of the State or interfere with the right to privacy of any other person.’ The Media Council’s role is to censor offensive material but in practice, police and other state agents intervene without contacting the council, meaning that it remains ineffective (Pressreference). Before foreign media employees work in Uganda, they must obtain an accreditation card from the Media Council.

Uganda is ranked 104th out of 179 countries by the Reporters without Borders (RSF) 2013 global Press Freedom Index. Media is today an active and prosperous sector in Uganda, but historically it has struggled in the unstable political climate. The ambiguity of the laws is often used in favour of government officials and journalists have experienced unwarranted restrictions on civil liberties. For example, on July 13, 2011 radio journalist Augustine Okello was arrested and held incommunicado for two weeks and then charged

with treason; he was later released from custody without charges after the Human Rights Network for Journalists intervened (Human Rights Report, 2011). State Security Forces (SSF) and government officials occasionally interrogated and detained radio presenters who publicly criticised the government, thus restricting their freedom of speech.

The 2012 Human Rights Report states: ‘The UPF’s Media Crimes Unit closely monitored all radio, television, and print media, and SSF subjected numerous journalists to harassment, intimidation, and arrest.’ Consequently, media practices self-censorship to avoid government harassment which as one article suggests, downplays important political issues in favour of reporting social news (African Media Barometer Uganda, 2012). The Committee to Protect Journalists (CPJ) states that two journalists have been killed since 1992 and in 2012 there were twenty four assaults on journalists, mostly by police during political opposition-related events. Local authorities sometimes prevented journalists from covering public events deemed ‘sensitive’ and that the SSF ‘arrested, assaulted, harassed, and intimidated journalists, and confiscated and maliciously damaged equipment’. This harassment also occurred with some journalists covering sensitive court cases (Human Rights Report, 2012). There were no reports in 2012 for restrictions on freedom of expression via the internet.

MAIN NEWSPAPERS IN UGANDA

DAILIES:

All newspapers are published in Kampala.

- *New Vision* (leading paper, state owned, national circulation)
- *Daily Monitor* (independent)
- *Bukedde* (Luganda language)
- *The Red Pepper* (tabloid)
- *Uganda Confidential* (anticorruption

investigatory paper)

WEEKLIES:

- *The Observer*
- *The Independent*
- *The Razor*
- *Orumuri* (Luo-language)
- *Etop* (Ateso-language)

TRENDS IN MEDIA

On newspapers, one report argued that ‘newspapers play an extremely important agenda-setting role: they are read by the urban, educated elite of policymakers, politicians, business people and academics, and they strongly influence which stories are taken up by radio and television’ (Panos Eastern Africa, 2011). Besides the newspapers listed above, Uganda has a thriving market for tabloids and popular magazines. Radio was dominated by Radio Uganda until the early 1990s. As of 2011 Uganda had 276 radio stations, including CBS, UBC, Sanyu FM and Radio Simba. One survey showed that 68% of respondents listened to the radio daily, and 9% got their news from newspapers, the majority of whom lived in urban areas. Moreover, 89% of households own a radio and signal coverage reaches over 80% of Ugandan territory (African Media Barometer, 2012).

Uganda Television (Uganda Broadcasting Corporation) was the sole television station until the late 1990s; today Uganda has over 72 television channels. In general, television and radio focus on music, political talk shows and news and the majority of television is viewed in urban areas, primarily Kampala. Internet is still a relatively new media platform in Uganda because of broadband and accessibility issues. Facebook is the most popular website. Some newspapers such as *The Monitor* and *New Vision* are also available online and are popular sites (Pressreference). In 2011 approximately 13% of Ugandans used the Internet, and 4.5% of households had Internet

access (International Telecommunications Union). Media plays an important role in the HIV/AIDS campaign, and in the campaign against poverty.

FGM PRACTICES IN UGANDA

TYPE OF FGM

PREVALENCE OF FGM IN UGANDA BY TYPE

Among the Sabinu (Sebei) people Type II FGM (excision) is practised (Refugee Review Tribunal Australia, 2005), although more recently both Types I and II have been reported which may reflect a trend to cut less flesh (Kiiya and Kibombo, 2000). The Pokot primarily practise Type III (UNFPA, 2011). Genital elongation (categorised as Type IV) is practised by the Baganda (Pérez and Namulondo, 2010) (see below).

THE BAGANDA: GENITAL ELONGATION

Genital elongation is the process of gradually stretching the labia minora and is practised by girls before they reach menarche/start menstruation. This practice is sometimes termed female genital modification (FGMo) and there is some debate about its inclusion in the FGM classification as Type IV. Genital elongation is an expansive, rather than reductive practice and it is arguably practised to increase sexual pleasure in men and women, rather than denying it. Female elongation is classed by WHO as FGM because of the pressure on young girls to perform it, and the resulting permanent anatomical changes it creates. This type of FGM has received far less attention than the reductive forms, though it also involves significant health risks and violates human rights (Grassivaro Gallo and Busatta, 2009). The Baganda people from the Wakiso district are the primary practising group in Uganda, although it is also found among the Bagisu, Bakiga, Banyankole, Banyoro and the Batolo (Grassivaro Gallo and Busatta, 2009). The Baganda call this procedure okukyalira ensiko ‘visiting the bush’, because it is practised in secluded forest clearings; it is a cultural rite of passage for a girl to transition into womanhood and be eligible for marriage.

For the Baganda, the construction of gender

is dependent on social and cultural practices like genital elongation, and not just biology (Sylvia Nannyonga-Tamusuza, 2001 as cited in Grassivaro Gallo and Busatta). This ceremony gives the girl’s father special status and his ‘manhood’ is reflected by her genital elongation (Grassivaro Gallo and Busatta, 2009). Stretching occurs between the ages of 9 and 16 and the girls must elongate their labia minora up to a minimum of one and a half inches before they start menstruating. The process can also be repeated after giving birth. Health risks include: discomfort, pain, swelling, bleeding, neurosensitivity, anxiety, and infection. Infection is common due to dust, ashes, corrosive herbs, and manufactured creams being used to prevent fingers from sliding when stretching. This practice occurs in rural areas as well as in urban and suburban areas around Kampala. It has also been adopted by non-Baganda women and some seek commercial assistance to elongate their labia.

One study by Pérez and Namulondo interviewed thirty one Baganda men with daughters to understand their perceptions of genital elongation and to plan sexual health education programmes in order to minimise the risks of the practice. The interviewees claimed that the practice was a necessary cultural ritual and that genital elongation brings greater sexual pleasure. These men were generally ignorant of how the practice is performed as discussing sexual issues with their daughters is a cultural taboo. They also interviewed ssengas or ‘aunties’ who are mentors responsible for educating Baganda girls in reproductive issues and marriage duties. The study notes that because girls often go away to boarding school, peers and teachers, or even hired ssengas, have adopted the role of assisting in genital elongation.

Unless otherwise stated, all information from Pérez and Namulondo, 2011.

FGM IN UGANDA BY ETHNICITY

Ethnicity appears to be the most determining influence over FGM within a country (UNICEF, 2005). FGM is practised in only select ethnic groups in Uganda. The prevalence rate of FGM is

low when considering the country's population. The table below puts FGM practise in Uganda into perspective by showing the total population

| Ethnic Group | Male | Female | Total | % of Total Population |
|------------------|--------|--------|---------|-----------------------|
| Sabiny | 89,413 | 91,181 | 180,594 | 0.8 |
| Pokot | 37,702 | 32,655 | 70,357 | 0.3 |
| Tepeth (So) | 10,606 | 10,921 | 21,527 | 0.1 |
| Nubi | 12,919 | 13,145 | 26,064 | 0.1 |
| Somali Refugees* | n/a | n/a | 14,240 | |

Uganda Bureau of Statistics, 2002. *Somali Refugee population as of January 2013 (UNHCR, 2013).

In terms of the districts and the sub-counties where action is critical, see table below.

| District | Total Population of District | Number of sub-counties where action is critical |
|----------------|------------------------------------|---|
| Kapchorwa | 87,000 | 5 – all sub-counties |
| Nakapiritpirit | 154,494 | 1 – Mourita sub-county |
| Moroto | 128,311 (after Napak is taken off) | 2 – Katikekile and Tapak sub-counties |
| Amudat | 95,900 | 4 – all sub-counties |
| Bukwo | 58,300 | 8 – all sub-counties |
| Kween | 85,000 | 9 – all sub-counties |

UNFPA, 2011.

ETHNIC GROUPS PRACTISING FGM

IN NORTH EASTERN UGANDA

The Sabiny, Tepeth (in the Moroto district), Pokot (in the Amudat and Nakapiritpirit districts) and Kadama (in Nakapiritpirit district) all practise FGM. They are ethnic cousins of the Maasai from Kenya/Tanzania, who also practice FGM.

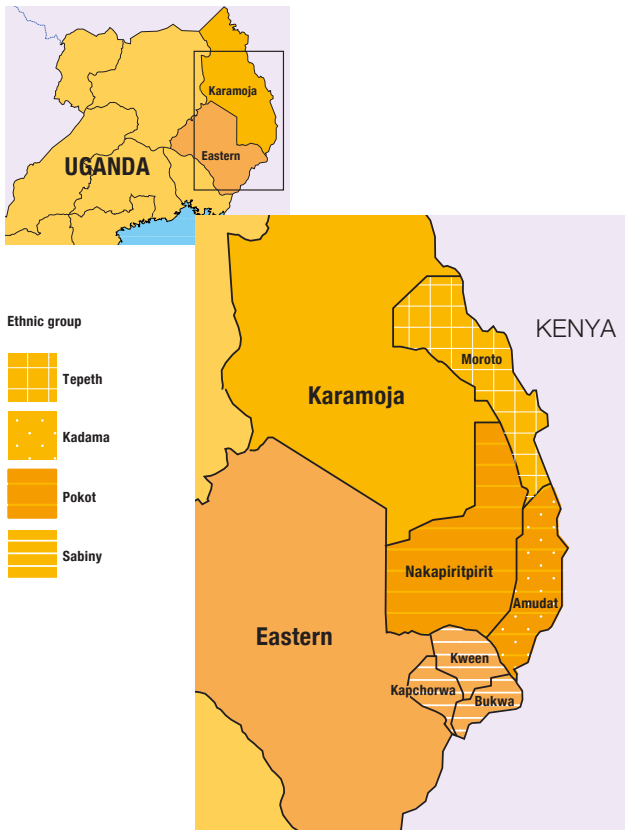
Among the Pokot, FGM is near universal at 95% and the practice is estimated at approximately 50% among the Sabiny (UNFPA, 2011). FGM in Uganda remains a practice associated with particular ethnic groups, deeply rooted in traditions and happening on a local rather than national level.

numbers for the ethnic groups that participate in FGM.

With education about the dangers of the practice being a key factor, it is in the remote un-sensitised areas where FGM is practised. Generally, those who are most vulnerable to FGM in Uganda are young girls or young mothers, from the above mentioned ethnic groups, not educated, impoverished and of agricultural or pastoralist backgrounds. The origin of FGM in Uganda is difficult to trace. For the Sabiny, controlling women's sexuality was an integral component of the cattle herding lifestyle. Founder of the NGO REACH, Martin Chelangati, suggests that because the Sabiny were pastoralists, the men were absent for long periods of time and the women resorted to finding other men. Thus, FGM was practised to control the Sabiny women's sexual desires (Namulondo, 2009). For the Pokot, the aspect of controlling women's sexuality was the same. The Tepeth adopted the practice recently in the 1990s due to sharing pastoral resources with the Pokot and intermarriage (Miti, 2012).

Pokot girls, photographed by Betty Maureen Chelangati @ Godparents Association





Ethnic Groups in North Eastern Uganda © 28 Too Many

SABINY

ANTHROPOLOGICAL BACKGROUND

The Sabiny (also called the Sebei, Sabei, Sapei and Sabyni) are a small ethnic group and they live in and around the Kapchorwa, Bukwo and Kween districts in North Eastern Uganda, on the Ugandan side of Mount Elgon. During British rule, the Sabiny were administered as a county in Bugisu district. The Bagisu and Sebei are culturally and linguistically very different. The Sabiny complained of being marginalised during the years it was part of Bugisu, and by the eve of independence of Uganda, Sabiny councillors had stopped attending council meetings in Mbale, accusing councillors from Bugisu of deliberately stifling the development of Kapchorwa. They vowed not to have any dealings with Bugisu district and demanded separation. The government yielded and Sebei district was born in 1960. As Uganda was becoming independent from Britain, so Sebei became independent of Bugisu. In 1980, the

government renamed the administrative units and Sebei district became Kapchorwa district. Kapchorwa district has now been divided into three districts: Kapchorwa, Kween and Bukwo (Masaba, 2012). The Sabiny speak Kupsabiny, a Kalenjin dialect.

Traditionally the Sabiny are pastoralists but they have become mainly agriculturalists as grazing land has become limited. Despite this, cattle are still the primary measure of wealth. It has been argued that the Sabiny are very superstitious, fearful of death and of women and their supposed 'supernatural power as witches, and their secular power as shrews'. The Sabiny are also described as being profoundly jealous and hostile (Benintendi, 2004). This guarded nature and distrust in women could be a contributing factor to their continued practice of FGM.

TYPE OF FGM & AGE

The type of FGM varies according to geographical location. One study showed that 31% of women/girls had the clitoris removed (Type I), 36% had the clitoris and labia minor removed (Type II), and 27% had the clitoris, labia minora and majora removed (Type III). Type III was not reported. (Kiirya and Kibombo, 2000).

FGM is usually performed on girls aged 12-15 who are reaching maturity for marriage (Horsfall and Salonen, 2000). 28 Too Many research supports these findings, but also extends the age at which FGM can be carried out to as young as the age of 10. Even for women that do not undergo FGM as girls, there is a risk of being cut after marriage due to pressure from her in-laws (28 Too Many in-country research).

One report states that the Sabiny only cut in December of even-numbered years (UNFPA-UNICEF, 2010). In Sabiny areas, however, it is reported that cutting now takes place any time and many do not wait until the normal even-numbered year and cutting is done at night rather than with public ceremony, due to the outlawing

of the practice (Godparents Newsletter, December 2012).

REASONS

Within the Sabiny, FGM is practised as a rite of passage for a girl into womanhood, but is also carried out following marriage due to societal pressure. Women who do not undergo FGM are stigmatised (see below). Custom, the preservation of chastity and fidelity, social acceptance and marriageability are the key reasons FGM is practised by the Sabiny (Womankuyu, 2010). FGM is a traditional rite of passage into womanhood. FGM is considered by many village elders to be a ritual sanctioned by their ancestors; a practice that has existed for over 2,000 years as a means to convert female community members from childhood to adulthood (Womakuyu, 2010). For the majority of the organisations surveyed by 28 Too Many, marriage prospects and rite of passage were cited as the two most important reasons for practising FGM (28 Too Many questionnaires). Like for the Pokot, FGM is related to bride price. For the Sabiny, this dowry can be 5-12 heads of cattle and goats, hens and other items like clothes, utensils and money (Kuka, 2004). Undergoing FGM brings pride to the family and often the girl is presented with gifts (Anguia, 2008). Finally, the Sabiny believe that the practice of FGM distinguishes their culture from other Ugandan ethnic groups. (28 Too Many in-country research).

PREVALENCE AND TRENDS

According to REACH, the cases of FGM among the Sabiny people have declined in recent years.

The increase in prevalence in 1998 can be attributed to a backlash among the Sabiny to the REACH programme (see Challenges Faced by Anti-FGM Initiatives below).

TRADITIONAL EXCISORS ('SURGEONS')

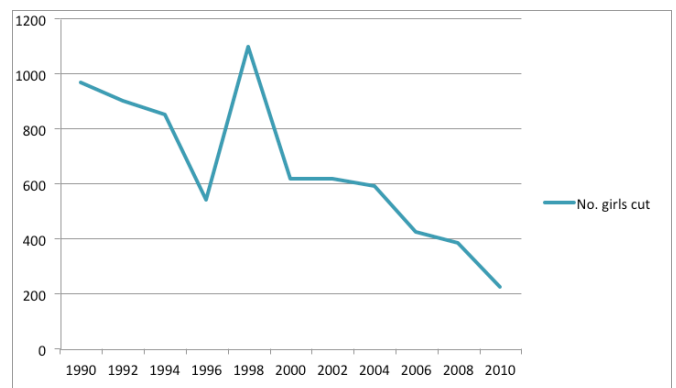
The women within the communities who carry out FGM are referred to as 'surgeons', although they have no medical training. They are usually between the ages of 40-70 (Refugee Review



Sabiny musicians in traditional dress, with traditional instruments, at Culture Day 1998, © Godparents Association

| | |
|------|-------|
| 1990 | 971 |
| 1992 | 903 |
| 1994 | 854 |
| 1996 | 544 |
| 1998 | 1,100 |
| 2000 | 621 |
| 2002 | 619 |
| 2004 | 592 |
| 2006 | 426 |
| 2008 | 385 |
| 2010 | 197 |
| 2012 | 120 |

Cases of FGM by Year in Kapchorwa and Bukwo districts (REACH)



Cases of FGM by Year in Kapchorwa and Bukwo districts (REACH)

FGM as part of initiation ceremonies of the Sabiny

FGM is part of an important ritual celebration among the Sabiny. Traditionally the celebration lasts three weeks as is comprised of FGM on girls of around 15 years old and circumcision of boys of 17 or 18. Once the season is declared open by the elders, for about three weeks male circumcision candidates run through the villages of the district, collecting gifts from friends and relatives, who often join in the run to the next village. During this time, a boy collects the foundation for the bride price to be offered for a newly cut girl to be his wife.

Female cutting candidates do not tour the district but remain in the family home, where they are prepared for FGM. On the night before the cutting, age cohorts and school mates gather together, separated by gender and dance and sing through the night. At dawn the 'secrets' and history of the culture are imparted to the initiation candidates. Young men and women are exhorted never to reveal their tribal secrets to uncircumcised Sabiny or to outsiders.

Cutting is performed in separate locations; traditionally men could not be present during the girls' ceremonies, but this appears to have changed somewhat in recent years. Sabiny girls are expected to be brave during the procedure and are not restrained. After the excision, the girls are allowed to recover without much aftercare. The wound is traditionally treated with cow's urine. FGM often now happens in secret without much ceremony as a result of the law (28 Too Many in-country research, testimony of former excisors).

Tribunal Australia, 2005). Sabiny excisors are paid for their services and can receive payment in cash up to (the equivalent of) US\$30 per girl, or payment in kind (chicken, meat, local brew (Komek)). One traditional surgeon has stated that circumcising girls is her only means of living and it enables her to educate her children (Refugee Review Tribunal Australia, 2005).

They are well known and highly respected, however few excisors exist in Kapchorwa.

Whenever there are a large number of girls to be cut, most of them come over from the Kalenjin ethnic group in Kenya (Kiirya and Kibombo, 2000). In Sabiny practice, surgeons do the majority of the cutting, although they do not participate in the accompanying celebrations. Traditional birth attendants (TBAs) can be involved to finish a poorly executed procedure. TBAs may also refer women to excisors if they have not been cut (28 Too Many in-country research). Since FGM was criminalised, many excisors have denounced their roles but others continue to practise in secret (28 Too Many in-country research).

Highly respected members of the community who act as mentors/guardian also have an important role to play. They help mentally prepare the girls/women to undergo FGM. They check that the excision was done 'well', collect the blood that spills, ensure that the cut genital parts are properly disposed of and nurse the girls/women. They are also paid by the parents for their role (Kiirya and Kibombo, 2000).

STIGMATISATION AND TABOOS

Married women who have not undergone FGM are subject to discrimination that has become institutionalised within Sabiny culture. Un-cut women cannot take up positions of responsibility within the community, climb into the granary for grain, step into the kraal (cattle enclosure) to collect cow-dung for smearing onto houses or milk cows, or serve food to elders. Taboos are associated with these norms if a women contravenes them. For example, it is believed that if an uncut woman milks a cow, because they are seen as 'unclean', they will contaminate the milk (Kiirya and Kibombo, 2000). Superstitions such as 'if the clitoris touches a man's penis the man will die' and 'if a baby's head touches the clitoris the baby will die or the breast milk will be poisonous' have also been noted (FGM Education and Networking Project, 2009). Although one study suggests that these are taboos are being abandoned, they still provide a firm foundation for the continuance of FGM (Kiirya and Kibombo, 2000).

POKOT



Pokot girls gather on their coming out day, when the seclusion period has ended after FGM. Their seclusion hut is in the background. © Godparents Association

The Pokot (also called the Upe) live in the North Eastern part of Uganda, especially in the Nakapiripirit district, as well as in Amudat and Moroto districts. The Pokot, whose name means 'survivors', were originally from Kenya but were relocated to Uganda by the British administration to occupy part of the Pian territory. They are also called the Suk and are related to the Kenyan West Pokot (Minority Rights Group International, 2001). The Pokot span Ugandan/Kenyan border and many have identity cards for both countries (Godparents Association Newsletters, March 2012).

The region has a long history of neglect and abuse, including the government's attempts at forcing a sedentary lifestyle, beginning in the

British era. Though the development of Karamoja was part of Museveni's Ten Point Programme, the problems of isolation, insecurity and poverty remain (Godparents Association Newsletter, February 2012). Based on regional and cultural differences, the Pokot people can be divided into two groups: the Hill Pokot and the Plains Pokot. The Hill Pokot live in the rainy highlands in the west and in the central south of the Pokot area and are both farmers and pastoralists. The Plains Pokot live in the dry and infertile plains, herding cows, goats and sheep. Pokot values are community based not individual-centred, and decisions are made by the elders (Godparents Association Newsletter, March 2012). Women from Karamoja are the most frequent out-migrants to Ugandan cities (Godparents Association Newsletters, August 2012).

For the Pokot, FGM occurs between the ages of 9 and 14, and it is a requirement for marriageability (Lokor, 2012). The Pokot practise Type III infibulation (UNFPA, 2011). Both the Pokot and the Tepeth cut their girls every year from July to September (UNFPA-UNICEF, 2010). Once married, a woman's risk of FGM decreases as her parents no longer have control over her. However, many men still do not accept a woman as a wife unless she has been cut.

FGM is a mark of cleanliness and chastity and therefore uncut older women can still face FGM due to societal pressure (28 Too Many research). FGM is a ritual practice for the Pokot that is said to promote cleanliness and chastity. FGM helps ensure a good bride price and for the Pokot, and this can be up to 60 heads of cattle depending on the groom's wealth (Kuka, 2004). Such is the pressure to be cut that girls have even resorted to cutting themselves (Godparents Association Newsletter, April 2011)

TEPETH

The Tepeth (also called the Soo, So, Tepes, Teu) are located in North Eastern Uganda in Moroto district, Napak and Kadam mountains border. They

are an agricultural society. If a harvest is bountiful, the village elders permit a ‘cutting ceremony’, in which girls aged 11 to 14 undergo FGM as a rite of passage. The ceremony is performed with a blunt knife and all or a portion of the external genitalia is removed (Type I and Type II). Once cut, the girls heal in seclusion in the remote mountains for up to three months. The parents send food, but only the excisor is permitted to see them. Further rite of passage ceremonies mark the healing process before the girls are reunited with their families.

After this process, girls are eligible for marriage offers, accompanied by a dowry given to the bride’s family, usually as cattle. UNFPA notes that it is common for older men – who have greater access to wealth and higher status – to marry additional young wives, and they are the individuals who demand that their wives be cut. (UNFPA, 2013). Among the Tepeth, FGM is also associated with bride price and child marriage and related to concepts of womanhood, marriage and purity. As in all practising communities, it is also interwoven with economics, identity and power roles that are integral for the community to function (UNFPA, 2013). Community level change is thus required before FGM can be eradicated. For more information on FGM eradication efforts in Tepeth groups, see entry in the NGO section on ASB and UNFPA-UNICEF Joint Programme.

KADAMA

The Kadama live on Mount Kadam in Nakapiritpirit district in the Karamoja region. They are closely related to the Tepeth and some regard them as a sub-group of the Tepeth. Although little has been written about them, local oral history tells that the Kadam, along with the Tepeth (and other groups) lived in what is present-day Karamoja and took refuge in the mountains when the Karamojong arrived from Ethiopia in the 1600s.

OTHER GROUPS THAT PRACTISE FGM

NUBIANS

Nubians in Uganda are descendants of Sudanese military recruits who entered Uganda in the late nineteenth century as part of the army employed to quell popular revolts. Nubians had varied ethnic origins, but many spoke Western Nilotic languages similar to that spoken by the Acholi people, their closest relatives in Uganda. Today, many Nubians also speak a variant of Arabic, and are Muslims (U Penn., Uganda Ethnic Groups). The Nubi are found in Bombo, 50 kilometres north of Kampala, Arua, and elsewhere; living near military installations. Owing to their ancestral identification with Sudan, Nubians face discrimination in employment, and are somewhat removed from Ugandan society (Minority Rights Group International, 2001). They are believed to practice FGM (BBC, 2009). There is, however, very little data available on FGM among the Nubi.

SOMALI

There is a minority population of Somali refugees/migrants living in Uganda, primarily in Kampala. FGM is practised at a very high rate in Somalia and this tradition continues to be practised by Somalis who have migrated (Independent, 2013).

RELIGION AND FGM

There is no specific data on the prevalence of FGM by religion available for Uganda. However, the table below illustrates the religions practised by ethnic groups who engage in FGM. This gives a sense of religious diversity of FGM practices

| Ethnicity | Catholic | Anglican/ Protestant | SDA | Orthodox | Pentecos- tal | Muslim | Traditional | Others |
|------------------------------|----------|-------------------------|-----|----------|------------------|--------|-------------|--------|
| Pokot | 27.8 | 7.5 | 0.0 | 0.0 | 0.5 | 0.7 | 49.2 | 14.3 |
| Sabiny | 23.4 | 40.5 | 0.6 | 0.1 | 18.3 | 9.7 | 0.3 | 7.0 |
| Tepeth | 75.5 | 1.0 | 0.0 | 0.0 | 0.02 | 0.05 | 18.3 | 4.7 |
| *Nubi (Nu- bians) | 2.5 | 1.8 | 0.3 | 0.1 | 0.6 | 94.4 | 0.0 | 0.3 |

Uganda Bureau of Statistics, 2002.

As in other countries, FGM predates religion and is not exclusive to one religion. FGM has been justified under Islam yet many Muslims do not practise FGM and many agree it is not in the Qur'an. Within Christianity, the Bible does not mention the issue of FGM, meaning that Christians in Africa who practise FGM do so because of a cultural custom. FBOs and officials are involved in the eradication of FGM. In 2006, Target sponsored a conference between Muslim scholars from many nations; they deemed FGM to be against the Islamic faith as it is a harmful attack on women (Target, 2006).

More than 80% of Ugandans are Christian, Anglicans or Roman Catholics, the remainder being Muslim. Leaders of both established churches have spoken out against FGM. In both the districts of the Pokot and Sabiny faith leaders have spoken against FGM to little effect. It is, however, among the increasing number of Ugandan 'saved' or born again churches that action is being taken to combat FGM. (Godparents Association Newsletter, August 2011). Such churches include the Pentecostal and Body of Christ Churches. One study explained how, following the overthrow of Amin and the relative improvement in the freedom of religion, the Body of Christ Church intensified advocacy and spiritual campaigns against FGM through open air crusades, Sunday church services, seminars,

in Uganda. In relation to the ethnic groups that practise FGM, the 2002 census shows that traditional beliefs are prevalent amongst the Pokot, various forms of Christianity amongst the Sabiny and Tepeth, while the Nubi are predominantly Muslim.

fellowship, ordaining elders as church leaders and anti-FGM campaigners. As a result, a number of uncircumcised girls who joined the Body of Christ Churches after being rejected by their families and leaving school were sponsored by the Church until they had finished school (Kiirya and Kibombo, 2000). Such churches are often opposed to FGM because of its association with witchcraft (some excisors ritually revere their cutting instruments and some claim supernatural power over women through witchcraft using the cut genital parts) (Godparents Association Newsletter, August 2011). They also believe that FGM is one of the ways in which the temple of God (the body) is defiled (Kiirya and Kibombo, 2000).

Some churches in the Kapchorwa and Bukwo districts have aligned with the Inter African Committee Uganda (IACU) and REACH to combat FGM among the Sabiny and Pokot. One pastor in the Bukwo district declared that FGM is a covenant and the resulting blood is a curse. He argued that the practice is not biblical and that the churches

'We claim it's our practice but biblically it's wrong, therefore the churches must come in full to fight against it' (Pastor in Bukwo district)

must fight against FGM (Aeiong, 2011). The Pentecostal and Body of Christ Churches dissuade members from undergoing FGM or getting their daughters cut. Their strategies include excluding persons from church if they participate in FGM, preaching against immoral behaviour associated with the initiation ceremonies, prayer and counselling. This has enabled the Church to get many converts and discourage women and girls from undergoing FGM (Kiirya and Kibombo, 2000). The Church has also protected girls and promotes marriage within the Church community, therefore providing marriage prospects for girls who have not undergone FGM (Godparents Newsletter, August 2011). A former Pokot excisor attributed her decision to retire to the teaching of the Church, an indication that religion can have influence and is beginning to reach out to people in rural areas of Uganda (Desert Flower, 2011).

A 2009 report of the Pokot in Kenya states that: ‘The most significant decrease in the practice of female circumcision is observed in areas that have had schools for a long time and where the Church is well established compared to marginalised sections of the larger Pokot district where communities are yet to embrace girl child education and Christianity.’ The Church is seen by the community as a ‘unique platform in influencing at stopping this practice’ (Kristensen and Nairesiae, 2009).

28 Too Many interviews with both the Pokot and Sabinu people have revealed that work by religious groups has had some effect, but that cultural changes have a stronger influence. One spokesperson for the Pokot states that religious groups within the Pokot have publicly spoken against FGM and that the majority of Pokot are Christian, though few actively practise. Instead, many Pokot groups practise local traditional religions (and witchcraft) and because of this, culture plays a larger role than other religions in FGM. The spokesperson also noted that the Pokot lack development education and that the Pokot Elders Association views FGM as part of

their cultural rite, without considering the law, human rights perspective, or medical dangers of the practice (28 Too Many in-country research). Among the Sabinu, religious leaders for both Islam and Christianity denounce FGM. Programmes facilitated by local organisations for community dialogue have successfully involved religious leaders from both religions in the district.

WOMEN’S HEALTH AND

INFANT MORTALITY

There are numerous health concerns associated with FGM. Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue, such as causing fistula (incontinence) from cutting through the urethra. Long-term consequences can include recurrent bladder and urinary tract infections; cysts; infertility; an increased risk of childbirth complications and newborn deaths and the need for later surgeries. For example, Type III infibulation needs to be cut open later to allow for sexual intercourse and childbirth (WHO, 2013). There are reports that women who have undergone FGM have reduced sexual desire, pain during intercourse, and less sexual satisfaction (Berg and Denison, 2011).

In relation to psychological issues surrounding FGM data suggests that following FGM, women were more likely to experience psychological disturbances (have a psychiatric diagnosis, suffer from anxiety, somatisation, phobia, and low self-esteem) (Berg and Denison, 2011). More research is needed to understand better the relationship between FGM and consequential psychological, social and sexual problems (Berg and Denison, 2011). A recent study on FGM in Iraq showed that girls who have undergone FGM are more prone to mental disorders, including post-traumatic stress disorder (PTSD). Among 79 circumcised girls studied in the Kurdistan region of northern Iraq, the study found rates of mental disorders up to

seven times higher than among uncircumcised girls in the same region but comparable to rates among girls who had suffered early childhood abuse: 44% suffered PTSD, 34% depression, 46% anxiety, and 37% somatic disturbances (symptoms unexplainable by physical illnesses). The girls studied were aged 8-14 and had not otherwise suffered a traumatic event (IRIN, 2012).

It is reported that in Uganda, every Sabin family is said to have at least one casualty of FGM, and it the deaths of their sisters that have led to many joining anti-FGM campaigns in the Kapchorwa district. Dr Michael Muwanga, the sole doctor practising in Bukwo District, has attributed FGM for the very high numbers of mothers dying during birth in Bukwo, (520 deaths per 100,000 deliveries, compared to 310/100,000 for Uganda as a whole) (Mafabi, 2009). Olive Chelukett Avelle, a Kapchorwa midwife, told the Godparents Association that she always feared the outcome when assisting a woman who had undergone FGM

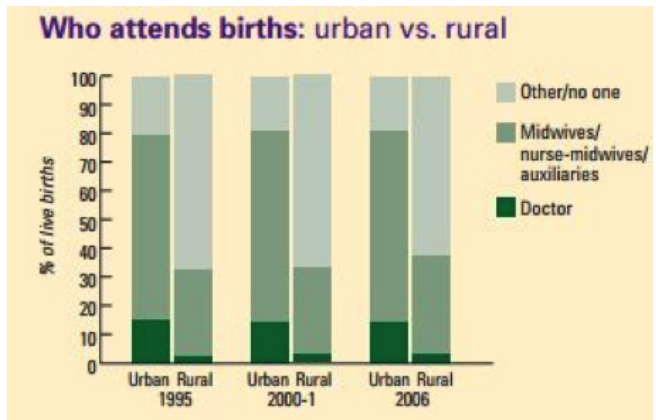
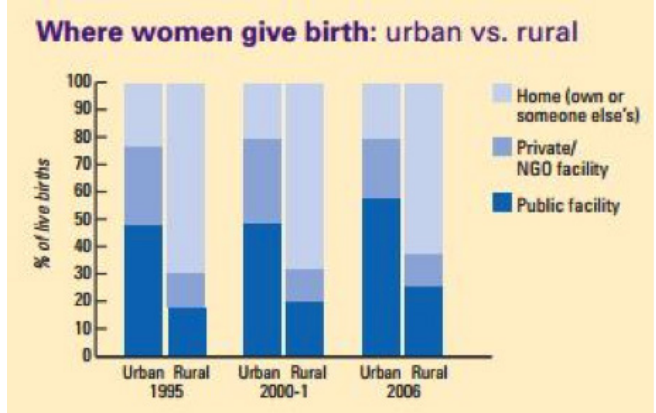
'In Uganda, every Sabin family is said to have had at least one casualty of FGM' (Godparents Association)

went into labour. Due to extensive scarring caused by Sabin excision, a 'normal' delivery requires a bilateral horizontal cut in the mother's body once the baby's head is visible.

An inexperienced birth attendant may need to make multiple cuts and sometimes the baby is injured, and the mother may haemorrhage. Sabin and Pokot midwives do not suture the incisions after delivery and infections are common (Godparents Association Newsletter, March 2013). In relation to the increased risk of birth complications a WHO multi-country study, in which over 28,000 women participated, confirmed that women who had undergone FGM had a significantly increased risk of adverse events during childbirth.

Higher incidences of caesarean section and post-partum haemorrhage were found in the women with Type I, II and III FGM compared to uncut women and the risk increased with the severity of the procedure. The consequences for women not giving birth in a hospital setting are likely to be even more severe (WHO, 2006). The high incidence of postpartum haemorrhage is particularly concerning where health services are poor or inaccessible (WHO, 2008). As with other areas of Ugandan health care, maternal health lacks both physical and human resources. With seven midwives per 1000 live births and 653 birth complications per day, 85% of these occurring in rural areas, it is difficult to ensure that a trained midwife is present at each birth. Midwifery is a government regulated profession, with around 9,701 midwives and 144 obstetricians in Uganda (UNFPA, 2011a).

The WHO also showed that death rates among newborn babies are higher to mothers who have had FGM. There was an increased need to



Births in Uganda by location and by attendants (UNFPA, 2011a).

resuscitate babies whose mothers had undergone FGM (66% higher in women with Type III). The death rate among babies during and immediately after birth was also much higher for those born to mothers with FGM: 15% higher in those with Type I; 32% higher in those with Type II; and 55% higher in those with Type III. The study estimated that FGM leads to an extra one to two perinatal deaths per 100 deliveries (WHO, 2006).

| | |
|--|-------|
| Infant mortality rate (under 1), 1990 | 106 |
| Infant mortality rate (under 1), 2010 | 63 |
| Neonatal mortality rate, 2010 | 26 |
| Total population (thousands), 2010 | 33425 |
| Annual no. of births (thousands), 2010 | 1514 |
| Annual no. of under-5 deaths (thousands), 2010 | 141 |

UNICEF statistics on infant mortality in Uganda

Another WHO-sponsored study is examining the association between FGM and obstetric fistulae. The pilot study indicated that there may be an association but the final results are not expected until the end of 2013. In addition, a multi-country modelling study was set up to estimate the increased costs in obstetric care due to increased obstetric complications as a result of FGM. The annual costs was estimated to be US\$ 3.7 million and ranged from 0.1 to 1.0% of government spending on health for women aged 15-45 years (WHO, 2011).

EDUCATION AND FGM



‘Education is the key to this child’s future’ motto underneath Uganda’s coat of arms and motto, © 28 Too Many

In many cases, FGM has a negative impact on a girl’s education. One of the key causes of low completion of education among girls is FGM (Ministry of Gender, Labour and Social Development cited in the UNGEI Uganda Report, April 2012). Girls are taken out of school to be cut and the healing time takes several weeks, resulting in further school absence. Moreover, as FGM is considered by many groups to be a rite of passage into womanhood, it is likely that a girl’s education will end in order for her to be married. Studies have shown that education influences perceptions of FGM and that educated women are more aware of the health consequences. There is, therefore, a general correlation that the higher a woman’s education level is, the less likely she is to be in favour of FGM (Population Reference Bureau, 2001).

Most anti-FGM programmes in Uganda are education-based and in many cases, girls who

receive education from programmes decide to decline the practice and, further, communicate the dangers of FGM to their community (Namulondo, 2009). For example, Shara from the Kokop region made the decision not to get cut. Her choice was reinforced by school-based sessions on life-planning skills. Most schools in the region have introduced life skills planning as part of the informal curriculum (People and Planet, 2010). However, some have argued that schools are not the ideal setting for learning about sensitive and intimate issues, especially as many children are not enrolled in school and sensitisation needs to reach all levels of the community (WHO, 2008).

Beatrice Chelangat, the director of REACH says that the low levels of girl education in Bukwo are to blame for the continuing FGM. Chelangat comments, 'A girl who has completed a full course of primary education or reached form four, is more likely to denounce the practice'. It is estimated that 90% of Sabinu girls are married off before they turn 15 (Chekweli, 2011). Everline Tete, the female MP for Bukwo district, claims that FGM persists because of cultural attitudes, the failure to value girls' education and the high level of illiteracy among women (Masinde, 2013).

The Pokot have been historically resistant to education, and this is partially connected to the political influence of Uganda's education. Education is seen as a way to bring problematic pastoralists under state control, to seditarise and integrate them. However, formal schooling does not accommodate traditional pastoralist lifestyles. Karamoja (where Pokot districts of Amudat and Nakapiritpirit are located) have very low school attendance and test scores and empty classrooms. The region's literacy rate is the lowest in Uganda (12% men; 6% women). Moreover, 50.3% of girls and 49.7% of boys of school age have never accessed education (UNGEI, 2006). Drop-out rates increase as much as 70% if the government does not take up food distribution in the region. Aid organisations have continued to build more schools, but these results are invisible

'One of the key causes of low completion of education among girls include FGM' (Ministry of Gender, Labour and Social Development).

or short-lived as most NGOs are perceived locally as more corrupt in Karamoja than anywhere else in Uganda (Guardian, 2011, reporting particularly on food aid).

In the Amudat District, it is estimated that 95% of the girls do not complete primary seven due to FGM (Miti, 2012). This statistic is not unique to the Amudat district, as a path to womanhood and marriage marks the end of education for many girls. In his 2011 research as a student at Makerere University on FGM among the Pokot, Ambrose Tityon found that nine out of ten girls he interviewed in Amudat were not in school, but girls who reach Primary 7 and secondary school are at very low risk of being cut. Since education is only gradually gaining value, Tityon stressed the importance of sensitising girls to attend and remain in school, and this is the first step in combating FGM (Godparents Association Newsletter, October 2011). A report on the Pokot over the border in Kenya found that: 'The most significant decrease in the practice of female circumcision is observed in areas that have had schools for a long time and where the church is well established compared to marginalised sections of the larger Pokot district where communities are yet to embrace girl child education and Christianity' (Kristensen and Nairesiae, 2009).

One report on the UNFPA/UNICEF Joint Programme highlights the lack of education in Moroto District. The report highlights that some sub-counties in Moroto do not have a primary school. In addition Moroto District has a history of being dependent on food support by the World Food Programme. After food support to schools was withdrawn by the World Food Programme, there has been a reduction in the number of children in school (Weber, 2012).

Literacy rates for the Ugandan population were reported at 66.8% (male 76.8% and female 57.7%) in the 2002 census. Literacy rates are generally low in areas where FGM occurs and thus education for the whole community needs to be factored in for FGM sensitisation programmes to be effective.

A novel approach to education adapted to the pastoralist lifestyle

Save the Children, together with the District Local Governments, launched a scheme in 1998 that tried to fit education around the pastoralist lifestyle and is now called the ABEK (Alternative Basic Education for Karamoja). ABEK is a non-formal approach designed to provide basic education to children from pastoral communities. It targets children aged 6-18 years and has mainly been held close to homesteads. It provides education that is flexible, with flexible hours and a curriculum that is context-based and relevant. By 2006, ABEK had enabled 32,770 children in Karamoja to access education 2,536 of these into formal schools. The programme has been a great success. Some studies revealed that 85% of the children enrolled were girls as most boys were away in cattle camps (kraals). The programme was then extended to 20 mobile kraals. The programme has had challenges in Pokot areas since the whole community leaves the homestead (manyatta) during migration seasons, leading to low enrolment rates (Save the Children Norway, 2006 and 2011).

FGM BY AGE

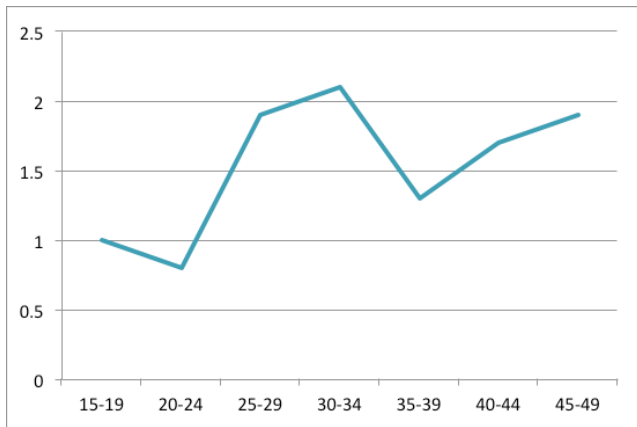
There are varying sources stating the age at which FGM occurs, in general within Uganda it appears that those subjected to FGM are young girls (often early teens) or young women, (18+), who had previously avoided being cut. Among the Sabiny, FGM is usually performed on girls aged 12-15 who are reaching maturity for marriage (Horsfall and Salonen, 2000). 28 Too Many research supports these findings, but also extends the age at which FGM can be carried out to as young as the age of 10. For the Pokot, FGM occurs between the ages of 9 and 14 and for the Tepeth it is between the ages of 11 and 14 (see section on FGM by Ethnicity). It should be noted that the legal age of consent is age 18, however some groups like the Sabiny and Pokot mark adulthood by FGM and marriage and therefore their FGM practices often go against legislation on child marriage.

| | 2006 | 2011 |
|--------------|------|------|
| Total | 0.6 | 1.4 |
| 15-19 | 0.5 | 1.0 |
| 20-24 | - | 0.8 |
| 25-29 | - | 1.9 |
| 30-34 | - | 2.1 |
| 35-39 | 0.8 | 1.3 |
| 40-44 | - | 1.7 |
| 45-49 | - | 1.9 |

Prevalence of FGM in women and girls by age (%) (DHS 2011)

| Age | % of women who have heard of FGM | % of women who have had FGM |
|-------|----------------------------------|-----------------------------|
| 15-19 | 47.9 | 1.0 |
| 20-24 | 60.0 | 0.8 |
| 25-29 | 57.1 | 1.9 |
| 30-34 | 59.9 | 2.1 |
| 35-39 | 54.4 | 1.3 |
| 40-44 | 56.7 | 1.7 |
| 45-49 | 58.1 | 1.9 |

Knowledge and prevalence of FGM by age (%) (DHS 2011)



Prevalence of FGM by age (%) (DHS 2011)

The sharp increase from the ages of 25-34 may be attributable to an increase in cutting that happened in the late 1990s as a result of a backlash to the REACH campaigns, when those women would have been within the at risk age-range for FGM (see Challenges Faced by anti-FGM Initiatives below).

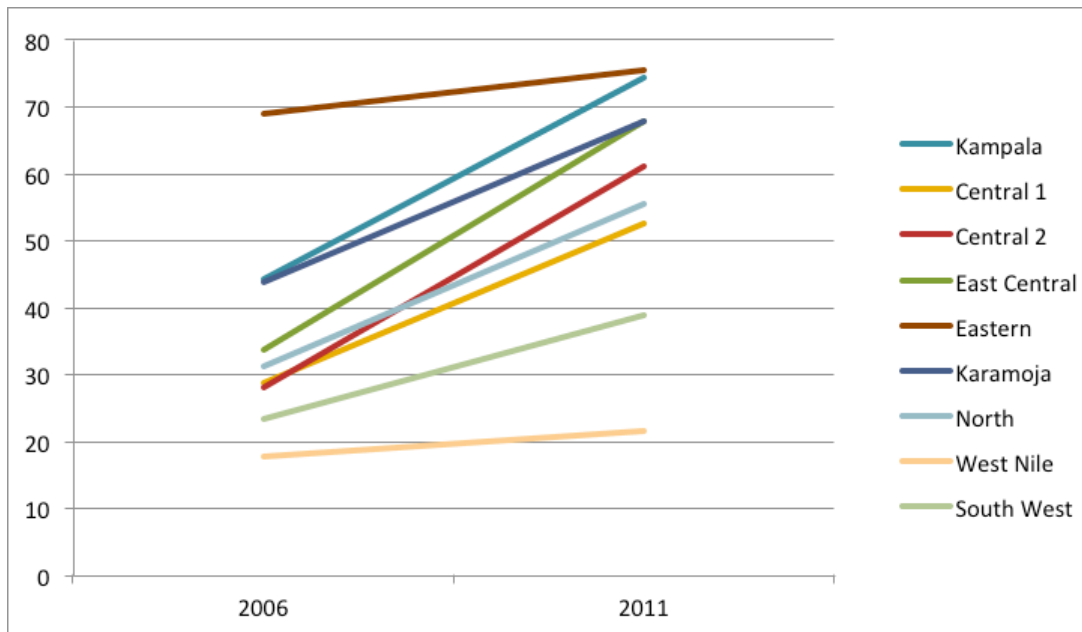
PUBLIC ATTITUDES TO AND KNOWLEDGE OF FGM

Recent findings published on public attitudes to FGM in Uganda are presented according to age, locale, education and wealth (DHS 2011). The age statistics show that, in contrast to Kenya,

the youngest in the age group surveyed ranked higher for believing FGM should continue than the oldest age group. Urban opposition to FGM was higher than those surveyed in rural areas, and the northern region of the country scored highest for wanting to continue the practice. There is a positive correlation between education access/level and belief that FGM should be stopped. This correlation is the same with wealth; the poorest regions scoring higher in the 'continue' FGM category.

| Region | % of women who have heard of FGM (2006) | % of women who have heard of FGM (2011) |
|--------------|---|---|
| Kampala | 44.1 | 74.2 |
| Central 1 | 28.7 | 52.6 |
| Central 2 | 28.0 | 61.1 |
| East Central | 33.6 | 67.8 |
| Eastern | 68.9 | 75.4 |
| Karamoja | 43.8 | 67.8 |
| North | 33.1 | 55.5 |
| West-Nile | 17.7 | 21.6 |
| Western | 21.1 | 37.6 |
| Southwest | 23.4 | 38.8 |
| IDP | 21.2 | - |

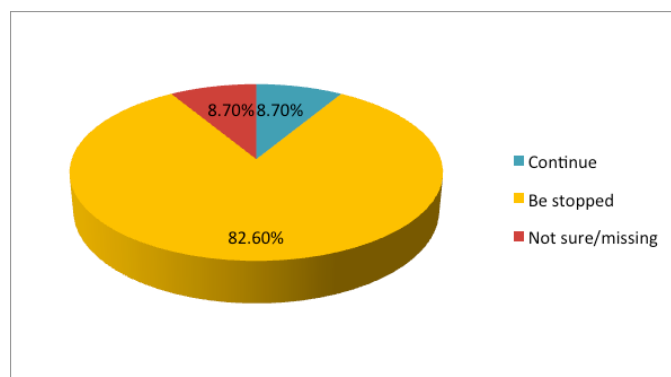
Regional variation for percentage of women who have heard of FGM (%) (DHS, 2006 and 2011)



Regional variation for percentage of women who have heard of FGM (%) (DHS, 2006 and 2011)

| Background characteristic | Distribution by whether practice should be continued or stopped | | |
|---------------------------|---|-------------|------------------|
| | Continue | Be stopped | Not sure/missing |
| Age | | | |
| 15-19 | 12.8 | 80.6 | 6.6 |
| 20-24 | 9.4 | 83.2 | 7.4 |
| 25-29 | 7.4 | 84.8 | 7.8 |
| 30-34 | 8.9 | 80.6 | 10.5 |
| 35-39 | 7.1 | 82.6 | 10.3 |
| 40-44 | 5.5 | 81.9 | 9.5 |
| 45-49 | 4.3 | 86.1 | 9.5 |
| Residence | | | |
| Urban | 3.8 | 90.5 | 5.7 |
| Rural | 10 | 80.3 | 9.7 |
| Province | | | |
| Kampala | 3.8 | 90.5 | 5.7 |
| Central 1 | 8.8 | 86.6 | 4.5 |
| Central 2 | 5.3 | 86.3 | 8.4 |
| East Central | 6.3 | 83.3 | 10.3 |
| Eastern | 8.2 | 78.9 | 12.9 |
| Karamoja | 10.9 | 80.1 | 9 |
| North | 16.9 | 73.1 | 10 |
| West-Nile | 13.3 | 78.5 | 8.2 |
| Western | 9.5 | 85.3 | 5.3 |
| Southwest | 13.5 | 77.7 | 8.8 |
| Education | | | |
| No education | 11.1 | 76.5 | 12.4 |
| Primary | 10 | 79.9 | 11.5 |
| Secondary + | 6 | 88.4 | 5.7 |
| Wealth Quintile | | | |
| Lowest | 13.1 | 74.5 | 12.4 |
| Second | 10.6 | 77.9 | 11.5 |
| Middle | 10.6 | 81.9 | 7.5 |
| Fourth | 7.4 | 83.1 | 9.4 |
| Highest | 5.4 | 89 | 5.6 |
| Total | 8.7 | 82.6 | 8.7 |

Percentage of women who believe FGM should be continued or stopped (DHS 2011)



Percentage of women in Uganda who believe FGM should be continued or stopped (DHS 2011)

One survey in Kapchorwa district (mainly Sabinu men and women) revealed that 50% of women wanted their daughters to marry well and undergo cultural rituals like FGM because their grandmothers went through the same tradition. Approximately 30% of the women surveyed argued that they are in their right to continue the practice. However, around 20% were against FGM because of the pain they experienced that they do not wish for their daughters (Aleyk, 2002). A further survey targeting Sabinu men in Kapchorwa found that 65% of men supported FGM because it ‘tamed women’ and kept them from infidelity and prostitution. 25% of the men said that FGM endangered women and that it should be abolished (Refugee Review Tribunal Australia, 2005).

***‘You say that FGM is culture. Yes, it is culture, but it is culture that was based on insufficient information.... If we find that we were doing something that is, in fact, very dangerous, only because we did not have enough information, then we stop doing it’
(President Yoweri Museveni 1st July 2009 Pokot Culture Day)***

A more recent survey cited by the Godparents Association however found that Sabinu boys, living mostly in Kapchorwa and Bukwo Districts, overwhelmingly said that they would prefer to

marry young women who had not been cut. This may be due to the impact of longstanding anti-FGM campaigning in Kapchorwa/Bukwo, or because more boys go to school in the districts. The Godparents Association state, however, that in Pokot areas there are fewer schools and

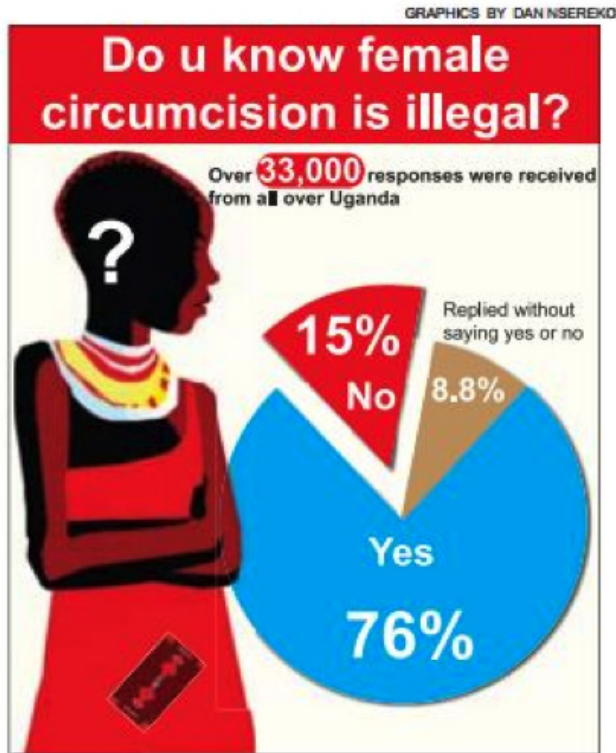
because of the area's isolation, Pokot boys are less aware of the harmful effects of FGM (Godparents Association website, see also profile of Godparents Association in Local Organisations below).

The UNICEF U-report text campaign has also published surveys on attitudes to FGM, focusing on larger issues surrounding FGM in Uganda including the legislation and the conflict between law and culture (UNICEF, 2012).

HIV/AIDS AND FGM

The 2012 Human Rights Report stated the follow concerning HIV/AIDS: 'Discrimination against persons with HIV/AIDS was common and prevented such persons from obtaining treatment and support.' However, 'international and local NGOs, in cooperation with the government, sponsored public awareness campaigns to eliminate the stigma of HIV/AIDS'.

The link between HIV and FGM is a complex and a contested issue amongst researchers. The WHO multi-country study found that although no studies link HIV/AIDS and FGM directly, haemorrhaging subsequent to the operation, bleeding during sexual intercourse as a result of lasting damage to the genital area and anal intercourse where infibulations prevent or impede vaginal intercourse are all potential sources of HIV transmission (WHO, 2006). One source notes that in Amudat, the Pokot FGM 'surgeons' (excisors) are known to use one unsterile knife on up to 30 girls at a time, increasing HIV/AIDS risk (IRIN, 2006). To date, there are no studies on the link between FGM and HIV/AIDS specific to Uganda.



Public attitudes to FGM in relation to law and culture (UNICEF, 2012)

LAWS RELATING TO FGM

INTERNATIONAL & REGIONAL TREATIES

Uganda has signed several international human rights conventions, which provide a strong basis for the characterisation of FGM as a violation of international human rights:

- Convention on the Elimination of Discrimination Against Women (CEDAW)
- Convention on the Rights of the Child (CRC)
- International Covenant on Economic, Social and Cultural Rights (ICESR)
- African Charter on the Rights and Welfare of the Child
- Maputo Protocol to the African Charter on Human and Peoples’ Rights on the Rights of the Women in Africa (the ‘Maputo Protocol’)
- African Charter on Human and People’s Rights (the ‘Banjul Charter’)
- The African Union declared the years from 2010 to 2020 to be the Decade for African Women and Uganda is expected to continue its commitment to promote and protect the rights of women.
- In December 2012, the UN passed an historic resolution, calling on countries to eliminate FGM, and in 2013 the 57th UN Convention on the Status of Women’s agreed conclusions included a reference to the need of states to develop policies and programmes to eliminate FGM as well as other forms of violence against women (UN, 2012).

The CEDAW and the CRC clearly prohibit traditional practices that discriminate against women and harm children. Article 2 of CEDAW directs ‘State Parties...(f) To take all appropriate measures, customs and practices which constitute discrimination against women.’ Additionally, Article 5 states, ‘State Parties shall take all appropriate

measures: (a) to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes...’. Article 24(3) of the CRC states that, ‘State Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children’. In addition, Article 19(1) provides that ‘State Parties shall take all appropriate legislative, administrative, social, and educational measures to protect the child from all forms of physical or mental violence, injury, or abuse’. Uganda ratified CEDAW in 1985 and CRC in 1990.

Under the ICESCR, FGM is a violation of the right to health. Article 12(2) provides that ‘[t]he steps to be taken by State Parties to the present Covenant to achieve the full realization of [the right to health] shall include those necessary for: (a) The provision for...healthy development of the child’. ‘Health’ is defined so as to include ‘maturity, reproductive and sexual health’. FGM thus violates the convention due to the numerous health consequences, as discussed in the section Women’s Health and Infant Mortality above.

The African Charter on the Rights and Welfare of the Child requires members states of the African Union to abolish customs and practices harmful to the ‘welfare, dignity, normal growth and development of the child and in particular: (a) those customs and practices discriminatory to the child on the grounds of sex or other status’.

The Maputo Protocol explicitly refers to FGM. Under Article 5, ‘state parties shall prohibit and condemn...through legislative measures backed by sanctions, (b) all forms of female genital mutilation, scarification and para-medicalisation of female genital mutilation and all other practices in order to eradicate them’.

The Banjul Charter includes provisions related to the right to health (Article 16), right to physical integrity (Articles 4 and 5).

The East African Legislative Assembly announced on Zero Tolerance Day in Kampala in 2012 that lawmakers are considering EAC (East African Community) wide anti-FGM action. Dora Byamukama, a legislator at the East African Legislative Assembly (EALA) member has said that although Kenya and Uganda both now have anti-FGM laws, EAC legislation will hopefully improve cross-border enforcement and she called for serious enforcement efforts to ensure that the law is successfully implemented. 'Having the law is good but without enforcement, it will come to nothing' (Ssenkaaba, 2012).

Unless otherwise stated, all references in this sub-section are to Mgbako et al, 2010.

NATIONAL LAWS

AGE OF SUFFRAGE, CONSENT AND MARRIAGE

In Uganda, the age of suffrage is 18 and the age of consent is 18 (The Children Act, 1996). It is illegal to have sexual contact outside of marriage with girls less than 18 years of age and is considered 'defilement' under the law with a maximum sentence of death (Human Rights Report, 2011). The minimum age for marriage is 18, however arranged marriages for underage girls is common, particularly in rural and impoverished areas, and is not actively enforced by the law (Human Rights Report, 2012). A 2009 UN report stated that 32% of marriages involved underage girls (Human Rights Report, 2011). UNICEF estimates that 12% of women 20 to 24 years old were in a union (marriage) before aged 15, and 46% were married before age 18 (Human Rights Report, 2012).

HISTORIC POSITION

Several articles in the Uganda constitution relate to FGM, though they do not specifically cover the practice. Article 32(2) prohibits customs and traditions that are against the dignity, welfare or interest of women and Article 44(a) prohibits any derogation of the right to be free from torture, cruel inhumane or degrading treatment. Article 34 provides for the rights of children and Article

34(1) states that in addition to laws enacted in the children's best interests, care of children by their parents or those entitled to them by law is paramount. The Uganda Penal Code Act also prohibits grievous harm, unlawful wounding, assault and actual bodily harm, and that consent to a person's own maim does not affect the criminal responsibility of the act. However, as Namulondo has noted, the complexity and ambiguity of the Penal Code made it hard to enforce in relation to FGM in rural areas, where the practice was (is) viewed as cultural and not harmful or assault (Namulondo, 2009).

Prior to the 1990s there was no government stance on FGM as it was a taboo topic. When the current government came to power in 1986, there was new focus on women's development and human rights led by Yoweri Museveni. During this time Museveni was an advocate for education, equality and advancement of women. FGM gained attention as a serious issue and the president supported (and attended) the Sabinu Culture Day, which featured an ARP. In 1989 the District of Kapchorwa had a ban on FGM, but this did not go to the national level. As a result of this district ban, the Kapchorwa District Council enacted a law making FGM compulsory in 1988. After intervention from district representative Jane Frances Kuka, the Cabinet Minister for women in Kampala, went to the district to prevent forced FGM and the law was changed, making FGM optional (Horsfall & Salonen, 2000).

DISTRICT BY-LAWS PASSED (2006 AND 2008)

In Kapchorwa, FGM legislation has been advocated for by REACH and the Sabinu Elders Association. In 2004 they worked with LAW Uganda on a document that would prohibit FGM. In 2005, 100 community leaders from the 16 sub-counties petitioned to enact a by-law based on their document, and this by-law passed in 2006 (UNFPA-UNICEF Joint Programme, 2011).

In 2008, UNFPA, LAW Uganda and the Kapchorwa district council helped enact a district

level prohibition of FGM.

FGM LAW (2010)

On 29th July 2009, the Constitutional Court declared the practice of FGM unconstitutional. In December 2009 the Ugandan parliament passed the Prohibition of Female Genital Mutilation Act and this came into effect on 9th April 2010. The maximum penalty is life imprisonment, with a normal sentence of 10 years, and ‘neither culture, religion, nor the consent of the victim is an allowable defence’ (Human Rights Report, 2012). Life imprisonment is the penalty for aggravated FGM, defined as: ‘... situations where death occurs, a victim is disabled or is infected with HIV/AIDS... also where the cutter is a parent, guardian or a person having control over the victim or where the act is done by a health worker’ (Womakuyu, 2010).

ENFORCEMENT OF THE LAW

The UNFPA-UNICEF Joint Programme reported that in 2011, there were ten legal actions brought against perpetrators of FGM (UNFPA-UNICEF Joint Programme, 2011a). By July 2012, 20 arrests had been made that were pending investigation as well as two prosecutions and one successful prosecution with a sentence of a caution.

Guidelines on the use of the law were developed by the Ministry of Gender, Labor and Social Development to provide guidance to police and prosecutors on the implementation of the law and the protection of victims.

Law Uganda supported by the UNFPA/UNICEF Joint Programme, in addition to being instrumental in the enactment of the law, have a programme in place to build the capacity of law enforcement officers and use the law to provide protection for girls through seeking compensation for injuries from FGM.

Under this project, community awareness activities have been carried out and child protection committees have been set up in

practising communities, and developed simplified versions of the law in local languages. For example, in Moroto, the district leads a team which is an alliance of members from the education sector, health sector, church, civil society organisations, youth, local leaders and the UN. Officers from Law Uganda, district police and local government report that the programme has contributed significantly to the implementation of the law and a reduction in the prevalence of FGM.

There are various challenges to prosecuting cases of FGM:

- Prosecution is difficult as FGM is increasingly being done in secret or across the border in Kenya.
- Police have found it difficult to penetrate the communities where FGM is practised, as there is often a lack of cooperation with the police by communities wanting to protect their culture.
- There is a high turnover of police officers due to the fact that they are transferred after 6 months because of the hardship of working in the areas where FGM is practised (training and guidelines have been used to overcome this challenge).
- Health workers have not always cooperated in completing the paperwork necessary for a prosecution and it has therefore been difficult to collect medical evidence. In addition, they have sometimes asked for money from victims and suspects to perform medical examinations despite the fact this should be free.

One unfortunate consequence of the law is that many cases of FGM received no medical treatment as they were not reported due to fear of punishment from the FGM law (UNFPA-UNICEF Joint Programme, 2011a).

There was defiance against the new law by some communities (see Challenges Faced by anti-FGM Initiatives below).

A number of recommendations have been suggested for the Joint Programme, including:

- Continuous efforts are needed to ensure that the law is properly implemented. Capacity of the police authorities needs to be continued, especially training guidelines and materials, transport and communication.
- Health sector included in the programme to ensure that medical evidence can be collected.
- Using education as a tool to empower young girls to say 'No'.
- Communities should be encouraged to pass by-laws in their respective areas.

In addition, police officers have suggested using radio and drama shows in the local languages and illustrated posters to raise awareness of the harmful effects of FGM, especially in remote areas.

All references in this section are to Weber, 2012 unless otherwise indicated.

INTERVENTIONS AND ATTEMPTS TO

ERADICATE FGM

HISTORICAL OVERVIEW

Looking at the international picture, there were early attempts to persuade communities to abandon FGM, first by missionaries and British authorities in the early 20th century, and later by Western feminists in the 1960s and 1970s. These attempts were largely considered to be Western imperialism and something imposed on communities by outsiders. The International Conference on Population and Development in 1994 and the Fourth World Conference on Women in Beijing in 1995 marked a turning point. FGM was now being discussed in terms of health

and human rights and it was acknowledged that efforts to eradicate FGM needed to be locally-led initiative with communities, health professionals and policy makers involved (Feed the Minds, 2010).

In Uganda, historical initiatives to end FGM have mainly started at a grassroots level, but also include NGO and government efforts (see further National Laws > Historic Position above). The Sabinu Elders Association (SEA) was founded in 1992 to promote peaceful development and preserve culture, but also to eliminate harmful traditions such as FGM (see section on Local Organisations below). The SEA was started after some members of the Sabinu community became concerned that their culture was being eroded. The SEA eventually sought support from President Museveni and the President contacted UNFPA. In 1996, UNFPA, in collaboration with SEA launched the Reproductive, Educative and Community Health Project (REACH) and established the first Sabinu Culture Day, which has been in existence ever since.

GOVERNMENT POLICY AND SUPPORT

The Ministry of Gender, Labour and Social Development is active in fighting FGM directly and indirectly in Kapchorwa. REACH receives partial funding from the Ministry to help carry out sensitisation programmes in the communities as well as involvement of officials from the Ministry in undertaking sensitisation in the community.

In partnership with UNFPA, UNICEF and the French Embassy in Uganda, the government (Social Development Fund) created a programme in 2011 to accelerate FGM abandonment initiatives in Uganda. The French Embassy invested 200,000 Euros (700,000,000 shillings) to be used on FGM projects in Amudat, Nakapiripirit, Moroto, Kween, Bukwo, and Kapchorwa. This issue will also address the cross-border issue with Kenya. In 2012, the French Embassy met with Ugandan MPs in effort to strengthen the commitment of MPs to ending FGM in the Karamoja region. The partnership programme with the French Embassy

continues and uses a community and education based approach that is culturally sensitive. They also call for a multi-sectored response to ending FGM and emphasise the need for girl's education and health staff involvement (Ugandan French Embassy website).



Campaign against FGM – a road sign near Kapchorwa, Uganda © Amnon Shavit, 2004

OVERVIEW OF INTERVENTIONS

A broad range of interventions and strategies have been used by different types of organisations to eradicate FGM:

1. Health risk/harmful traditional practice approach
2. Addressing the health complications of FGM
3. Educating traditional excisors and offering alternative income
4. Alternative rites of passage and Culture Days
5. Religious-orientated approach
6. Legal approach
7. Human rights approach
8. Intergenerational dialogue

9. Promotion of girls' education to oppose FGM
10. Supporting girls escaping from FGM/child marriage

HEALTH RISK / HARMFUL TRADITIONAL PRACTICE APPROACH

Strategies that include education about the negative consequences of FGM have been the most frequently used globally for the eradication of FGM, and are a common element of programmes within Uganda. The main work of anti-FGM initiatives is delivered through education. The idea to sensitise people against the dangers of FGM has been favoured by many NGOs, REACH having set the precedent. One example of this has been the UNFPA/UNICEF Joint Programme in conjunction with ASB and MAZIDEP in Moroto District where they have raised awareness of FGM among primary children and students at informal learning centres using a video show. In addition, the project's aim is to use the students who want to abandon FGM as peer educators.

(See International Organisations and National Organisations).

ADDRESSING THE HEALTH COMPLICATIONS OF FGM

The Joint Programme notes that although much progress has been made involving health professionals, there is still a long way to go. The Joint Programme has a referral network for medical issues related to FGM. In 2011, the organisation identified 96 survivors of FGM suffering from severe gynaecological problems, nine of whom were taken to hospital for treatment (that was partially funded). Two of the girls died from haemorrhage as a result of delays in reaching the hospital. Most cases received no medical treatment as they were not reported due to fear of punishment from the FGM law (UNFPA-UNICEF Joint Programme, 2011a).

In one report, it was recommended that there

was a need to focus on the treatment of those who experienced FGM (e.g. for repair of fistula) as well as on the prevention of FGM (Weber, 2012).

OFFERING ALTERNATIVE INCOME TO EXCISORS

Educating traditional excisors about the health risks and providing them with alternative means of income as an incentive to stop practising FGM is a further strategy used by organisations. In Uganda, there has been a steady increase in excisors denouncing the practice. Some excisors have been given government jobs including working as street cleaners and in the town council. Illustrating their authority and community status, ex- excisors interviewed stated that they believe FGM will only end when the excisors believe the practice should stop (28 Too Many in-country research).

'It is essential we modernise and that our culture is not left behind. Education is the answer. The less ignorant we are, the more this practice will die out' (Mr Cheborion, Chairman of the Sabiny Elders Association)

TPO Uganda is one organisation that has been training excisors as village health team members and educating them on the negative aspects of FGM (see NGO section below). In addition, the Inter-African Committee of Uganda donated grain grinding machines to over 254 former Sabiny excisors in Kapchorwa as an alternative means of living (Violence is not our Culture, 2011). TPO Uganda reports that former excisors face harassment and hostility when they abandon the practice (28 Too Many questionnaire). In some programmes there has been the expectation that excisors declaring their abandonment of the practice would be given assistance in setting up an alternative livelihood (Weber, 2012).

Although such initiatives may be successful in

supporting excisors in ending their involvement in FGM, they do not change the social convention that creates the demand for their services. Such initiatives may complement approaches that address demand for FGM but alone it does not have the elements necessary to end FGM (UNICEF, 2005a).

ALTERNATIVE RITES OF PASSAGE (ARPS) AND CULTURE DAYS

For those ethnic groups where FGM is part of a rite of passage initiating girls into adulthood, one approach that has shown some success is Alternative Rites of Passage (ARPs). ARPs substitute the cutting part of the ceremonies with alternative rituals that preserve the cultural traditions while eliminating the cutting. ARPs have been implemented with varying degrees of success. The success of APRs depends on the community practising FGM as part of a community ritual such as a rite of passage. In addition, ARPs will have limited impact unless they are accompanied by education which engages the whole community in collective reflection and leads to changes in the expectations of community members. The use of APRs is further limited by the trend for communities to cut girls at a younger age and with less ritual. (UNICEF, 2005a).

ARPs are used by some NGOs in Uganda. For example, ARPs may sometimes constitute an element of Culture Days. Culture Days are events designed to celebrate positive aspects of the culture and are often accompanied by community dialogue regarding FGM and public declarations of abandonments. The Culture Days, hosted by the UNFPA-UNICEF Joint Programme and REACH, have had some success among the Sabiny. As part of these days, girls are taught about home economics, healthy marriages, raising children, gender rights and sexual and gender-based violence. Graduation ceremonies are organised and certificates are given out before the children are 'passed out' (graduate). Sometimes certificates are given to the girls (28 Too Many Research & Namulondo 2009). However, in one study (although relatively

old), Kiirya and Kibombo found that among the Sabiny surveyed, although the Culture Days were appreciated and commended some suggested that they had not yet provided the excitement, enthusiasm and values equivalent to those associated with FGM (Kiirya and Kibombo, 2000).

The educational element to APRs builds on the traditional knowledge that is imparted to girls as part of the traditional initiation ceremonies, which takes place during a period of seclusion, but is enhanced with additional information on sexual and reproductive health (UNICEF, 2005).

ARPs and Culture Days are often viewed as two separate approaches by communities (and NGOs), particularly among the Pokot. 'Culture Day' appears to be more of an umbrella approach incorporating community dialogue and public declarations of abandonment and may or may not include an actual alternative rite of passage.

There are reports of communities abandoning FGM and excisors relinquishing their tools at Culture Days (see POZIDEP profile in Local Organisations below). There are, however, some reports that despite the Culture Days and ARPs (or proposed ARPs) in Pokot communities, many girls are still being cut. The Culture Days are, however, less established among the Pokot and this may be a reflection of the need to continue efforts to engage the community in dialogue, education and collective reflection and ensure that all members of the community are targeted. (28 Too Many Research).

RELIGIOUS ORIENTATED APPROACH

A religious orientated approach refers to approaches which demonstrate that FGM is not compatible with the religion of a community, thereby leading to a change of attitude and behaviour. The 'saved' or born again churches, notably the Pentecostal and Body of Christ Churches have taken action to combat FGM. Strategies have included open air crusades, preaching, seminars, excluding members if they

participate in FGM, as well as supporting girls who have refused to be cut and have been rejected by their families.

One report on the Pokot (in Kenya) found that the Church is seen by the community as a 'unique platform in influencing at stopping this practice', as well as recognising the importance of education. They found that: 'The most significant decrease in the practice of female circumcision is observed in areas that have had schools for a long time and where the church is well established compared to marginalised sections of the larger Pokot district where communities are yet to embrace girl child education and Christianity' (Kristensen and Nairesiae, 2009). Despite reporting on Kenya this study is nevertheless instructive as the Pokot lives on both sides of the border.

LEGAL APPROACH

Please refer to Laws relating to FGM above, under section on National Laws.

This approach is most effective when accompanied by awareness raising and community dialogue. If anti-FGM laws are introduced before society has changed its attitudes and beliefs, or is not accompanied by the requisite social support, it may drive the practice underground, encourage people to cross the border to undergo FGM in a neighbouring country (UNICEF, 2005a) and prevent people seeking medical treatment for health complications.

There has been some success, with UNFPA-UNICEF reporting a number of legal actions, including two prosecutions as of July 2012, guidance of police and prosecutors in place and a programme to build the capacity of law enforcement officers.

There have, however, been challenges with reports that the law has pushed the practice underground. The practice is taking place in secret or girls are being taken over the border to Kenya to be cut to avoid detection. Moreover, there are difficulties in penetrating uncooperative

communities, a high police turnover and problems collecting medical evidence (Weber, 2012), as well as many women not receiving medical treatment (UNFPA-UNICEF Joint Programme, 2011a). There was also a backlash against the law among the Sabiny who were openly defiant to the law and apparently 'outraged' at the criminalisation of FGM without proper consultation (Masaba, referred to by Godparents Association Newsletter, January 2011).

All references in this section are to Weber, 2012 unless otherwise indicated.

HUMAN RIGHTS APPROACH, INCLUDING PUBLIC DECLARATIONS

A human rights approach acknowledges that FGM is a violation of women's and girls' human rights. This approach is sometimes used alongside other strategies to eradicate FGM based on the social abandonment theory of FGM (derived from the social change theory behind foot-binding in China). The components of this theory include (i) a non-judgemental human rights approach; (ii) community awareness raising of the harmfulness of the practice; (iii) a decision to abandon FGM that is a collective decision by the entire community; (iv) the requirement of community public affirmation of abandonment; (v) intercommunity diffusion of the decision and (vi) a supportive change-enabling environment, including the commitment of the government. This approach was pioneered by Tostan in Senegal (UNICEF, 2005a). This approach has been adopted by the Joint Programme and in 2011, thirty-six communities in Uganda announced their commitment to abandoning FGM (UNFPA-UNICEF Joint Programme, 2011a). See further profiles of Joint Programme and POZIDEP in International Organisations and National Organisations below.

INTERGENERATIONAL DIALOGUE

This approach is based on the principle of listening and questioning between different generations, aided by a facilitator. It enables participants to reflect on their values, customs,

traditions and expectations and to consider whether, when, how and under what conditions change should take place. Uganda NGOs often used community dialogue to facilitate conversations regarding FGM with stakeholders, religious leaders, tribal elders and community members.

For example, the Joint Programme dialogue sessions include the following questions:

1. How is FGM practised in the community?
2. Why is FGM practised (what are the community's perceived positive effects)?
3. What negative consequences of FGM has the community encountered?
4. Has the community tried to stop FGM?

From this last question they introduce the topic of FGM law. Joint Programme dialogue sessions run by ASB are held with youth and elders separately, followed by a group discussion. This form of dialogue is effective because it allows community members to speak first and, following receiving information on FGM, they can work towards their own solutions as a community (Weber, 2012).

PROMOTION OF GIRLS' EDUCATION TO OPPOSE FGM

There is a strong link between FGM and early marriage among some ethnic groups. Research suggests that women and girls who do not achieve higher levels of education were more likely to undergo FGM. Education can therefore make a significant contribution to the eradication of the practice. Not only does education protect girls from undue social pressure to undergo FGM but also increases women's capacity to make independent decisions. Kiirya and Kibombo suggest that while community sensitisation and peer education are crucial in changing attitudes, the formal education of girls is necessary to bring about long term sustainable change (Kiirya and Kibombo, 2000).

Many of the NGOs in Uganda focus on girl's education (see International Organisations and National Organisations below). As part of their programme, REACH has trained secondary school students as peer educators to educate their classmates about FGM (28 Too Many questionnaire). Godparents Association pays school fees of girls who pledge not to be cut, as well as boys in the community. These girls graduating from their programme are then able to sensitise their home communities against FGM and can show the benefits of eschewing FGM and early marriage and instead pursuing an education. The girls are brought to the Peace High School in Kampala as it was realised they were still at risk of FGM if they stayed in their home district.

SUPPORTING GIRLS ESCAPING FROM FGM/ CHILD MARRIAGE

Rescue centres shelter girls who are running away from FGM and/or child marriage, particularly in communities where there is a strong link between FGM and child marriage. Following the successful implementation of such projects in Kenya, local authorities and organisations are advocating for the creation of a girls' boarding school and a safe refuge for girls escaping FGM and early marriage and who cannot return to their communities (Weber, 2012).

REACH recently received funding from the Netherlands Embassy to build a rescue centre and it was due to be completed in December 2012. A number of organisations (including POZIDEP, Maendeleo Women Group, Visioncare, Resident District Commissioner (RDC) Amudat, District Education Office and the District Council) have worked together in a 'Go back to school' campaign to ensure that children are safely staying at school. These children do not go home for holidays for fear of early marriage and FGM. The District has made two schools as rescue centres (28 Too Many research) and it is reported that 400 school going-age children in Amudat District fled their homes in the last 10 months for fear of being subjected to FGM. The District Inspector of Schools stated that

the education authorities have been overwhelmed at the rate children are running away from their homes (Hinamundi, 2013).

MEDIA INFLUENCE

The UNFPA-UNICEF Joint Programme uses media campaigns in a number of African countries to communicate the dangers of FGM and encourage people to abandon the practice. These campaigns often centre on the International Day of Zero Tolerance of FGM. In 2011, the Joint Programme had fifty-eight radio programmes in Uganda. Radio talk shows focused on why communities practise FGM as well as its side effects, and six of these talk shows had around twenty call-ins per show.

The Joint Programme also screened anti-FGM videos in schools and communities and discussions held before and after the screenings showed that the communities changed their perception of FGM from a benign to harmful cultural practice. UNFPA-UNICEF reported that after watching the video, schoolgirls requested that they be protected at school and boys said they felt comfortable marrying uncircumcised girls. Additionally, sensitive video dramas portraying girls' experiences with FGM were viewed by over 500 people. These videos aroused anger and caused many people to reject the practice. Two theatre troupes were also trained to perform in the Sabinu region. Finally, three youth groups received six days of training in music, dance and drama to enable them to develop educational messages on FGM (UNFPA-UNICEF Joint Programme, 2011a).

One example of an FGM focused radio programme is on Kapchorwa Trinity Radio (KTR) 94.1 FM, which is hosted three times a week by Mr Sande Geoffrey, Programme Officer of IAC Uganda. This programme holds a live phone-in session on FGM and talks on empowerment of the girl-child. This broadcast reaches all of Kapchorwa as well as Teso and Pokot areas. Geoffrey believes that the best alternative to FGM is educating girls (Inter-African Committee website). An FM radio station sponsored by Dutch embassy has begun

broadcasting information about the law to rural parts of Bukwo district (Sabiny) (Godparents Association Newsletter October 2012).

In those regions most affected by FGM there is low coverage of FM radio and TV is relatively inaccessible. Media messages must therefore be tailored to the communities and there needs to be a creative use of media. The UNFPA suggests such media may include (UNFPA, 2011):

- innovative use of folk media
- radio programmes addressing the role of leaders in FGM abandonment
- interactive radio programmes targeting community members
- radio listening clubs for targeted groups e.g. schools
- innovative use of other media

A UNICEF project called U-Survey targeted young Ugandans in a survey sent via SMS on mobile devices. This survey was about raising awareness on the illegal nature of FGM and asked about the importance of culture over law. 76% of the responders knew FGM was illegal and there were over 32,000 responses received in twelve hours from all over Uganda. This SMS survey reached 85,000 participants and all of these individuals are now aware of FGM laws (UNICEF, 2012). The response rate shows that FGM is a pressing issue for young Ugandans but it is important to continue communicating its illegal nature as there is little evidence to show that those who responded are directly affected by FGM.

Newspapers in the capital such as *Monitor* and *New Vision*, provide coverage of FGM. Sometimes the reporting is sensationalised and exploitative which the Sabiny believes damages their reputation (Godparents Association Newsletter, January 2011). In 2011, however, thirty journalists from sixteen different media outlets were trained by the Joint Programme in how to proactively cover

stories on FGM (UNFPA-UNICEF Joint Programme, 2011a).

Article in *The Monitor* newspaper 7th June 2010 ©28 Too Many

COMMUNITY DESIRES



A study in 2000 in Kapchorwa (funded by UNFPA, REACH and FPAU*) found that the following changes were desired by the community (Kiirya and Kibombo, 2000):

| Changes/measures desired (n=429) | Frequency | % |
|--|-----------|----|
| Mass community education and sensitisation on FGM dangers | 258 | 60 |
| More NGO support to REACH and FPAU to intensify community activities | 173 | 40 |
| Free primary and secondary education for girls | 150 | 35 |
| Campaigns should concentrate efforts in villages with high FGM incidences | 143 | 33 |
| Initiate and support new anti-FGM initiatives at village level | 142 | 33 |
| Counsels parents and girls in self pride and esteem even without undergoing the ritual | 102 | 24 |
| More involvement of important Sabiny personalities in the FGM campaign | 70 | 17 |
| No suggestions/FGM should instead be promoted | 66 | 15 |

| | | |
|--|----|----|
| Sensitise excisors and their aides to cut a small part of the clitoris | 46 | 10 |
| Involve all categories of community in peer education | 29 | 7 |
| Facilitate elders/teachers in anti-FGM/create other sources of income for circumcisers | 25 | 6 |
| Sensitise other service providers | 7 | 2 |
| Anti-FGM campaigns should not be allowed/entertained | 3 | 1 |
| Facilitate churches to enable them to intensify their campaigns | 5 | 1 |
| Complete reconstruction and equipping health centres to provide RH services | 5 | 1 |
| Other FGM eradication measures proposed by the community | | |
| FGC should be allowed because community members might react negatively | 51 | 12 |
| Enact a law abolishing FGM* | 13 | 3 |
| FGM should be voluntary/optional | 10 | 2 |
| Promote evangelisation among girls and community | 9 | 2 |
| Let it end by itself | 9 | 2 |

As this survey is over ten years old it would be interesting to see how current attitudes have changed, and also to see what changes are desired by the Pokot and other ethnic groups practising FGM. This is nevertheless still a useful indicator of community wishes.

*** FPAU (Family Planning Association of Uganda) is now called Reproduction Health Uganda and is profiled under Local Organisations below.**

INTERNATIONAL ORGANISATIONS

There are numerous international organisations working in Uganda to help eradicate FGM, the work of these organisations is aided by the 2010 anti-FGM Act. These groups work with the government, women’s groups, local NGOs and local leaders to combat FGM through education (Human Rights Report 2010).

Please see Appendix for full list of organisations.

INTER-AFRICAN COMMITTEE ON TRADITIONAL PRACTICES

IAC advocates for the removal of harmful traditional practices that affect the health of women and children. IAC applies a multi-pronged approach to influence policy and action and to create positive attitudinal change through the implementation of projects at the community level.

PATH (PROGRAMMES FOR APPROPRIATE TECHNOLOGY IN HEALTH)

PATH runs programmes on FGM eradication based on the belief that discontinuation of FGM must be addressed at the community level. Its purpose is to introduce community workers to the concept of ‘communication for change’ and to inspire and transfer skills for community-based approaches to problem-solving.

UNFPA-UNICEF JOINT PROGRAMME

The UNFPA-UNICEF Joint Programme for ending FGM was founded in 2008 and has been extended to December 2013. Uganda entered the programme in 2009. The Joint Programme is currently working on an innovative system of enforcing national law against FGM in Uganda. In 2011, the Joint Programme and its local partner organisations trained local police and community monitors to enforce FGM law. When the local girls come home from school for summer holidays (the time they would normally be cut), the monitors circulate through the villages and identify which families are planning to carry out the procedure,

and when. The monitors then use their mobile phones to notify police.

In 2011, the Joint Programme also supported seventy community dialogues and fifty-two education sessions on FGM, including themes such as cultural identity and children's rights. They report that 317 girls in one district (does not specify) opted not to undergo FGM in 2011 and 436 uncut girls were honoured at the 16th Sabinu Culture Week. The Joint Programme notes that although much progress has been made involving health professionals, there is still a long way to go. The Joint Programme has a referral network for medical issues related to FGM. In 2011, the organisation identified 96 survivors of FGM suffering from severe gynaecological problems, nine of whom were taken to hospital for treatment (that was partially funded). Two of the girls died from haemorrhage as a result of delays in reaching the hospital.

Most cases received no medical treatment as they were not reported due to fear of punishment from the FGM law (UNFPA-UNICEF Joint Programme, 2011a). As of 2011, the Joint Programmes partners include: the Sabinu Elders Association, the Church of Uganda, the Catholic Church, REACH, the Rafiki Theatre Ltd., Sebei Diocese, the Kapchorwa Human Rights Initiative, the Sabinu Athletics Association, the National Agricultural Advisory Society, Law Uganda and the Uganda National Teachers Union. Moreover, during the 2011 Sabinu Culture Day, the local council chairman declared the fourth day of every month a day for mobilising communities around the abandonment agenda (UNFPA-UNIFCEF Joint Programme, 2011a).

ARBEITER-SAMARITER-BUND (ASB) - FUNDED BY THE JOINT PROGRAMME

ASM is a German aid and welfare organisation. They recently completed a survey and are implementing a project funded by the Joint Programme to encourage the abandonment of FGM through community dialogue in Tepeth

groups in Moroto. Their report suggests that, prior to their project, Tepeth communities were unaware of the problems associated with FGM and that in some cases, parents were unaware for months following ceremonies that their daughters had died or were permanently disabled due to FGM. Dialogue sessions used a health education approach, focusing on the risks of FGM including HIV/AIDS. In 2012 the ASB dialogue project reached 1,500 people and they are helping change the perception of FGM as a taboo topic. One of their biggest challenges is the inaccessibility of the region, but they have been able to facilitate dialogue sessions in the remote communities of Tapac and Katikekile. The ASB project also uses media and by mid-2012 an education video on FGM was screened twenty times in primary schools and community centres, reaching 1,000 children in the Moroto district, as well as elders of the community. This video was produced in Kenya by MAZIDEP (a faith-based organisation) and was translated into the local language. As a result of ASB community dialogues they report:

- Fifty seven local leaders received training on FGM law to communicate to their communities
- Demand for law enforcement is growing.
- In 2012, only one girl was cut in the nine parishes of Katikekile and Tapa sub-counties (Tepeth region).
- The Tepeth have requested a culture day. On this day, October 25, 2012, seventy two excisors denounced the practice and relinquished their tools.
- Seventeen community leaders now monitor and report on FGM and facilitate discussion at community meetings.
- Elders have expressed interest in being trained to conduct community dialogue sessions so that they can talk to other Tepeth communities and get them to abandon FGM.

(UNFPA website, 2013, Weber, 2012)

USAID

USAID have been assisting Uganda since independence in 1962 and provide a variety of health services and aid relief. USAID partially fund TPO Uganda for the alternative livelihoods project for former excisors. USAID also supports the DHS and conducts research via the Population Council (Population Council, 2007).

LOCAL ORGANISATIONS

Local organisations working to eradicate FGM are varied and include national NGOs, CBOs and faith-based organisations. Most are heavily dependent on funding from international donors. There is overlap between those NGOs and charities working to protect the rights of women and children or health organisations and FGM. This is especially the case as FGM is directly linked to the MDGs, in particular Goal 3 (promote gender equality and empower women and Goal 5 (improve maternal health). For example, the African Youth Alliance (AYA) run by Pathfinder International, PATH and UNFPA works on sexual health and gender equality projects in Uganda, meaning their work touches on FGM. Several NGOs and non-profits seem to operate through REACH, they are well established in the communities they work in and have a high profile within Uganda. There is good co-operation between them and they support each other's work.

Please see Appendix for full list of organisations.

FOOD FOR THE HUNGRY

Food for the Hungry is an international FBO that operates in the Piswa-Kween District in Eastern Uganda. It is an NGO based out of the US and the Uganda programme began in 1988, the Piswa programme in 2006. An anti-FGM programme was due to begin in October 2012 (28 Too Many in-country research). They focus on physical health and education, as well as sanitation and safe water, and aim to help women of reproductive age. Food

for the Hungry's strategy to end FGM focuses on: information, education and communication; positive deviance; and child sponsoring. Their anti-FGM programme in Piswa will utilise the CARE group model of changing attitudes towards FGM and teaching women on how to discuss FGM with their husbands. Men, excisors and religious leaders will also be involved in community dialogue sessions, which will be broken down into three groups for family, leaders and churches.

GODPARENTS ASSOCIATION

This is a US organisation, with a parallel organisation called Godparents Uganda registered in Uganda. It was formed to support alternatives to FGM and empower women. The organisation pays school fees of girls who pledge not to be cut. These girls graduating from their programme are then able to sensitise their home communities against FGM. They can show the benefits of eschewing FGM and early marriage and instead pursuing an education. The organisation has taken to concept of 'Godparents', without the religious significance. The 'Godparents' are mainly from the United States, with some from Europe, UK, and Australia, and they sponsor the girls' education.

Since its formation in 1999, the organisation has helped dozens of girls to study to secondary level and beyond. Realising that girls were at risk of FGM if they stayed in their home district, since 2000, girls are brought to the Peace High School near Kampala to study, where they are exposed to wider opportunities, can learn English to a higher standard and gain a more rigorous education. Most serve as models and are eager to speak out against FGM in their communities. Some have chosen graduate-degree training that will enable them to be employed in professional anti-FGM work.

Godparents Association also operates enrichment programmes during school holidays to prepare girls for exams and take them to Kampala where they meet influential women. The girls have achieved success in the educational

attainment, with a number of them first scoring at the highest level in national O-levels exams by 2007 (among the top 8% of Ugandans), and going on to achieve tertiary degrees. These girls are usually the first in their communities to earn tertiary degrees and provide an example of what uncut women can do. In the first few years the girls were ostracised and ridiculed at home, whereas they are now widely admired and envied. The organisation has also started sponsoring boys. This followed a request by the local Member of Parliament, the Hon Francis Kiyonga, so that the Pokot girls who graduating from Peace High School without undergoing FGM would be able to marry within their home communities.

KAPCHORWA CIVIL SOCIETY ORGANIZATIONS ALLIANCE

The Kapchorwa Civil Society Organizations Alliance (KACSOA) works in the regions of Kapchorwa, Kween and Bukwo. They started in 2007 and focus on human rights, physical health, education, livelihoods, and faith based and elder councils. KACSOA uses a human rights based approach to ending FGM, with an emphasis on information, education and communication and local networking. Their work is on enhancing the rights of Sabiny women using sensitisation and community dialogue meetings and they involve elderly people (not only tribe elders) in discussions to maintain the importance of culture. Topics of culture are discussed in separate groups of men, women and youth and these discussions gradually transition into the topic of FGM.

MAENDELEO WOMEN GROUP

Maendeleo Women Group started as a group of Christian women who came together to improve their standard of living by increasing their household income. A group of twenty women in 1998 put their efforts together in making beads, belts and also sewing clothes for a daily income. These women saw it prudent that whenever they are empowered, their children will have basic needs that they need in a family. With these activities therefore they felt that most domestic

wrangles will be minimised through their ability to provide for their families. As the group increased in number and activities increased, members decided in 2002 to have a women's group and gave a name called 'Maendeleo' meaning development. Development is in various spheres: economic, social, and cultural. Maendeleo's vision is to empower women of Pokot to be self-reliant and be able to create an environment conducive for positive child development and positive social co-existence. Its mission is to develop skills and knowledge of the women and other vulnerable groups to be able to support their social, spiritual and economical wellbeing through income generating activities. Their aims and objectives are:

- To promote awareness on women and child rights
- To empower women to be self-reliant
- To strengthen women to be able to promote child protection issues amongst their communities
- To build capacity of women and other target members through vocational training
- To promote awareness on Gender based violence
- To promote and encourage children and Christians to join religious vocational life
- To promote community dialogue between the law enforcing bodies and the communities on legislative issues

This organisation is separate to Maendeleo Ya Wanawake (MYWO) in Kenya.

MIFUMI

MIFUMI is an international aid and development agency NGO in Uganda. This organisation was established in 1994 and is based in Tororo, including eleven counselling centres for women.

They focus broadly on human rights, and in particular fight to protect women and children against violence, child marriage and bride prices. The MIFUMI Human Rights Defenders Network works in districts: Iganga, Busia, Tororo, Mbale and Soroti and their regional network is in Eastern Uganda, Kenya, Tanzania, South Africa and the UK. Much of their work looks at the relationship between bride price and FGM.

POKOT ZONAL INTEGRATED AND DEVELOPMENT PROGRAM (POZIDEP)

The Church of Uganda’s Pokot Integrated and Development Program (POZIDEP) is based Amudat and is part of the UNFPA/UNICEF Joint Programme. They work to (i) change attitudes among leaders and community members towards the promotion of women’s and children’s rights; (ii) raise awareness on FGM abandonment and (iii) demonstrate to others that important persons within the community who have traditionally supported FGM have now abandoned it.

This programme uses information, education and community dialogue. POZIDEP has worked with community elders who are against FGM and are perceived as the custodians of Pokot culture. They have also targeted mutilators, political and cultural leaders and youth. Part of their strategy has been to work with role models within the community who would publicly declare their commitment to abandon FGM during the celebration of Cultural Days in order to show other community members that they openly denounced the practice.

In addition, Pokot elders are selected to meet with the Sabinu Elders Association each year, demonstrating the ‘diffusion’ of the abandonment of FGM, whereby communities that are abandoning FGM engage others to do the same. There has also been diffusion among the Pokot, with communities that have declared abandonment talking to other communities who have reportedly been impressed by the positive changes within the former communities. POZIDEP

works with local leaders during the Pokot cutting season (July – September) to discover which girls are due to be cut and meet the parents to explain the health consequences, and then monitor the girls every two week to ensure they have not been cut. The elders and girls who have done the public declarations are also trained to raise awareness of the law within their communities.

Pokot Culture Day is on 30th June and the programme reported that in 2012, seven excisors relinquished their cutting tools and abandoned the practice and public declarations were made by five communities.

Challenges remain for the programmes, including community members facing discrimination by other community members who make public declarations to abandon FGM. In addition, the size of the communities makes disseminating information a challenge especially to remote and hard to reach areas, and former excisors and girls expect support in the form of alternative livelihoods and education after publicly declaring FGM abandonment.

(28 Too Many in-country research and Weber, 2012).

REACH

Reproductive, Educative and Community Health Programme (REACH) is a National NGO working in Kapchorwa, Bukwo, Nakipiripirit, and Amudat. It was started as a pilot project in 1996 and was UNFPA funded and became a registered NGO in 2007. Their work with the Pokot began in 2006-7. The organisation’s goal has been to preserve cultural practices that are benign and that promote human rights, such as story-telling, proverbs, community celebrations, marriage ceremonies and traditional foods, while eliminating practices ‘that are brutal and dehumanize some sections of the community’ (28 Too Many research).

REACH works on child protection, human rights, education, and laws/advocacy/policy, using media as one method of outreach. They believe that FGM

continues to be practised as part of cultural heritage and their approach to eradication is encouraging collective abandonment using information and education, and focusing on positive deviance and targeting excisors. Their primary target group are excisors and elders. Media-REACH produces radio talkshows intended to sensitise on the health issues of FGM, FGM legislation, and current advocacy programmes. This programme runs twice weekly, however the signal is restricted to Kapchorwa and Bukwo districts and it is reported that men often restrict their wives from listening to the radio (28 Too Many research). Community dialogues are facilitated, which involve stakeholders, religious leaders, tribal elders and community members. REACH runs an ARP programme as well as culture days. REACH is part of the Kapchorwa Civil Society Organizations Alliance (KACSOA). REACH is partially funded by: UNFPA, the Ugandan government, the Netherlands Embassy, DAN Church Aid, ZOA, and UNICEF. For more information on the challenges faced by REACH see section below.

Reach banner © 28 Too Many



REPRODUCTIVE HEALTH UGANDA (RHU), FORMERLY FAMILY PLANNING ASSOCIATION OF UGANDA (FPAU)

RHU's Rise-Up Project centres on reproductive health and gender rights. With support from the Swedish International Development Agency (SIDA) RHU is implementing a project in Apac and Kapchorwa districts and aims to ensure access to sexuality and reproductive health information and services to young Ugandans. This project advocates ending sexual and gender-based violence, including FGM. RHU aims to increase utilisation of these health services by girls and young women and hopes to increase community and district support for the reduction of violence against women through policy making. The project sets out to train RHU and its partners to address issues concerning violence against women and children and focuses on male involvement in reproductive health rights and reducing violence against women. Their primary audience is girls and young women aged 15-30 and their secondary target audience is men, community leaders and district leaders.

SABINY ELDERS ASSOCIATION

The Sabiny Elders Association (SEA) is an association that was formed in 1992 by Sabiny elders from 161 clans in Kapchorwa, and they are considered to be the group that spearheaded the fight against FGM in Uganda. Their aim is to unite the Sabiny people and promote peaceful development, solve local problems without outside interference and protect Sabiny culture by preserving songs, dances, funerals and marriage rites. They also set out to eliminate the harmful traditions including FGM. The SEA was given an award in 1998 by UNFPA (United Populations Award) for its efforts to end FGM. The award money was used to build a headquarters and offices for other NGOs working against FGM. The SEA works closely with REACH.

SISTERS OF THE HEART

Sisters of the Heart is an outreach FBO in



With reformed excisors at the Sabiny Elders Association
© 28 Too Many.

Kapchorwa district operating since 2008. Whilst not directly involved in eradication programmes, they offer support to women who refuse FGM including child protection, education and empowerment through livelihood (vocational) training like sewing, in addition to spiritual guidance. Their child sponsorship vocational training programme is currently supporting twenty girls, who are now able to provide for themselves and their families. They note the challenge to their programme is that once girls graduate from the programme, unless they are able to obtain a sewing machine, they remain unable to support themselves. Future projects include opening a bakery for further vocational training. This programme is partially supported by a church in Oregon, US (28 Too Many in-country research).

TPO UGANDA

A national NGO, the Transcultural Psychosocial Organization (TPO) is based in Uganda operating in the Western Region, North West, Northern Uganda and North Eastern Uganda (Karamoja Region). The aim of TPO Uganda is to prevent violence against women and children, including areas related to sexual health, empowering women and psychosocial functioning, and they include FGM eradication efforts. Their work focuses on advocacy and laws, monitoring and evaluation, and they also provide training for sustainable livelihoods. TPO Uganda’s approaches to end FGM

include: collective abandonment; information, education and communication; positive deviance; and targeting excisors. Moreover, they are targeting clan leaders and working to promote girl education with an emphasis on child led rights clubs. They note that these clubs have created conflict with older community members, as the children try to assert their rights and resist FGM and child marriage. Children flee to the office of the resident district commissioner and the police, who take them to a nearby boarding school. They are part of a larger network spearheaded by UNFPA and the Ministry of Gender, Labour and Social Development, though due to lack of funding their quarterly meetings have ceased.

TPO Uganda’s FGM project is based in Karamoja and is part of their broader prevention programme on violence against women. Partial funding for their programme comes from UNICEF and UNFPA, however they stress that they do not have sufficient funding to cause structural change in most of the community. They report that there programme calls upon those who have been negatively affected by FGM to come forward for corrective surgery and acts as agents of change for their communities.

The Karamoja project also uses local governments to increase awareness on FGM practice, while maintaining a less coercive approach themselves so that communities can reach abandonment declarations independently and become role models for other communities. TPO Uganda states that community members themselves report to the police when they discover FGM being practised within their localities. A critical aspect of their programme involves clan elders and FGM surgeons and ensures that they maintain their community status by turning them into members of the village health teams. Providing them with additional training on the negative aspects of FGM and enables past surgeons to serve as traditional birth attendants (which are popular in the Karamoja region) (28 Too Many questionnaire).

In the Amudat district, TPO, in partnership with UNICEF, report that they have 2,654 support workers alongside KADI (Karita Development Initiative), a community based NGO, providing psychosocial assessment and support for survivors of FGM and their families. Nearly 11,000 individuals have been sensitised on FGM law by their programme and 7911 adults and children have attended community dramas, which educate on FGM practice, risks and the law. They also report that 144 FGM survivors have thus far been treated at health facilities and were sensitised about the FGM law and encouraged to report FGM cases to law enforcement. Their report includes case studies of FGM survivors, with common complications being health problems (bleeding, abdominal pain and infections), birth complications, financial burden from hospital visits, and marital problems including divorce. Furthermore, eighteen villages (including the elders and surgeons) have signed declarations denouncing FGM and twenty-one traditional excisors were reached by six outreach groups to discuss the experiences and challenges of FGM and abandonment (TPO Uganda, 2013).

VISION CARE

Vision Care is an organisation based in Amudat that uses education and community sensitisation/ dialogue to eradicate FGM. They suggest that segregation along ethnic lines is a further reason FGM continues, in addition to marriage and rite of passage. Vision Care's programme uses health workers as agents of change and they target excisors as well as sensitising young girls on their rights to education and good health. They have community dialogues with the elders, men, Karachunas (male youth who refuse to marry un-circumcised girls), women and female excisors.

WORLD SHINE MINISTRIES

World Shine Ministries is a small FBO based in eastern Uganda focused on preventing gender and sexual based violence, child protection and empowering women. Their strategies include using education, capacity building and media. World Shine Ministries uses collective abandonment

and education approaches to end FGM and they target youth, parents, leaders and excisors. The majority of their work has been youth workshops in Kapchowa, as well as radio shows and church leader workshops. They are currently working on engaging political leaders to help end FGM. World Shine Ministries is in the early stages of their work and they operate on small grants but are underfunded, delaying further research.

CHALLENGES FACED BY ANTI-FGM

INITIATIVES

PAST STRUGGLES TO END FGM (PRE- 2010 LAW)

In 1998, a group called Promote Sabinu Culture Project was formed to resist the work being done by REACH and SEA. This group was comprised of professors, magistrates, local government leaders and teachers, and during the Sabinu ‘cutting season’ in December 1998 they contributed 50,000 Ugandan Shillings (US\$23) and gifts to every family who had their daughter cut. The number of girls cut rose from 544 in 1996 to 1,100 in 1998. One reason for this backlash was because of perceived nepotism in the selection of girls to be peer educators, who were selected to receive a small stipend to be peer educators, speaking out against FGM at school (Horsfall and Salonen, 2000; Godparents Association Newsletter, March 2011). Nevertheless, anecdotal evidence indicates that the selection criteria for the peer educators was free and fair and based on strict criteria (Kiirya and Kibombo, 2000). In addition, campaigns showing people the violent truth behind FGM in a video were not well received as it made out that traditions were brutal and barbaric (Hosfall and Salonen, 2000). REACH’s education strategies have since been modified (see NGO section above).

Horsfall and Salonen note that the inconsistent levels of funding and the poverty of the local people combined to divide the community and slow the decline of FGM in Kapchorwa. The decision to not cut one’s daughter became tied to the expectation of receiving money. As a result of these challenges faced in the early stages of the project, today REACH cautions that paying people to abandon the practice will create further issues that may divide the community and that stopping FGM should be a reward in itself. If monetary aid is provided, it should be distributed on an equal basis.

DEFIANCE OF ANTI FGM LAWS (POST- 2010)

The outlawing of FGM in Uganda has caused many issues surrounding the practice. Although it has clarified the country’s stance on FGM and has defined the sanctions for those who carry out the practice, it is hard to control. FGM has always been surrounded by secrecy and traditions and now remains a practice in rural and remote areas only. Though ending FGM continues in a positive direction occasional backlashes occur and these tend to happen more on a regional, rather than local, level and are perhaps a reaction against intense media (UNICEF-UNFPA Joint Programme, 2011a). One Sabinu blogger reported that, contrary to his expectation, the Sabinu were openly defiant to the law. They are apparently ‘outraged’ that the Ugandan government had criminalised FGM, without proper consultation with the people affected (Masaba, referred to by Godparents Association Newsletter, January 2011). Godparents Association points out that among Sabinu culture, maintaining harmony in the community through showing respect to others is one of the strongest cultural values. The imposition of the FGM law without consultation, therefore, naturally went against the Sabinu grain and that persuasion, gradually reaching consensus through winning the hearts of the people, was abandoned to the force of law (Godparents Association Newsletter, January 2011).

Mr Sande Geoffrey, Programme Officer IAC-U notes the new developments of FGM rituals:

- Girls are cut at night
- Girls are cut in bushes or caves
- The practice is rushed due to the risks
- Girls are smuggled to Kenya (at time of quote practice was still legal in Kenya). Although the practice is now illegal in Kenya (2011) 28 Too Many research notes there is little enforcement of the law so people continue to make the journey.

- Excisors are brought in from Kenya
- Local militia and guards are hired to protect the ritual grounds. TPO Uganda reports that communities are sometimes armed 'with spears, pangas and guns ready to attack anyone deterring them from the seasonal ritual' (28 Too Many questionnaire).

(Nabusoba, 2012)

Among the Sabiny it has been reported that they do not fear the law and that the law was not initiated or brought by the Sabiny (Womakuyu, 2000). In 2011, Nelson Chelimo, an elder from Kween, stated, 'Sensitisation of the masses against FGM has not yielded enough results and even the law has not changed anything in our villages' (Mafabi, 2011). Moreover, the law in Sabiny tribal areas has now pushed the practice underground and this makes tracking statistics of FGM difficult (28 Too Many research).

The situation is similar in practising Pokot groups, where the law has pushed FGM underground, making it difficult collect data. One NGO worker from among the Pokot said that the law has done 'more harm than good' and that the Pokot have told him that the law 'scares them but cannot stop them from practising' (Godparents Association Newsletter, January 2011).

ISSUES ENFORCING FGM LAW

Please refer to National Law section above which discusses the issues with enforcing the law.

GEOGRAPHY

The geographical issue of FGM in remote areas and access to Kenya has been an on-going problem. Delivering programmes to remote regions is challenging due to terrain and impassable roads during the rainy season (28 Too Many in-country research). To reach Amudat by road involves a two day drive over a route known as the 'road of death', unpaved and frequented by armed bandits. Missionaries often fly to Nakapiritpirit and

Moroto. Travellers notice the marked diminished presence of NGOs and outside influence as they travel further into Pokot areas and a 2000 study quoted locals as believing that the government did not even know of their existence (Godparents newsletter, April 2011).

FUNDING

Funding is the number one obstacle for government and NGO work on ending FGM in Uganda. The enforcement of the 2010 FGM law is suffering greatly due to the lack of supportive funds from the government, as there are costs associated with travel and patrolling rural communities which continue to practice FGM. In one Sabiny community, it was reported that there have been few convictions due to FGM; most cases are handed locally with sentences involving community work in lieu of prison (28 Too Many research). The majority of organisations contacted by 28 Too Many cited lack of funding as a primary hindrance to continuing FGM research and programming.

The Joint Programme 2011 report shows that Uganda scored low on its budget implementation at a rate of 45% (with the country average being 86%). Out of a total budget in US\$7,636,790 for all 17 country offices, Uganda's budget was US\$352,684 with their estimated balance being US\$193,869. Uganda also had a low score for International NGO partners and this was due to their success in obtaining other funding that needed to spend in a shorter time frame. Although it is positive that Uganda was successful in obtaining a range of resources, it is equally troubling that the Uganda programme is not using all of its UNFPA-UNICEF allocated money, especially as so many NGOs cite lack of funding. See recommendations below for more information.

CONCLUSIONS

28 Too Many recognises that each country where FGM exists requires individualised plans of action for elimination to be successful. We propose the following general conclusions, many of which are applicable within the wider scope of international policy and regulation and some specific to Uganda.

RECOGNISING CULTURAL SIGNIFICANCE OF FGM

In Uganda it is extremely important to recognise that FGM is a cultural identity and tradition of a minority population who do not want to assimilate their culture with other ethnic groups. FGM is a key aspect of their adult identity, economic functions, and community status and all of these factors need to be considered in any anti-FGM programme or campaign. It is also important to bear in mind the importance of involving elders in community-wide discussions as they are influencers of change.

INCORPORATING OTHER ETHNICS GROUPS AND INTERNAL MIGRANTS WITHIN FGM STRATEGIES

It is notable that the most recent DHS statistics suggest that the prevalence of FGM is overall the same in rural and urban areas. Most reports suggest that FGM is most common in rural North East Uganda principally among the Sabiny, Pokot and Tepeth. There are, however, reports of FGM occurring among the Nubi and Somali but very little data is available on these communities. There is also likely to be cases of FGM among communities who have internally migrated from the North East to other part of Uganda. More data is needed on these communities and effective strategies need to be considered in order to reach these communities, such as mainstreaming FGM into other health/development programmes.

SUSTAINABLE FUNDING

Programmes and research studies concerned with the elimination of FGM require sustainable funding in order to be effective. Continued publicity of current FGM practices at a global

level, particularly through the UN and the WHO, is crucial for ensuring that NGOs and charities are given support and resources long-term. Prioritising charitable aid and grant funding is inherently challenging, and programmes for ending FGM are given less attention than those related to the health and poverty crises. However, as is discussed in this report, FGM is a focal issue connected to these crises and directly relates to several of the MDGs. As Horsfall & Salonen argue, when programmes are not consistent and sustainable this can lead to cynicism, resentment and community division, making it harder for successor programmes to make headway on ending FGM (Horsfall & Salonen, 2000).

FGM AND THE MILLENNIUM DEVELOPMENT GOALS

Considering FGM within the larger framework of the MDGs conveys the significant negative impact FGM makes on humanity. FGM is connected to promoting gender equality, reducing child mortality, improving maternal health and combating HIV/AIDS. Relating FGM to wider social crises is important when creating grant proposals and communicating anti-FGM initiatives to a wider audience because it highlights the need for funding anti-FGM programmes and research for broader social change. There has been a momentum for change, with the UN global ban on FGM in December 2012 and the UN CSW 57 focusing on violence against women and girls, including FGM. We hope that this momentum is continued and that violence against women, including FGM, are reflected in the post-MDGs agenda.

FGM AND EDUCATION

Education is a central issue in the elimination of FGM. Illiteracy remains high in the rural regions where FGM occurs. The lack of basic education is a root cause for perpetuating social stigmas surrounding FGM as they relate to health, sexuality and women's rights. FGM hinders girls' ability to obtain basic education and prevents them from pursuing higher education and employment opportunities. This lack of education directly

relates to issues surrounding child marriage. Anti-FGM programmes need to be focused on educating girls, however educating boys and the wider community on FGM is equally important. Lack of educational infrastructure in those regions of Uganda where FGM is most prevalent needs to be addressed and educational programmes need to be tailored to the pastoralist lifestyle of the Pokot in particular. Advocacy on the importance of education is equally important given that the value of members of the practising ethnic groups, particularly girls and women, is often in farming and working, not in an education.

FGM, MEDICAL CARE AND HEALTH EDUCATION

Health providers need to be better trained to manage complications surrounding FGM and there needs to be improved access to healthcare through the FGM complications referral programme to ensure women are receiving appropriate care quickly. Lack of access to and utilisation of adequate healthcare is also an issue that needs to be addressed. More resources are needed for sexual and reproductive health education, and more research and funding is needed on the psychological consequences of FGM.

FGM, ADVOCACY AND LOBBYING

Advocacy and lobbying are essential to ensure that the 2010 anti-FGM Act is being effectively communicated to rural areas and that the communities in such areas are aware national legislation has been put in place, that the law is being properly enforced and that the momentum gained by the change in law is sustained.

FGM AND THE LAW

With the passing of Uganda's FGM Act in 2010 progress has been made to stop FGM, however reports suggest that the law is not being implemented to the fullest extent. We welcome the capacity building that has already taken place among those responsible for upholding the new law. We recommend that such capacity building is increased to sustain the momentum already

gained. A number of suggestions have been made in relation to the Joint Programme (Weber, 2012), including continuing capacity building of the police, specifically training guidelines and materials, transport and communication, health sector initiatives so that medical evidence can be collected and encouraging communities to pass by-laws in their respective areas. We concur with these and consider that such suggestions may be applicable on a wider scale. In addition, collaboration with law enforcement agencies in Kenya and measures such as the EAC-wide action that has been considered would be welcomed, in order to deal with the issue of girls being taken across the border to be cut.

FGM IN THE MEDIA

Media has proven to be a useful tool against FGM and in advocating for women's rights. 28 Too Many supports the work that has been done with media on FGM and encourages these projects to continue, however, efforts should be made to avoid sensationalist reporting. Diverse forms of media should be used (including formal and informal media) to promote awareness of FGM and advocate for women's rights at a grassroots level, ensuring that such media are appropriate to communities with low levels of literacy and poor FM radio coverage and access to TV.

FGM AND FAITH-BASED ORGANISATIONS

With over 80% of the population in Africa attending a faith building at least once a week, religious narratives are essential for personal understanding, family and society. Faith-based organisations are a major agent of change, and their international, regional, national and local presence and structures offer platforms for teaching, education, support and health provision regarding issues such as FGM. They can also work with global bodies such as the UN and its agencies. The Church, particularly the Pentecostal and Body of Christ Churches have been active in advocating against FGM. Existing religious structures should be used to sensitise the community about FGM. All faith groups and those of no faith should be

included in policy development and dialogue, as they have an important role to play in supporting the delivery of key messages and programme deliverables to communities.

COMMUNICATION AND COLLABORATIVE PROJECTS

There are a number of successful anti-FGM programmes currently operating in Uganda, with the majority of the progress beginning at the grassroots level. We recommend continued effort to communicate their work more publicly and encourage collaborative projects. A coalition against FGM will be a stronger voice in terms of lobbying and will be more effective in obtaining sustainable funding and achieving programme success, and efforts in Uganda are headed in this direction.

A 2004 report on FGM resources developed in part by USAID acknowledged that the majority of NGOs in all countries working on FGM in Africa got information primarily from printed materials from research or advocacy groups (83%). 69% of the NGOs surveyed stated that the next popular resource was the internet. These statistics are particularly important in Uganda's case, where the majority of the respondents found accessing the internet difficult and 22 out of 29 surveyed preferred print materials. The report showed that there are information gaps on: best practices, success stories, and evaluating operations research. Moreover, Ugandan NGOs asked for operations research information, training manuals and support materials, links to other organisations and advocacy tools. Clearly, Ugandan NGOs require more collaborative research and better access to materials. In recent years internet access has improved, but many regions of Uganda still do not have internet access and only about 13% of Ugandans use the internet regularly. This need for better access to FGM materials combined with a lack of internet accessibility is an issue 28 Too Many and other organisations need to be mindful of when trying to network and disseminate information to Ugandan groups (USAID, 2004).

Strengthening networks of organisations working against FGM and more broadly on women's and girl's rights, integrating anti-FGM messages into other development programmes, sharing best practice, success stories, operations research, training manuals and support materials, advocacy tools, providing links/referrals to other organisations will all strengthen the fight against FGM.

APPENDIX – LIST OF INTERNATIONAL AND NATIONAL ORGANISATIONS CONTRIBUTING TO EFFORTS FOR THE ABANDONMENT OF FGM IN UGANDA

| | | |
|--|---|--|
| 28 Too Many | Ministry of Health | United States Agency for International Development (USAID) |
| Action Aid International Uganda | National Committee for Traditional Practices in Uganda (NCTPU) | Vision Care |
| The African Network for Prevention and Protection against Child Abuse and Neglect (ANPPCAN Uganda Chapter) | Netherlands Embassy | World Health Organisation (WHO) |
| Arbeiter-Samariter-Bund (ASB) | Ngenge Development Foundation | World Shine Ministries |
| African Youth Alliance (AYA) | Pathfinder International | ZOA Uganda |
| Catholic Church of Uganda | Pokot Integrated and Development Program | |
| The Community Development Resource Network (CDRN) | Population Council | |
| Community that Cares Uganda (COTHACU) | Population Secretariate | |
| DAN Church Aid (DCA) | Post Test Club (PTC) | |
| Desert Flower | Programmes for Appropriate Technology in Health (PATH) | |
| Church of Uganda | Reproductive, Educative and Community Health Programme (REACH) | |
| French Embassy | Reproductive Health Uganda (RHU) formerly Family Planning Association of Uganda | |
| Food for the Hungry | Sabiny Athletics Association | |
| Godparents Association | Sabiny Elders Association (SEA) | |
| Human Rights Network Uganda (HURINET) | Sebei Diocese | |
| Inter-African Committee Uganda (IACU) | Sisters of the Heart | |
| Kapchorwa Civil Society Organizations Alliance (KACSOA) | Swedish International Development Agency (SIDA) | |
| Kapchorwa Integrated Community Mobilization Program (KICOMPE) | The Association of the Re-orientation and Rehabilitation of Teso Women for Development (TERRE-WODE) | |
| Kapchorwa Family Planning Association | Transcultural Psychosocial Organization (TPO) Uganda | |
| Kapchorwa Human Rights Initiative | Uganda National Teachers Association | |
| Karamoja Save the Children | United Nations (Dept. of Social and Economic Affairs, Joint Programme on Gender Equality) | |
| LAW Uganda | United Nations Children Fund (UNICEF) | |
| Maendeleo Women Group | United Nations Development Programme | |
| Matheniko Zonal Integrated Development Programme (MAZIDEP) | United Nations Population Fund (UNFPA) | |
| MIFUMI | | |
| Ministry of Education | | |
| Ministry of Gender, Labour and Social Development | | |

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