



COUNTRY PROFILE:
FGM IN BURKINA FASO

DECEMBER 2015

 **28 TOO MANY**
FGM...
let's end it.



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PREFACE



Carly Fiorina, the former executive, president, and chair of the Hewlett-Packard Company, once said, ‘Our goal should always be to turn data into information, and information into insight.’

To me, Carly’s statement embodies what 28 Too Many has done with this Burkina Faso Country Profile. They have not only provided the data, but they have also turned this data into critical information and a useful insight into how we can all enhance our efforts to end FGM in Burkina Faso.

This report could not be timelier, as at a recent stakeholders meeting in Kenya convened by The Girl Generation¹, participants noted that there is limited information on the status of FGM in many countries and this lack of information is hindering progress towards its elimination.

We need to know the landscape, the hot spots, the success stories and what is working, as well as any new and untapped opportunities for engagement. It is through such information that we can harness past efforts to strengthen emerging ideas. That is why a report such as this one is a critical tool in this work. 28 Too Many has been at the forefront of compiling country data and sharing crucial statistics on the many African countries affected by FGM, and they have done it again. This Country Profile for Burkina Faso is a vital addition to the nine existing Country Profile reports.

For us at The Girl Generation, such reports provide a great backdrop on what is happening in these countries and a great foundation for our work. Specific to this report is the comprehensive information on FGM in Burkina Faso and details on current research, which provide some insights into the political, anthropological and sociological contexts in which FGM is practised and offer analytical perspectives on how to strengthen anti-FGM programmes and accelerate the eradication of this harmful practice.

I am convinced that as a reader of this report you will be exposed to new ideas that can help you shape your efforts and interventions, and this will draw us closer to ending FGM. Of importance is the inclusion of the emerging global development agenda, the Sustainable Development Goals 2015-2030 (SDGs). The report offers a useful contextualisation of these goals in regard to Burkina Faso as well as their potential contribution to ending FGM. Certainly the analysis offered in the report not only opens new opportunities for ending FGM in Burkina Faso, but it also exposes to the fullest extent the critical achievement of 28 Too Many, which is worthy of applause and gratitude for turning data into a useful and insightful information tool.



Dr. Faith Mwangi-Powell
Global Director, The Girl Generation

1. The Girl Generation: Together to End FGM is a social-change communications initiative, providing a global platform for galvanising, catalysing and amplifying the Africa-led movement to end FGM.

FOREWORD

For all those working within the movement to end female genital mutilation (FGM), September 2015 saw a significant step forward on the international stage as the United Nations (UN) launched the new Sustainable Development Goals (SDGs) to replace the former Millennium Development Goals (MDGs). With a deadline for achievement of 2030, the 17 new SDGs focus on five 'areas of critical importance for humanity and the planet' – people, planet, prosperity, peace and partnership (UN Department of Economic and Social Affairs, 2015). Specifically, Goal 5.3 of the SDGs aims to *Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation*.

FGM is a deeply embedded social practice that has no health benefits but very serious long-term physical and psychological health consequences, which can include post-traumatic stress disorder (PTSD), depression, anxiety and reduced sexual desire and satisfaction. Higher rates of neonatal death occur among babies born to mothers who have experienced FGM, and mothers can experience obstetric complications and fistulae. As we launch our tenth Country Profile on FGM in Burkina Faso, we once again come across the huge impact of this practice on the lives of so many women and girls in West Africa.

I was honoured to visit Burkina Faso in 2014 to attend the 8th General Assembly of the Inter-African Committee (IAC), of which 28 Too Many is proud to be the UK affiliate. This international conference brought together many who are working hard to bring an end to FGM and child marriage across Africa and the world. I was touched by the hugely warm welcome that I received in Burkina Faso and honoured to meet the former first lady, Madame Chantal Compaore, who has worked so hard on anti-FGM campaigns over the years. It was encouraging to see the strong links Burkina Faso has across Africa and the world through the IAC and the UN and I hope these relationships will continue and strengthen even

further in future. Some of the challenges that still need addressing were brought into sharp focus for me during my stay as I visited children's homes and a refuge for women accused of witchcraft, and once again witnessed gender inequality first hand.

As we share our research on Burkina Faso, its population is due to go to the polls and elect a new government to take forward leadership of this West-African state.¹ That new government will face a number of challenges. The position of women and girls in society and the work to abandon harmful traditional practices (HTPs) such as child marriage and FGM must be kept high on the agenda. Our research shows that while some 87% of women (who have had FGM) and men express the view that it should be stopped, overall the national prevalence of FGM in Burkina Faso remains high, at 76% of women and girls aged 15 to 49 (DHS 2010, pp.291&299). Knowledge of FGM is almost universal throughout the country (over 99% of women and 98% of men have heard of the practice [DHS 2010, p.290]) and FGM is practised across all regions, with rates varying from 54.8% in the Centre-West to 89.5% in the Centre-East (DHS 2010, p.291). FGM is practised across all religions and ethnic groups in Burkina Faso and analysis of available data suggests that the girls who are most at risk of FGM are those born to poorer mothers with no education living in rural areas. According to the Demographic and Health Surveys (DHS) Program (2010, p.291), Type II FGM (cut, with flesh removed) is the most common type performed in Burkina Faso (at 77%) and it is almost exclusively carried out by traditional practitioners (in 96% of cases).

As the first country to have introduced a law against FGM in 1996 and with its well-established networks of NGOs under the supervision of *Le Comité National de Lutte contre la Pratique de l'Excision* (The National Committee to Fight the Practice of Excision) (CNLPE), Burkina Faso should be in a strong position to tackle the problem of

1. *On 1 December 2015, just prior to publication, it was announced that the former prime minister, Roch Marc Christian Kaboré, has been elected president.*

FGM. Unlike in some African countries which 28 Too Many has studied, NGOs in Burkina Faso are able to work openly on anti-FGM programmes with support from Government departments, and there has been an increase in prosecutions for FGM in recent years. However, during our research for this Country Profile, evidence in both the media and from NGOs working on the ground suggests that girls are being cut younger (as infants and babies) and that they are being taken across borders to countries where there are no laws in place or where enforcement is less stringent. There is clearly still an obstacle to be overcome: the growing trend for stating that FGM brings no benefits (52% of women and 69% of men [UNICEF, 2013, pp.67&68]), and the increase in the number of women and men wanting to see an end to FGM is heartening. How, though, are these views to be put into practice in communities where FGM remains a strongly-articulated social norm and families will take increasingly extreme measures to ensure their traditions continue?

I was heartened during my time in Burkina Faso to see the level of youth involvement and enthusiasm for using songs and music to get anti-FGM messages across to the community. This report outlines the many ways that NGOs are working at a grassroots level to spread the word on abandoning FGM, including organising community-dialogue programmes, engaging traditional and religious leaders, working with men and boys as well as supporting women and girls, using media such as radio and film, and integrating FGM awareness into school curricula.

Moving forward, we hope that the support at a national level for these programmes will continue and the ability of the CNLPE to work in partnership

with NGOs will be further developed. We also hope that the introduction of the new SDGs will strengthen the position of all governments and organisations when developing and implementing policies and programmes to eradicate FGM from this point forward.

I look forward to visiting Burkina Faso again in future and partnering with others to build on the valuable work done to date and further progress the abandonment of FGM throughout the country.

Dr Ann-Marie Wilson
28 Too Many Executive Director



Fig. 1: Dr Ann-Marie Wilson in Burkina Faso, April 2014 (© 28 Too Many)

VOIX DES FEMMES

La lutte contre la pratique de l'excision nécessite des réadaptations constantes.

(The fight against FGM requires constant readjustments.)

Mariam Lamizana, President, Voix des Femmes
(Excision, parlons-en, 2015)

What appears clear in Burkina Faso, as in many of the countries 28 Too Many has researched, is that only a multi-pronged approach can successfully be used to tackle FGM.

Despite much work and effort, FGM remains prevalent. Ms Lamizana points out that the law in Burkina Faso 'protects and informs' (Excision, parlons-en, 2015) but it cannot be used on its own. As one of the leading NGOs working in-country, Voix des Femmes recognises that the law must be accompanied by a range of activities designed with local circumstances in mind. Such activities range from awareness-raising and community dialogue to engaging with traditional circumcisers and supporting survivors of FGM.

Voix des Femmes achieves success in the communities on the outskirts of Ouagadougou through its *Centre pour le Bien-être des Femmes et la prévention des mutilations génitales féminines – 'Gisèle Kambou'* (CBF). This purpose-built centre has proved very popular with the local community. It incorporates training facilities that host awareness-raising and educational activities, and support facilities where health screenings and psychological help for victims of violence (including FGM) are provided. Further key services include support for the sexual- and reproductive-health

needs of women and young people, assessments of the risk of FGM for individual girls and the provision of appropriate follow-up actions.

Originally designed and developed by the Italian Association for Women in Development (AIDOS), the CBF has become the focal point of a variety of support services for all age-groups in the local community. Voix des Femmes delivers these services through a range of professionals working out of the CBF, including a gynaecologist, midwives, nurses, psychotherapists and a lawyer. Services are successful because they are tailored to the age group or section of society being targeted. Information provided to us by Voix des Femmes shows that its work ranges from educational games with adolescents, through which they can discuss issues without any taboos, to workshops with local community and religious leaders to promote new social norms.



Fig. 2: The CBF has become a focal point for the community, providing vital information about FGM and support services for women and girls (©Voix des Femmes)

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 are building an information base, which includes detailed Country Profiles for each country practising FGM in Africa and the diaspora. Our objective is to develop networks 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 improve understanding of the issues relating to FGM in the wider framework of gender equality and social change. By collating the research to date, this Country Profile can act as a benchmark to reflect the current situation. As organisations continue to send us their findings, reports, tools and models of change, we can update these reports and show where progress is being made. While there are numerous challenges to overcome before FGM is eradicated in Burkina Faso, many programmes are making positive, active change.

USE OF THIS COUNTRY PROFILE

Extracts from this publication may be freely reproduced, provided that due acknowledgement is given to the source and 28 Too Many. We invite comments on the content and suggestions on how the report could be improved as an information tool, and seek updates on the data and contact details.

When referencing this report, please use: 28 Too Many (2015) *Country Profile: FGM in Burkina Faso*. Available at <http://www.28toomany.org/countries/BurkinaFaso/>.

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We are grateful to the rest of the 28 Too Many team who have helped in so many ways, including **Caroline Overton** and **Louise Robertson**. **Mark Smith** creates the custom maps used in 28 Too Many’s country profiles. **Rooted Support Ltd** donated time through its Director **Nich Bull** for the design and layout of this report. Thanks also go to **Malcolm Crawford** for volunteering his time as proof reader.

Photograph on front cover: Rita Willaert, 2009 (cropped) (<https://creativecommons.org/licenses/by-nc/2.0/>).

Please note the use of the photograph of the girl on the front cover does not imply she has, nor has not, had FGM.

LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARP	alternative rites of passage
CBF	Centre pour le Bien-être des Femmes et la prévention des mutilations génitales féminines – ‘Gisèle Kambou’
CBO	community based organisation

CEDAW	Convention on the Elimination of Discrimination Against Women
CHW	community health worker
CNLPE	Le Comité National de Lutte contre la Pratique de l’Excision (The National Committee to Fight the Practice of Excision)
CRC	Convention on the Rights of the Child
DHS	Demographic and Health Surveys Program
ECOWAS	The Economic Community of West African States
FBO	faith-based organisation
FC	female circumcision
FGC	female genital cutting
FGM	female genital mutilation
GBV	gender-based violence
GDI	Gender Development Index
GDP	gross domestic product
GII	Gender Inequality Index
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HTP	harmful traditional practice
IAC	Inter-African Committee
ICCPR	International Covenant on Civil and Political Rights
ICESR	International Covenant on Economic, Social and Cultural Rights
INGO	international non-governmental organisation
MCH	maternal and child health
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
NGO	non-governmental organisation
PPP	purchasing power parity
PTSD	post-traumatic stress disorder
SCC	The Superior Council of Communication
SDGs	Sustainable Development Goals 2015-2030
SGBV	sexual and gender-based violence
SIGI	Social Institutions and Gender Index
TBA	traditional birth attendant
UDHR	Universal Declaration of Human Rights, 1948
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children’s Fund
UNJP	UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting
US	United States of America
WFP	World Food Programme
WHO	World Health Organization

INGO and NGO acronyms are found in Appendix I.

EXECUTIVE SUMMARY

This Country Profile provides comprehensive information on FGM in Burkina Faso, detailing the current research and providing information on the political, anthropological and sociological contexts in which FGM is practised. It also reflects on how to strengthen anti-FGM programmes and accelerate the eradication of this harmful practice. The purpose of this report is to enable those committed to ending FGM, through the information provided, to shape their own policies and practices to create positive, sustainable change. This report also considers the new Sustainable Development Goals 2015-2030 and what they mean in the context of Burkina Faso and the work to end FGM.

In Burkina Faso, the estimated prevalence of FGM in women aged 15 to 49 is 76% (DHS 2010, p.291). This figure has not changed significantly in recent years and Burkina Faso continues to be classified as a 'moderately high prevalence country' (UNICEF, 2013a, p.27).

FGM is practised across all regions, ethnic groups and religions. There is some variation in FGM prevalence by place of residence, with 68.7% of women (aged 15 to 49) in urban areas having had FGM, and 78.4% in rural areas (where the majority of the population resides) (DHS 2010, p.291). The capital, Ouagadougou, contains 14% of the country's urban population and has an FGM prevalence of 64.8% for women aged 15 to 49 (DHS 2010, p.291).

The regions with the highest prevalence of FGM lie in a band across the country towards the north-east of the centre, and in the south-west: Centre-East (90%), Central Plateau and the North (88%), Centre-North (87%), and Hauts Bassins and Cascades (82%). Three regions in the centre and towards the south have the lowest rates: Centre-West (55%), Centre (which includes Ouagadougou) (66%) and Centre-South (68%). This regional dispersal broadly corresponds to the Mossi's dominance in the central band (the FGM prevalence among the Mossi is 78%), and the Fulani's to the north-east (84%). The Gourounsi, in the south, have a lower FGM prevalence of 60% (DHS 2010 p.291; UNICEF, 2013a, p.29).

Determining incidence rates is problematic because the DHS used different methods of measurement in datasets for its 1999, 2003 and 2010 surveys. Moreover, there may be inaccuracies arising from women reporting their own or their daughters' FGM status, particularly since the criminalisation of FGM in 1996. Data for 2010 (p.291) suggests, however, that the highest rates of practice were among the Sénoufo (87%) and Fulani (84%) and the lowest among the Touareg (22%). While FGM is highest amongst Muslims (81.4%), it is also fairly widespread among those holding traditional/animist beliefs (75.5%), Catholics (66.1%) and Protestants (60%).

Social acceptance is most commonly reported as a perceived benefit of FGM, with 24% of women (aged 15 to 49), and 10% of men (aged 15 to 49) citing this as the main reason for undergoing it (UNICEF, 2013a, pp.67&68). However, 52% of women aged 15 to 49 believe FGM has no benefits at all (p.67).

It appears that attitudes towards FGM have changed in Burkina Faso over the last 15 years. More than 80% of the population are against its continuation. The highest level of support for continuation is among women aged 45 to 49 (11.7%) and men aged 15 to 19 (12.2%) (DHS 2010, p.299). Among women aged 15 to 49 who have had FGM, 11.7% support its continuation, compared to 1.5% of women of the same age-group who have not had FGM (p.299). The level of support does not vary significantly according to urban (7.8%) or rural (9.8%) residences (p.300).

Support for the continuation of FGM appears to be influenced more by level of education than wealth in Burkina Faso. There is only a slight variation by wealth quintile: 10.8% of women (aged 15 to 49) in

the poorest quintile believe FGM should continue compared to 7.6% in the richest quintile (p.300). In contrast, 10.6% of mothers (aged 15 to 49) with no education are in favour of its continuation, compared to only 2.7% of mothers with secondary- or higher-level education (p.300). An analysis of the available data therefore suggests that girls born to poorer mothers living in rural areas who have had no education are the most likely to be cut (see also UNICEF, 2013a, pp.20&40).

FGM is practised mainly on infants and young girls. DHS 2010 suggests that among girls aged 15 to 19 who have undergone FGM, 91% were cut before age ten, 7% were cut between ten and 14, and only 1% were cut at age 15 or later (UNICEF, 2013, p.99). In addition, 89% of women aged 45 to 49 reported being cut, compared with 58% of girls aged 15 to 19 (UNICEF, 2013, page 101). This may indicate an overall decline in the practice across generations, since evidence suggests that few girls are likely to be cut in Burkina Faso after the age of 14 (Yoder and Wang, 2013, p.27).

Type II FGM (cut, flesh removed) was the most common type reported among women aged 15 to 49, at 77%. 17% reported having Type I (cut, no flesh removed) and only 1% reported having Type III (sewn closed). 5% did not know what type of FGM they had undergone. The Bobo had the highest percentage of Type III, at 2.3% (DHS 2010, p.291). Almost all FGM procedures on girls aged 0 to 14 were carried out by traditional practitioners (UNICEF, 2013a, p.44).

In 1996 Burkina Faso was the first African country to introduce a national law against FGM (UNICEFa, 2013, p.11). In 2001 funding for activities to eliminate FGM was integrated into the national budget, and in 2005 a reproductive-health law was introduced outlawing harmful practices (p.12). The number of successful prosecutions has risen over the years. In 2009 the authorities responded to 230 incidents (UNFPA, 2011, p.5). A National Action Plan 'to promote the elimination of FGM with a perspective of zero tolerance' was adopted for 2009 to 2013 (*Plan d'action national [2009 – 2013] de promotion de l'élimination des mutilations génitales féminines dans la perspective de la tolérance zéro, mai 2009*), and the Government has been a partner in the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting (UNJP), which aimed to eradicate FGM by 2015.

In 1990, prior to introducing the new laws, the Government of Burkina Faso established the CNLPE as an institutional framework for coordinating resources and actions to eradicate FGM. Through the National Action Plan, the CNLPE has conducted research and awareness-raising activities at national and local levels. It is also responsible for enforcing the law and increasing education on FGM in the school curriculum. It partners and supports a wide range of organisations and runs an 'SOS Excision' telephone hotline.

The political situation in Burkina Faso is currently in a state of transition. A failed government coup recently took place, which delayed planned elections. These were due to be held at the end of November 2015 (too late for this publication to comment on their outcomes and the potential impact on the work to end FGM).

There are numerous international non-governmental organisations (INGOs) and NGOs working to eradicate FGM, using a variety of strategies including the community-dialogue approach, addressing the health risks of FGM, raising FGM awareness in schools and utilising the media. Organisations in Burkina Faso are able to work openly on anti-FGM programmes and their endeavours have to date been supported by the Government and the CNLPE.

National initiatives that are proving successful in communities include the work of Voix des Femmes in providing activities and support services based at their purpose-built centre on the outskirts of Ouagadougou. Community-dialogue programmes involving key local traditional and religious leaders and

former circumcisers are being carried out in many areas by other NGOs such as Mwangaza Action and *Groupe d'Appui en Santé, Communication et Développement* (GASCODE) as part of the UNJP. Internationally, work is being done by German-based (I)NTACT with in-country partners to incorporate FGM awareness in the school curriculum. There is growing evidence that girls increasingly may be taken by their families across borders to be cut, so as to avoid prosecution. In response, organisations such as (I)NTACT and its partners are working to tackle this issue in communities in the south of Burkina Faso. A comprehensive overview of these organisations is included in this report.

We propose the following measures:

- Adopting culturally-relevant programmes. There is a strong national message against FGM, but change needs to take hold within communities and local drivers for FGM must be addressed.
- Providing long-term funding. This is a common issue across the development (NGO) sector. Organisations working against FGM need ongoing, sustained and committed support from Government programmes (particularly given the uncertain political landscape). They also need to continue reaching out for partnership opportunities.
- Considering FGM within the SDGs, in which the elimination of FGM is specifically stated as a target (at 5.3). The SDGs will be an incentive to countries to take more positive action against FGM.
- Facilitating education and supporting girls through secondary and further education.
- Improving access to health facilities and managing health complications due to FGM.
- Increasing enforcement of relevant laws and ensuring those responsible for FGM are prosecuted.
- Fostering effective media campaigns which reach out to all regions and sections of society.
- Encouraging FBOs to act as agents of change, to challenge misconceptions that FGM is a religious requirement and to be proactive in ending FGM.
- Increasing collaboration and networking between the different organisations working to end FGM, thereby strengthening and reinforcing messages and accelerating progress.
- Developing and introducing a new National Action Plan following the election of a new government.

Further work and research is required to:

- investigate whether the outlawing of FGM has affected the age of cutting and the level of cross-border movement to undertake the practice;
- gather more-complete data on what is working and changing in FGM programming, particularly with regard to the involvement of religious leaders;
- implement consistency in data collection and measure the accuracy of self-reported changes in FGM prevalence;
- conduct follow-up studies in communities that have declared abandonment, to measure the impact and level of ongoing commitment to the declarations and discover whether there is a need for continued support; and
- study the medical consequences of FGM in a Burkina Faso context.

INTRODUCTION

'It is now widely acknowledged that FGM functions as a self-enforcing social convention or social norm. In societies where it is practiced it is a socially upheld behavioural rule. Families and individuals uphold the practice because they believe that their group or society expects them to do so. Abandonment of the practice requires a process of social change that results in new expectations on families' (The General Assembly of the United Nations, 2009, p. 17).

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) is defined by the World Health Organization (WHO) (2015a) as comprising '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. Over 125 million girls and women alive today have had FGM in the 28 African countries where FGM is practised and in Yemen, and three million girls are estimated to be at risk of undergoing FGM annually (UNICEF, 2013a, intro., p.iv).

HISTORY OF FGM

FGM has been practised for over 2,000 years (Slack, 1988, p.439). Although it has obscure origins, there has been anthropological and historical research conducted 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, p.444). Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young female herders, as a custom among stone-age people in Equatorial Africa, or

as 'an outgrowth of human sacrificial practices, or some early attempt at population control' (Lightfoot-Klein in Wilson, 2013, p.4).

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 among different peoples (Lightfoot-Klein in Wilson, 2013, p.4), aided by Egyptian slave raids from Sudan for concubines and the trading of maids through the Red Sea to the Persian Gulf (Mackie in Wilson, 2013, p.4).

GLOBAL PREVALENCE AND PRACTICES

FGM has been reported in 28 countries in Africa 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 in Central Africa. It also occurs in some countries in Asia and the Middle East and among certain diaspora communities in North America, Australasia and Europe. As with many ancient practices, FGM is carried out by communities as a heritage of the past, and is often associated with ethnic identity. Communities may not even question the practice or may have long forgotten the reasons for it.

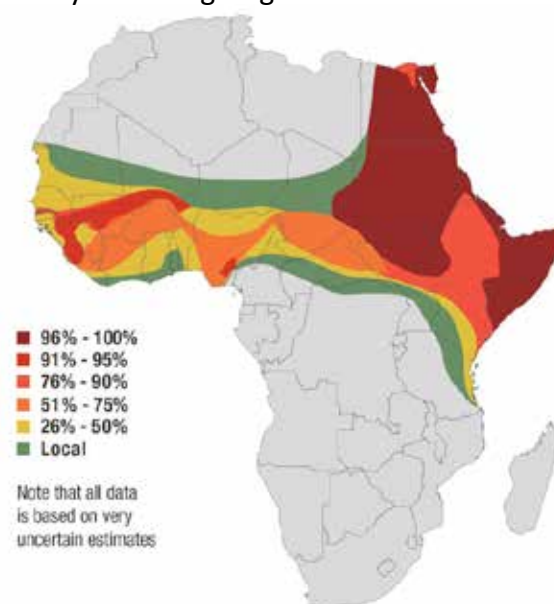


Fig. 3: Prevalence of FGM in Africa (Afrol News, 2006)

The WHO classifies FGM into four types (WHO, 2008, p4):

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).
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. Some communities consider that it ensures and preserves virginity and 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, practitioners often believe it 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 (WHO, 2008, p.1). 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 new-born deaths, and the need for later surgeries. For example, a woman with Type III infibulation needs to be cut open later to

allow for sexual intercourse and childbirth (WHO, 2015a).

The eradication of FGM is pertinent to the achievement of the SDGs. Goal 5 (*Achieve gender equality and empower all women and girls*) makes explicit reference to FGM at 5.3: *Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation*. Other goals which are particularly apposite to the elimination of FGM are Goal 3: *Ensure healthy lives and promote well-being for all at all ages* and Goal 4: *Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all*.

The vision of 28 Too Many is a world where every girl and woman is safe, healthy and lives free from FGM and other human-rights violations. A key strategic objective is to provide detailed, comprehensive Country Profiles for each of the 28 countries in Africa where FGM is practised. The reports provide research into the situation regarding FGM in each country, as well as more general information relating to the political, anthropological and sociological environments in the country, to offer a contextual background. This can also be of use regarding diaspora communities that migrate and maintain their commitment to FGM.

The Country Profile also offers an 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 practise 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 research report provides a sound information base which can contribute to determining the models of sustainable change necessary to shift attitudes and behaviours and bring about a world free of FGM.

During our research we have connected with many anti-FGM campaigners, CBOs, policy makers and key influencers. 28 Too Many wishes to continue to build upon its in-country networking to aid information-sharing, education and awareness of key issues, enabling local NGOs to be part of a greater voice to end FGM, locally and internationally.

GENERAL NATIONAL STATISTICS

This section provides an overview of the general situation in Burkina Faso and highlights a number of indicators of the country's context and development status. (All statistics are taken from the CIA World Factbook, 2015, unless otherwise stated.)

POPULATION

18,480,018 (Country Meters, 19 November 2015)
 Median age: 17.1 years (2015 est.)
 Growth rate: 3.03% (2015 est.)

HUMAN DEVELOPMENT INDEX

Rank: 181 out of 186 in 2012 (UN Development Programme, 2014)

HEALTH

Life expectancy at birth (years): 55.12
 Infant mortality rate (per 1,000 live births): 75.32 deaths
 Maternal mortality rate: 400 deaths/100,000 live births (2013) (WHO, 2015a, p.1)
 Fertility rate, total (births per women): 5.86 (2015 est.)
 HIV/AIDS – adult prevalence: 0.94% (2014 est.)
 HIV/AIDS – people living with HIV/AIDS: 107,700 (2014 est.); country comparison to the world: 42
 HIV/AIDS – deaths: 3,800 (2014 est.)

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

Total: 36%; Female: 29.3%; Male: 43% (2015 est.)
 Youth (15-24 years): 39% (female - 33%; male - 47%) (2014) (World Bank, 2014, p.2)

GDP (IN US DOLLARS)

GDP (official exchange rate): \$12.5 billion (2014 est.)
 GDP per capita (PPP): \$1,700 (2014 est.)
 GDP (real growth rate): 4% (2014 est.)

URBANISATION

Urban population: 29.9% of total population (2015)
 Rate of urbanisation: 5.87% annual rate of change (2010-2015 est.)

ETHNIC GROUPS

Mossi over 40%, other approximately 60% (includes Gourounsi, Sénoufo, Lobi, Bobo and Fulani)

RELIGIONS

Muslim 60.5%, Catholic 19%, animist 15.3%, Protestant 4.2%, other 0.6%, none 0.4% (2006 est.)

LANGUAGES

French (official), native African languages belonging to Sudanic family spoken by 90% of the population, including Mooré/Moré

SUSTAINABLE DEVELOPMENT GOALS

The eradication of FGM was pertinent to six of the UN's eight Millennium Development Goals (MDGs), which reached their deadline in 2015. In September 2015, the UN adopted the Sustainable Development Goals (SDGs), which replaced the MDGs and have a deadline for achievement of 2030. The 17 SDGs focus on five 'areas of critical importance for humanity and the planet' – people, planet, prosperity, peace and partnership (UN Department of Economic and Social Affairs, 2015).



Fig. 4: The Sustainable Development Goals

A document entitled *Transforming our World: the 2030 Agenda for Sustainable Development* (UN Department of Economic and Social Affairs, 2015), details the SDGs and states that they

seek to build on the Millennium Development Goals and complete what these did not achieve. They seek to realize the human rights of all and to achieve gender equality and the empowerment of all women and girls.

FGM in Burkina Faso was not eliminated by 2015, but the MDGs did provide a focus for encouraging activity that would lead to its elimination. The SDGs go further than the MDGs and make explicit reference to the elimination of FGM. This will strengthen the hands of governments, NGOs and multi-lateral organisations when implementing anti-FGM policies and legislation.

Sustainable Development Goal 5:

Achieve gender equality and empower all women and girls

Goal 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

Other SDGs have relevance for women and girls who have experienced or are likely to experience FGM, particularly those related to education, health and gender equality.

In addition to the SDGs, the African Union has declared the years 2010 to 2020 to be the African Women's Decade (African Union, 2011, p.2). This declaration will assist in promoting gender equality and the eradication of FGM and other forms of gender-based violence in Burkina Faso.

For a summary of all 17 SDGs, please go to <http://28toomany.org/fgm-research/research/>.

POLITICAL BACKGROUND

HISTORICAL

Burkina Faso is a landlocked country surrounded by Niger to the east, Benin to the south-east, Togo and Ghana to the south, Côte d'Ivoire to the south-west and Mali to the north. The country was previously known as the Upper Volta. Mossi tribes, originating from Ghana, immigrated into the region between the 10th and 11th centuries, forcing out the original Yonyonse inhabitants. The establishment of complex administrative systems, combined with the backing of strong armies, enabled the Mossi to create powerful states. The Mossi kingdoms were ruled by kings, or *nabas*, with the most prominent being headed by the *Mogho Naba* (great lord or chief) at Ouagadougou.

In the early 1890s the British and French military fought to claim parts of the country. Following the defeat of the Mossi kingdom of Ouagadougou in 1896 it became a French protectorate. In 1898 the British and French came to an agreement on the placing of borders. In 1904, as part of the reorganisation of their colonial empire, the French merged the Volta basin territories with their

French West Africa colony, which included Upper Senegal and Niger. In 1919 the French reversed this merger, separating the present Burkina Faso territory from Niger and Upper Senegal. The colony of Upper Volta was further dismantled in 1932, when it was split between French Sudan, Niger and Côte d'Ivoire. Agitation in the country following World War II led the French to reverse its status again, bringing Upper Volta back into the French Union in 1947. It eventually earned self-government status, becoming the Republic of Upper Volta in 1958, and gained full independence from France in 1960. Burkina Faso is divided into 13 administrative regions, as shown in Figure 5.

The first president following independence was Maurice Yaméogo, who was deposed in 1966 after a military coup d'état. Further coups and changes in government followed until, in 1983, Thomas Sankara, a military captain, seized power. In 1984 he changed the name of the country from Upper Volta to Burkina Faso, which means 'the land of honest men'. Sankara was widely viewed as a radical leader and was assassinated during a French-backed coup in October 1987.

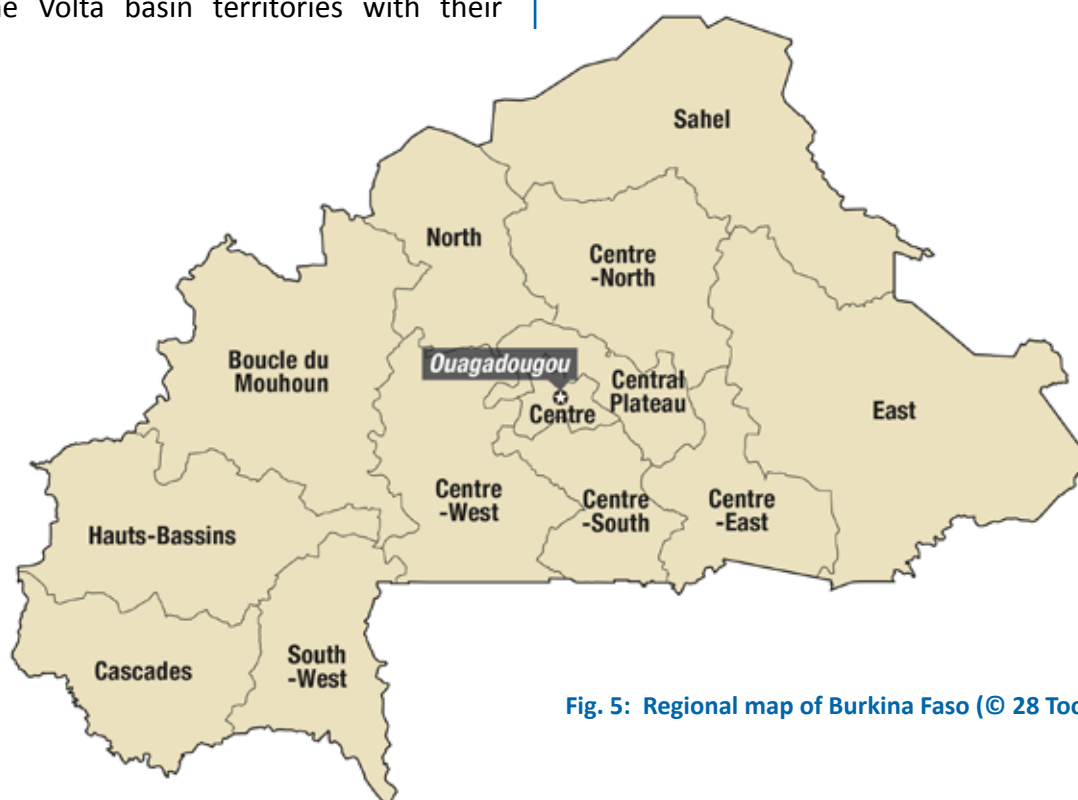


Fig. 5: Regional map of Burkina Faso (© 28 Too Many)

CURRENT POLITICAL CONDITIONS

Blaise Compaore succeeded Sankara as the leader of the country but was not formally elected as president until, following constitutional reforms, the first multiparty elections in the country were held in 1991. From the mid-1990s the Congress for Democracy and Progress was the main political party in the country. Blaise Compaore was president for 27 years, winning four elections. In October 2014 he was forced to step down following mass protests triggered by proposed changes to the Constitution to allow an extension to the presidential term in office. A brief period of army rule followed, before a transitional government was put in place in November 2014.

General elections were scheduled to take place in Burkina Faso in October 2015, but in September 2015 officers of the Regiment of Presidential Security announced the dissolution of the transitional government and arrested President Kafondo, who headed it. A week later, following intervention by the army and leaders of several West African countries, Kafondo was reinstated as president and the Regiment of Presidential Security was disbanded. Elections were rescheduled for 29th November 2015.

ANTHROPOLOGICAL BACKGROUND

Burkina Faso is a diverse nation with more than 60 ethnic groups. In pre-colonial times a large part of present-day Burkina Faso was under the control of the Mossi empire. The north and east were frontier lands of the Fulani and Gourmantche kingdoms. In the west and south-west the population was (and is) comprised of various ethnic groups including the Lobi, the Dagara, the Bobo and the Karaboro (Hagberg, 2001, pp.15-16).

The Mossi remain the largest ethnic group, comprising over 40% of the population, followed by the Fulani (10%), Bobo (7%) and Lobi (7%). Other groups include the Bissa, Bwa, Dioula, Gourounsi, Mandé and Sénoufo (CIA World Factbook, 2015; One World, 1998-2014). French is the official language but Mooré/Moré, the language of the Mossi, is also widely spoken. Other spoken languages include Dioula, Gurmanche and Fula (Minority Rights Group International, 2007).

Many of the country's traditional societies have their own hierarchies. For example, Mossi society differentiates between aristocrats (*Nakomse*), commoners (*Talse*) and slaves or captives (*Yemse*). As well as class stratification, individuals can be categorized by occupation. For example, in the

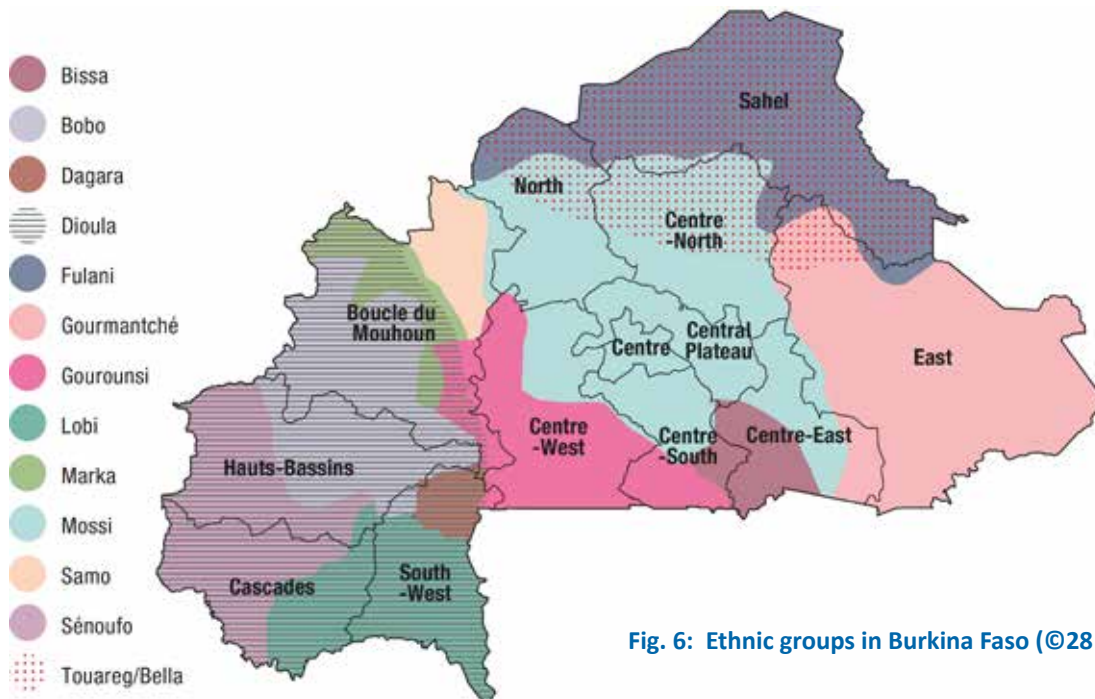


Fig. 6: Ethnic groups in Burkina Faso (©28 Too Many)

west, which is influenced by Mandé tradition, blacksmiths and praise singers (*Griots*) form caste-like groups (*Nymakallaw*); traders such as the Dioula in the west are also generally respected (WCE, 2015a).

As with many other African cultures, the extended family is important in Burkina Faso, with most Burkinabé (as the people of Burkina Faso are known) living in an extended-family environment. The clan or lineage plays a major role in both traditional and urban settings. A clan or lineage can be made up of a number of dispersed people or a locally-defined unit on common clan territory. The majority of Burkinabé live in patrilineal societies where kinship is recognised according to the father's line. However, in the west and south-west there are several societies with a matrilineal system, where kinship is recognised according to the mother's line. In some cases a double-descent system exists. For example, among the Lobi, 'magical and ritual powers are transmitted through the father's line, and material wealth and the means of production are transmitted in the mother's line' (Helmfrid, 2004, p.8). The practice of levirate marriage, when a widow is forced to marry a relative of her late husband, is common among many of the ethnic groups found in Burkina Faso (Zare, Yaro and Ibrahim in UNECA, 2008, pp.20-21; Immigration and Refugee Board of Canada, 2014). Marriage to first or second cousins ('consanguineous marriage') is also common in some groups.

ETHNIC TENSIONS

Under colonial rule the nation's boundaries were marked out in a somewhat arbitrary way. As a result, people from the same ethnic groups were separated and people without any cultural or historical affinities were grouped together. In spite of this a national identity has formed, and Burkinabé have a strong sense of community and generally live in harmony (WCE, 2015a).

Important in cultural life are the 'joking relationships' that help to re-inforce social

cohesion and group membership: when 'joking partners' meet, they may insult each other in a humorous way but it is forbidden to take any offence. These relationships relieve tension and are highly developed among many ethnic groups, especially between the Mossi and Samo, the Bissa and Gourounsi, the Fulani and Bwaba/Bobo, and the Guin/Karaboro and Lobi/Dagara (WCE, 2015a&b).

There is high tolerance of different religions among Burkinabé. About 60% of Burkinabé are Muslim. The western and southern regions are dominated by Christianity and there are many Christians among the people of the elite class in the cities. Animism and other traditional religions and beliefs are also prevalent (CIA World Factbook, 2015; Our Africa, undated).

Over the years, conflict has arisen between some ethnic groups over natural resources (IRIN News, 2012). For example, in 2007 hundreds of nomadic Fulani families left Burkina Faso following a dispute between a Fulani cattle herder and a Mossi farmer (Lacville, 2010).

ETHNIC GROUPS

BISSA

The Bissa are primarily located in the south-eastern corner of Burkina Faso, in the province of Boulgou (Berthelette, 2001, p.3). It is believed the Bissa migrated from present day Ghana and arrived in the area in two waves, during the 13th and 15th centuries. They follow a mix of traditional religion, Islam and, to a lesser extent, Christianity (Curtis in Berthelette, 2001, p.6). FGM prevalence is one of the highest at 83.1% (DHS 2010, p.291).

BOBO

The Bobo have lived in western Burkina Faso and Mali for centuries, possibly as far back as 800 AD. The Bobo are primarily an agricultural people. They have a decentralised social system, which is based on patrilineal relationships (Africa Guide, 2015). FGM prevalence is 68.4% (DHS 2010, p.291),

and the Bobo cut their girls' genitals shortly after they are born and without any specific ceremony (Helmfrid, 2004, p.13).



Fig. 7: Grubs for sale – a Bobo woman in the market (Photographer: Adam Jones)

DAGARA (DAGAABA/DAGABA/DAGARTI/DAGARI)

The Dagara people are primarily located in north-western Ghana and south-western Burkina Faso. Farming is central to this group's way of life and they often migrate in search of better land. FGM prevalence is 69.3% (DHS 2010, p.291).

DILOLA (DYULA/DIULA/JULA)

Historically the Dioula were gold traders and skilled craftsmen, providing a trade link between Burkina Faso, western Sudan and north Africa. Most Dioula are Muslims. Alongside Mooré and French, Dioula is widely spoken as a trading language (Encyclopaedia Britannica, 2015a). Polygamy is still commonplace, with girls usually marrying at 16, preferably to cousins within their own clans (Joshua Project, undated). FGM prevalence is 72.8% (DHS 2010, p.291).

FULANI (FULA/FULBE/PEUL)

The Fulani are a historically nomadic, pastoralist group found throughout West Africa. They are

primarily located in the north of Burkina Faso and many continue to lead their nomadic life style. The majority are Muslims (WCE, 2015c) and FGM prevalence is high at 83.9% (DHS 2010, p.291). The Fulani are a patrilineal society and polygamy is common. As arranged first marriages are typically accompanied by a 'payment of bridewealth' (usually cattle), Hampshire and Smith (2001) have suggested that the frequency of consanguineous marriage among the Fulani may be due to a lack of cattle, and 'bridewealth' demands are likely to be less when marrying close family (i.e. cousins).

GOURMANTCHÉ (GURMANCHE/GURMA/GOURMA)

Gourmantché are primarily found in the town of Fada N'Gourma in eastern Burkina Faso. They are believed to have migrated from present-day north-eastern Ghana. They are mostly farmers (Encyclopaedia Britannica, 2015b) and have one of the lower FGM rates at 64.3% (DHS 2010, p.291).

GOUROUNSI (GURUNSI/GRUNSHI)

The Gourounsi are primarily located in northern Ghana and southern Burkina Faso. There are numerous ethnic subgroups among the Gourounsi, including the Bwa of Burkina Faso and Mali, and the Kassena and Nankani, who inhabit both Ghana and Burkina Faso (kwekudee, 2013). The Gourounsi record the second-lowest FGM rate of all groups, at 60.3% (DHS 2010, p.291).



Fig. 8: Gourounsi woman (Photographer: Rita Willaert)

LOBI

The Lobi are farmers and hunters, originally from north-western Ghana. Traditionally they lived in extended families with no larger political structure, and were highly resistant to the imposition of colonial and then post-colonial central government. The Lobi have generally retained their cultural identity and are well known for their animist beliefs (Gateway Africa, undated). FGM prevalence is also high at 83.2% (DHS 2010, p.291).

MOSSI



Fig. 9: Girl with Mossi doll (Children and Youth in History)

The Mossi form the largest ethnic group in Burkina Faso, making up almost half of the population. Primarily, they occupy the central plain around Ouagadougou and Ouahigouya.

Mossi culture emphasises the importance of family and kingdom values. They are said to have the most centralised and hierarchical political system in Burkina Faso, which dates back to pre-colonial times (Helmfrid, 2004, p.8). Today the Mossi remain active in local and national politics, bound by the traditions of the Mogho Naba, king or emperor of the Mossi, who is given powers to secure the safety of the kingdom. The Mogho Naba still holds a ceremony in Ouagadougou each week that is attended by Mossi leaders.

Rites of passage are important to the Mossi, including the circumcision of boys and girls before they become adults; later, '[f]ull adulthood is

marked by marriage' (WCE, 2015b). Among the Mossi, FGM prevalence is 78.4% (DHS 2010, p.291).

SÉNOUFO

The Sénoufo people are mainly found in a region that encompasses parts of the nation-states of Burkina Faso, Côte d'Ivoire and Mali. The Sénoufo are primarily an agricultural people for whom community is as important as family and kinship ties. The Sénoufo are an animistic society, believing that blessings or afflictions are a result of their attentiveness to their ancestors' spirits (Spurlock Museum, 2001; Art & Life, undated). FGM prevalence is the highest of all ethnic groups at 87.2% (DHS 2010, p.291).

TOUAREG (TUAREG/BELLA)

The Touareg are Berber people who traditionally have a nomadic, pastoralist lifestyle. Most of the Touareg live in the Saharan and Sahelian regions; in Burkina Faso they are mostly found in the north-east. Most Touareg are Muslims but their traditional belief system and rituals overlap with Islam. Unlike women in many other Islamic societies, most Touareg women do not wear veils in public. They may also independently inherit property. Traditionally the Touareg have married within their own social category; however, this has changed in recent times (WCE, 2015d; Taylor, 2012). FGM prevalence is much lower than all other groups, at 22.2% (DHS 2010, p.291).



Fig. 10: Touareg in the market (Tropenmuseum, part of the National Museum of World Cultures)

OVERVIEW OF FGM IN BURKINA FASO

This section gives a broad picture of the state of FGM in Burkina Faso. Other sections of this report

give more detailed analyses of FGM prevalence, set within sociological and anthropological frameworks, and efforts towards its abandonment.

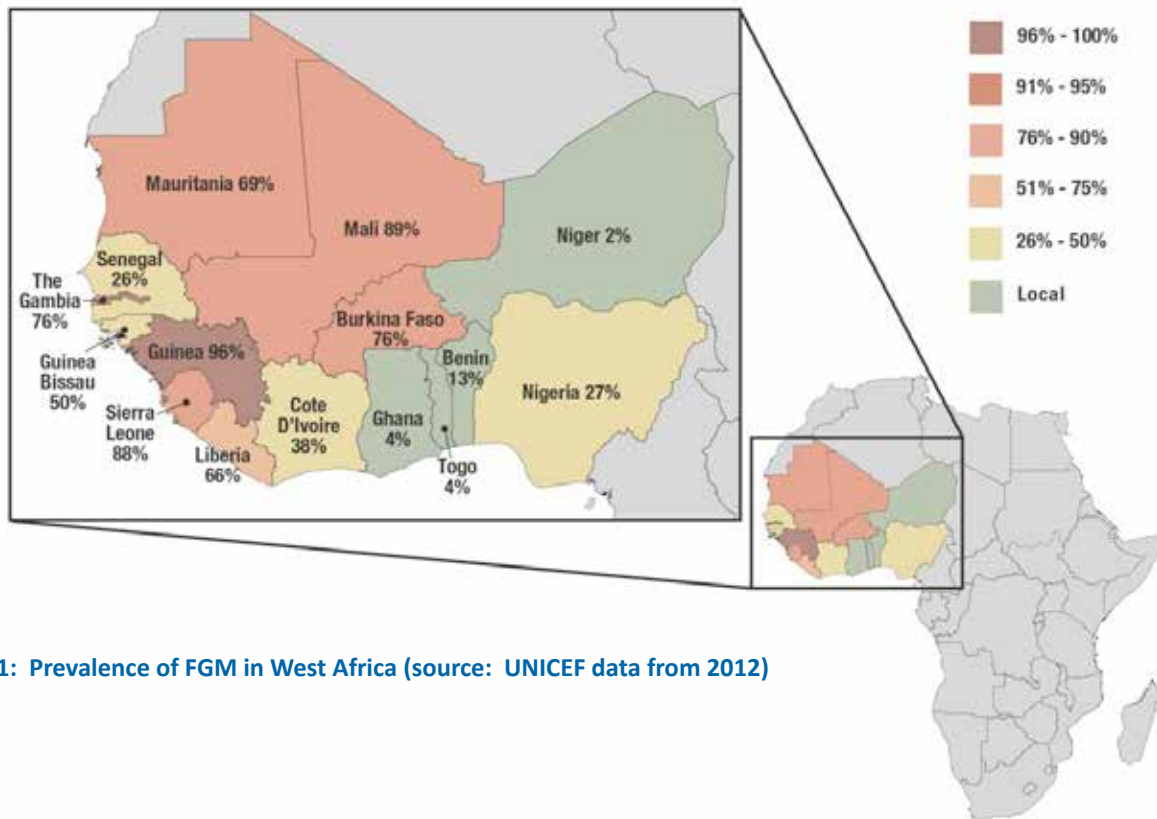


Fig. 11: Prevalence of FGM in West Africa (source: UNICEF data from 2012)

A NOTE ON DATA

UNICEF (2013a, p.24) highlights that self-reported data on FGM ‘needs to be treated with caution’ since women ‘may be unwilling to disclose having undergone the procedure because of the sensitivity of the topic or the illegal status of the practice.’ They may also be unaware that they have been cut, or the extent to which they have been cut, especially if FGM was carried out at a young age.

DHS data before 2010 does not directly measure the FGM status of girls aged 0 to 14. Prior to 2010 the DHS surveys asked women whether they had at least one daughter who had been cut, or whom they intended to have cut. This could not be used to calculate accurately the prevalence of FGM among girls under the age of 15, as they may have been cut after the date of the survey, or the mother may have had several daughters who had been cut. From 2010 the DHS methodology changed so that women are now asked the FGM status of all their daughters under the age of 15 (UNICEF, 2013a, p.25).

Measuring the FGM status of this younger age group (0 to 14 years), who have most recently undergone FGM or are at most imminent risk of undergoing FGM, gives an indication of the impact of current efforts to end FGM. Alternatively, responses to this question may indicate the effect of laws criminalising the practice, which make it harder for mothers to report that FGM was carried out as they may fear incriminating themselves. Additionally, unless they are adjusted, these figures do not take into account the fact that girls may still be vulnerable to FGM after the age of 14 (UNICEF, 2013a, p.25).

The DHS/MICS 2010* for Burkina Faso includes a question about girls who have been cut between the ages of 0 and 14 (DHS 2010, p.294) but makes the point that girls not cut at this lower age may be cut later on, and therefore these figures should not necessarily be taken as indicators of a change in overall incidence rates (DHS 2010, p.294).

**In 2010 Burkina Faso was the first country to combine the DHS and MICS surveys, updating information on FGM and collecting prevalence data on girls under age 15 for the first time (UNICEF, 2013a, p.13)*

NATIONAL STATISTICS AND TRENDS

RELATING TO FGM

The estimated prevalence of FGM in women aged 15 to 49 is 76% (DHS 2010, p.291). Burkina Faso is classified as a 'moderately high prevalence country' (UNICEF, 2013a, p.27). There was little change in the prevalence of the practice since the previous DHS survey in 2003, when it was 77% (DHS 2003, p.204), although the Multiple Indicator Cluster Survey (MICS) carried out in 2006 gave a rate of 73%, which could suggest there was a slight increase between 2006 and 2010 (MICS in UNFPA, 2013b, p.1).

Statistics on the prevalence of FGM are compiled through large-scale household surveys in developing countries – the DHS and the MICS. For Burkina Faso reports were published by the DHS in 2000 and 2004, and by the MICS in 2008, followed by the combined DHS/MICS report in 2012. Data

in the latter report is based on FGM status at the time of the 2010 DHS/MICS survey of Burkina Faso, which is the most recent set of data available for the country and is referred to throughout this Country Profile as 'DHS 2010'.

PREVALENCE OF FGM IN BURKINA FASO BY PLACE OF RESIDENCE

While more than half the women and girls across the whole of Burkina Faso have undergone FGM, there are distinct regional variations as shown in Figure 12 below. FGM prevalence ranges from 54.8% in the Centre-West to 89.5% in the Centre-East.

According to DHS 2010 (p.291) nearly 10% more women aged 15 to 49 are cut in rural areas (78.4%) than urban areas (68.7%) in Burkina Faso. Prevalence in the capital Ouagadougou is 64.8% (p.291). To put this in context, in 2015 over two-thirds of the total population of Burkina Faso

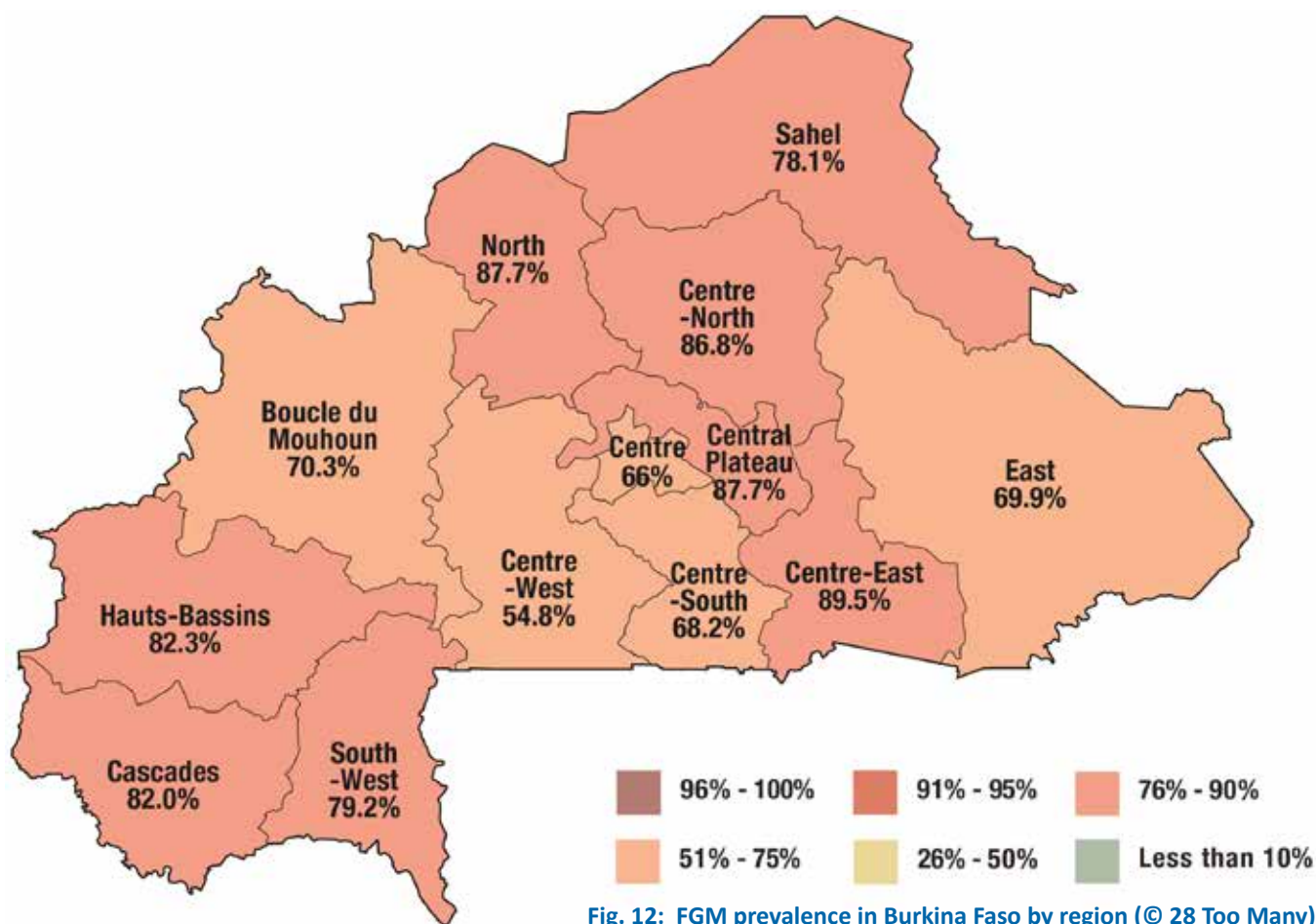


Fig. 12: FGM prevalence in Burkina Faso by region (© 28 Too Many)

were living in areas classified as rural (CIA World Factbook, 2015). Understanding these regional and rural/urban differences goes alongside understanding difference by ethnicity. People from the Bissa and Mossi groups reside in the regions showing the highest prevalence, such as the Centre-East, and these groups have some of the highest prevalence figures, at 83.1% and 78.4% respectively (see Figure 14 below). In contrast, the Centre-West is dominated by the Gourounsi people, who have a lower FGM rate of 60.3% (DHS 2010, p.291).

Residence may not be a direct influence, however, as a woman may not live in the place she was cut or she may have moved since she was cut, particularly if she was cut at a young age. For this reason it is more helpful to look at prevalence among young girls and their place of residence (UNICEF, 2013a, p.37).

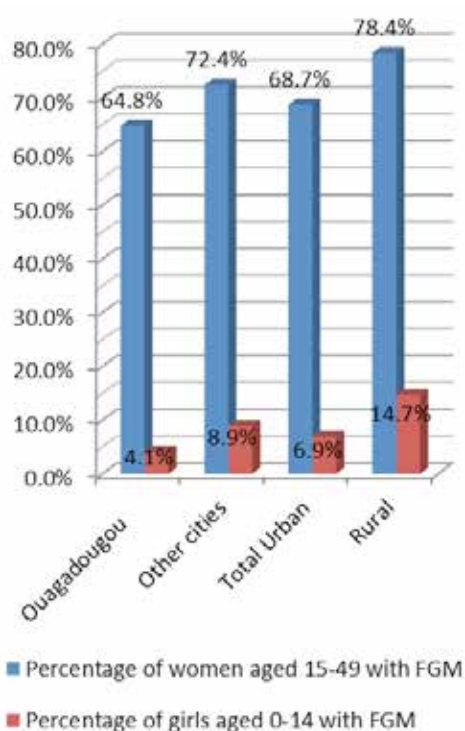


Fig. 13: Percentages of women and girls with FGM, according to place of residence (DHS 2010, p.291; UNICEF, 2013a, p.176)

As shown in Figure 13 above, girls living in Burkina Faso’s rural areas are more likely to be cut than those living in urban areas. Among girls in the

0 to 14 age-range, mothers living in rural areas reported that nearly 15% of their daughters had been cut, compared with almost 7% of daughters with mothers reporting from urban areas (UNICEF, 2013a, p.176). These figures appear on the low side; however, these girls represent the first in this age cohort included in a DHS survey since the introduction of the law against FGM (refer to accompanying box ‘A Note on Data’) and care should be taken when interpreting the figures. ‘A simple percentage of all girls aged 0 to 14 who have been circumcised at the time of the survey will understate the magnitude of the practice for this age group as a whole’ (Yoder and Wang, 2013, p.26).

Another issue associated with location arises because Burkina Faso shares borders with six other countries, all of which have laws against FGM except Mali. To date Burkina Faso’s laws have been more strongly enforced than its neighbours’. A 2008 UNIFEM study raised concerns that laws against FGM in countries like Burkina Faso were potentially driving the practice underground and across borders, meaning that families were taking their daughters to countries where such laws did not exist or the enforcement of such laws was less strict. The study concluded that outlawing the practice had ‘deeply biased the discourse on female excision’ (UNIFEM in Sayagues, 2009). The study cited groups moving across borders to have their daughters circumcised, such as the Fulani moving between Burkina Faso and Niger; the Gourmantché between Burkina Faso and Niger; the Dagara and Lobi between Burkina Faso and Ghana; and the Mossi and Yagse communities travelling with their daughters to Mali (Sayagues, 2009).

PREVALENCE OF FGM BY ETHNICITY

Ethnicity has been given as another factor in the continuation of FGM. This can be seen from the following graph, which shows wide divergence in the prevalence of FGM between ethnic groups, with the Sénoufo at 87% and the Touareg at 22%.

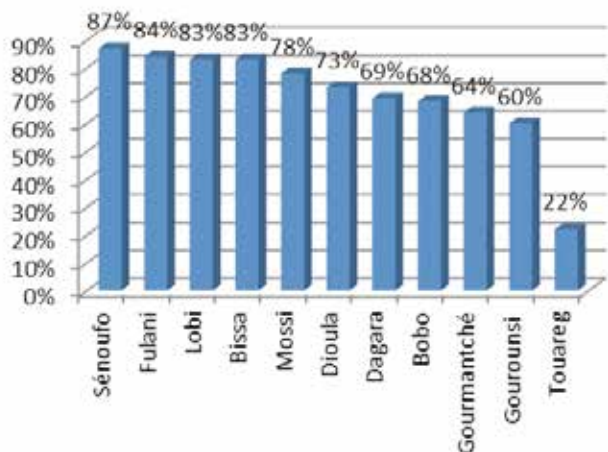


Fig. 14: Percentage of women aged 15 to 49 with FGM according to ethnic group (DHS 2010, p.291)

PREVALENCE OF FGM IN BURKINA FASO BY AGE

Data collected for DHS 2010 suggests that among girls aged 15 to 19 who have undergone FGM, 91% were cut before they were 10, 7% were cut between the ages of 10 and 14, and only 1% were cut at 15 years of age or later (UNICEF, 2013a, p.100). FGM prevalence appears to be lower among adolescent girls than middle-aged women: 89% of women aged 45 to 49 reported being cut compared with 58% of women aged 15 to 19 (UNICEF, 2013a, p.101). This suggests there may be a decline in the practice across generations, since few girls in Burkina Faso are likely to be cut after they reach 14 years of age. This trend can be seen in the following graph.

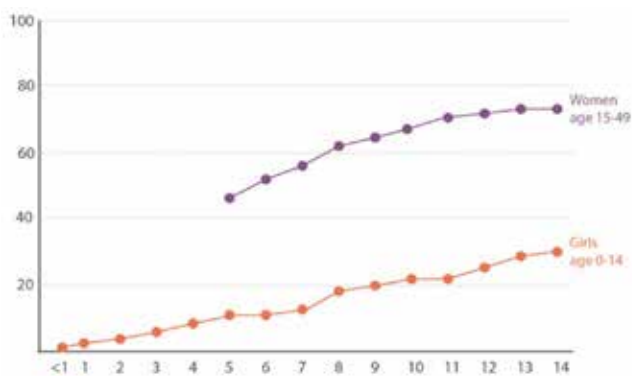


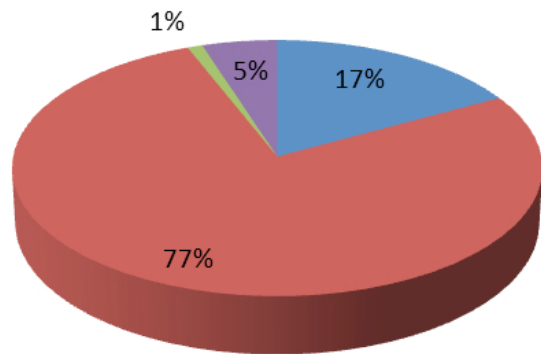
Fig. 15: Percentage of women (aged 15-49) and girls (aged 0-14) with FGM by age cut (Yoder, P.S. and Wang, S., 2013, p.27)

Notable in the above graph is the increased percentage of 0- to 4-year-olds who have been cut

among the 0 to 14 age-cohort. This may be because older women cannot accurately recall when they were cut, or it has been suggested (Chikhungu & Madise, 2015, p.9) that more infants are being cut in recent years to avoid criminal prosecution as they are unable to report their parents or the excisors to the authorities.

TYPE OF FGM AND PRACTITIONERS

In Burkina Faso the most common type of FGM reported among women aged 15 to 49 is Type II (cut, with flesh removed), at 77% (Figure 16 below). Type I FGM (cut, no flesh removed) is reported by 17% and Type III (sewn closed) by only 1% (DHS 2010, p.291)



- Type I - cut, no flesh removed/nicked
- Type II - cut, flesh removed
- Type III - sewn closed
- Type not determined/not sure/don't know

Fig. 16: Percentage of women with FGM according to type (DHS 2010, p.291)

While Type II is the most common form of FGM among all ethnic groups, variations can be seen. Over 90% of cut women and girls in the Gourmantché, Lobi and Bissa groups have had Type II FGM, compared to just over 60% among the Bobo and Touareg (among whom Type I is most common, at 28% and 38% respectively). While overall the occurrence of Type III is low, at 1.3%, again, prevalence varies between groups (2.3% among the Bobo, 1.7% among the Sénoufo and no recorded cases among the Touareg) (DHS 2010, p.291).

Figure 17 shows the type of FGM by place of residence in Burkina Faso. Again, Type II is the most common form, ranging from 63% of cut women and girls in the capital Ouagadougou to 78% in rural areas. It should also be noted that, although it is much less common, Type III FGM is reported more in urban than rural areas (1.9% in the capital compared to 1.1% in rural areas) (DHS 2010, p.291).

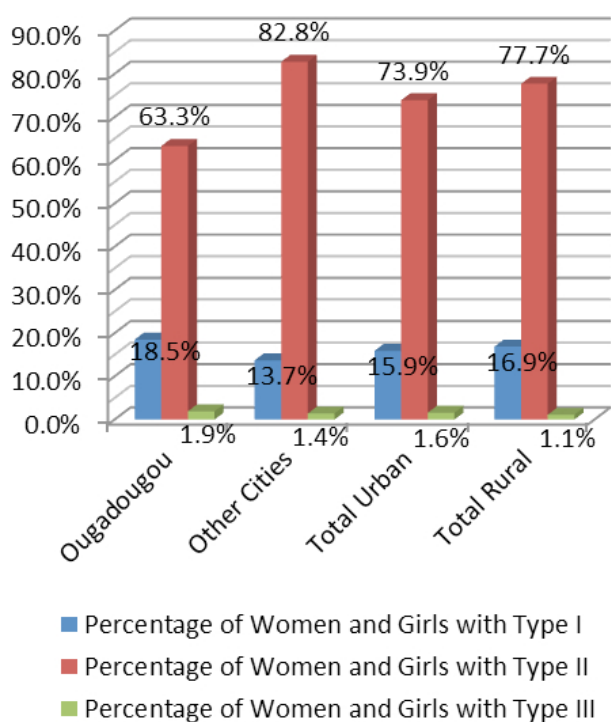


Fig. 17: FGM type by place of residence (DHS 2010, p.291)

FGM procedures are almost exclusively carried out by traditional practitioners (96%). These may be traditional circumcisers or traditional birth attendants; they are generally older women in the community (UNICEF, 2013a, p.42). Properly trained medical staff are rarely used (less than 1%), probably because the law (Article 381 of The Penal Code) in Burkina Faso states ‘the maximum punishment shall be meted out if the guilty party is a member of the medical or paramedical profession’ (translation by the Inter-Parliamentary Union).

SOCIOLOGICAL BACKGROUND

ROLE OF WOMEN

Article 1 of Burkina Faso’s Constitution (1991) guarantees equality of all persons and prohibits ‘discrimination of all sorts’. However, discriminatory practices persist despite the Government’s efforts and commitment to developing policies and legal provisions to address gaps between the law and daily reality (SIGI, 2015). Laws such as the Code on the Individual and the Family (1989) may be disregarded by society and authorities in favour of customary laws that uphold discriminatory practices against women, especially in rural areas (UN CEDAW, 2010a, p.11).

The 2014 Social Institutions & Gender Index (SIGI) categorises the level of gender inequality in Burkina Faso as ‘High’ (SIGI, 2015). The Gender Inequality Index (GII) is a measure of gender-based inequalities in economic activity (measured by market participation), empowerment (measured by number of women in Parliament and attaining higher education) and reproductive health (measured by maternal mortality and adolescent birth rates). Burkina Faso’s GII value of 0.607 ranked it 133 out of 152 countries in 2013, which is a representation of the high level of inequality that women face in the country (UN Development Programme, 2014).

Article 238 of the Code on the Individual and the Family (1989) sets the minimum age of marriage at 17 for women and 20 for men. However, an age exemption can be granted by a civil court allowing a woman to marry at age 15 and a man at age 18. In practice there is a high prevalence of early marriage, which is linked to forced marriage, as many families arrange for their daughters to marry as soon as they reach puberty as a way of alleviating household poverty through receipt of a dowry (SIGI, 2015). This occurs despite the fact that forced marriage is prohibited (Art. 234) and marriage must be entered into freely with the consent of both parties (Art. 240).

Monogamy is the recognised marriage regime in the Code on the Individual and the Family (1989);

however, under Article 258, polygamy is allowed 'under certain conditions' (Art. 232). According to DHS 2010 (p.86) 42% of married women live in polygamous marriages.

The practice of *levirate*, though illegal, is still common. According to this custom, widows are required to marry a brother of their deceased husband in order to retain custody of their male children; otherwise custody automatically transfers to their deceased husband's family (SIGI, 2015). This is despite the fact that under Article 236 of the Code on the Individual and the Family (1989) both parents are given equal parental authority, while Article 519 provides that, upon the death of one spouse, custody is granted to the surviving spouse.



Fig. 18: Group of Bobo women vendors (public domain)

PHYSICAL INTEGRITY

The physical integrity of women has limited protection in law. Violence against women appears to be widely tolerated (UN CEDAW, 2010a, p.5). There are no specific laws addressing domestic violence. According to DHS 2010 (p.303) one in five women has suffered some form of physical violence in their lifetime since the age of 15. Victims rarely report cases of domestic violence due to shame, fear and reluctance to take their spouses to court (USDOS, 2014, p.15). The Government provides limited counselling services in each of the 13 regional 'Maison de la Femme' centres, but provides no shelters for victims. The Ministry of Social Action and National Security has

organised workshops and campaigns to inform women of their rights (USDOS, 2014, p.16).

DHS 2010 (p.282) reported that up to a third of women (aged 15 to 49) in Burkina Faso felt that their husbands were justified in beating them for one of the proposed reasons: arguing with him (32%), going out without informing him or neglecting the children (31%), refusing to have sex with him (20%) or burning the food (10%). In some regions, particularly rural areas (for example, in the Sahel and Centre-West), up to 50% of women felt their partner's violence was justified for one or more of these reasons.

Rape is criminalised under Article 417 of The Penal Code (1996). The law does not recognise spousal rape (UNECA, 2009, p.68). Victims often do not report rape cases due to cultural barriers and fear of reprisal. While police generally investigate reports of rape, statistics of prosecution are not available (US DOS, 2014, p.16). Rape is punishable by five to ten years' imprisonment, and up to 20 years if the victim is vulnerable due to pregnancy, illness, disability, or is less than 15 years of age (Art. 417, The Penal Code, 1996). NGOs such as the Association of Jurists in Burkina Faso, Roman Catholic and Protestant missions and the Association of Women and Promofemmes provide counselling for rape victims (US DOS, 2014, p.16).

While there is no specific legal framework in place to deal with sexual harassment, the 2008 Labour Code at Articles 37 and 422 explicitly prohibits sexual harassment in the workplace. It is punishable by up to five months' imprisonment and fines of between 50,000 to 600,000 CFA (US\$95 to US\$1,140). However, the law is largely ineffective because sexual harassment is considered culturally acceptable by many Burkinabé (US DOS, 2014, p.17).

RESOURCES AND ENTITLEMENTS

Despite the fact that the law provides for equal property and inheritance rights for women and men, women in Burkina Faso face numerous cultural restrictions in relation to property and

land ownership (SIGI, 2015). As a result, women are often denied the right to own property, particularly land (US DOS, 2014, p.19).

In part this is due to the fact that inheritance is the primary means of accessing land and women's rights to inherit are often violated. Articles 742 to 744 of the Code on the Individual and the Family (1989) give widows and female children equal rights to inherit property, but this law is often disregarded in favour of customary law, which grants no inheritance rights to widows or minor children. Girls are expected to cede land that they have inherited to their brothers (SIGI, 2015). This condition is exacerbated by the fact that 75% of marriages are defined as common-law unions (through only a religious or traditional ceremony) and are not legally binding. In rural areas land owned by a woman becomes the property of the family of her husband after marriage. Many citizens, particularly in rural areas, hold on to traditional beliefs that do not recognise inheritance rights for women, and class a woman as property that can be inherited upon her husband's death (US DOS, 2014, p.19).

The Government continues to use media campaigns to change attitudes toward women. The Ministry of Women's Promotion is responsible for increasing women's awareness of their rights and is working to facilitate their access to land ownership. The Government has sponsored a number of community-outreach efforts and awareness campaigns to promote women's rights (US DOS, 2014, p.19).

Statistics from DHS 2010 (pp.277-278) show that 5% of women, compared to 54% of men, are sole owners of a home. 51% of men declared owning land compared to only 32% of women. Women face difficulties in accessing credit facilities such as bank loans because they are considered 'high risk' applicants, lacking collateral (UN CEDAW, 2010a, p.8).

There are no restrictions on women accessing credit but there exist social and cultural barriers

that close some entrepreneurial activities to women who reside in rural areas. Government schemes are in place to increase women's access to credit, including microcredit and loans in the form of farm materials, equipment and input (SIGI, 2015). Microcredit institutions such as the Support Fund for Women's Income-Generating Activities and the Support Fund for Income-Generating Activities for Women Farmers have been established. The Ministry of Finance and the Budget adopted a strategic microfinance plan in 2005 (UN CEDAW, 2010b, p.25).



Fig. 19: A woman waters her crops and vegetables in Yatenga (Climate Change, Agriculture and Food Security, cropped)

CIVIL LIBERTIES

There are no legal restrictions on Burkinabé women's access to public space, including their full participation in politics, nor are there legal restrictions to freedom of movement; however, according to DHS 2010 (p.279), 46.6% women declare that it is primarily their husbands who decide whether they can visit parents and relatives, compared to 35.2% who declare that they can make this decision.

In April 2009 a law on quotas for women's participation in legislative and local elections in Burkina Faso was officially adopted. The law, which took effect in the 2012 elections, requires political parties to have a minimum of 30% female candidates on their party lists in legislative and municipal elections. Parties failing to meet these

quotas are subject to a 50% cut in their electoral-campaign funding. Representation of women at national and local levels of government has steadily increased since the law was passed, but it remains low. The proportion of women winning seats at local-government level rose from 8.9% in 1995 to 35.8% in 2006 (SIGI, 2015). In 2014 there were 24 women in the 127-seat former National Assembly and five women in the former 33-member presidential cabinet. There were four women among the 26 ministers in the transitional government and 11 women in the 90-member National Transitional Council (US DOS, 2014, p.14).

In 2012 the Government created the National Council for the Promotion of Gender, which it charged with advising and giving public voice to advocates for greater gender equality. National campaigns have also been run to inform women of their civic and political rights, to encourage more women to assume positions of leadership and to counter discriminatory attitudes towards women as leaders. For example, the National Democratic Institute organised a week-long Young Women Political Party Activist Leadership Academy in July 2011. Fifty young Burkinabé women from the main political parties attended sessions on communications, advocacy, conflict-resolution and coalition-building. They also learned strategies to manage their multiple roles as mothers, employees and politicians. The training prepared them to run for office, move their priority issues onto party platforms with more confidence and take immediate action in their parties (SIGI, 2015).

According to the country's labour laws all workers, men and women alike, must receive equal pay for equal working conditions, qualifications, and performance. Nevertheless, women generally receive lower pay for equal work, have less education, and own less property (US DOS, 2014, p.18). Discrimination against women is visible through limited and primarily low-level job access for women, their high participation in the informal sector and in poor-quality jobs, as well as an unemployment rate that is twice that of men's. The majority of women also lack social security or labour protection (UN CEDAW, 2010a, p.7).

HEALTHCARE SYSTEM

The healthcare system in Burkina Faso comprises the Ministry of Health (*Ministère de la Santé*) which is responsible for national policy; Regional Health Administrations (*Directions Régionales*); and Health Districts, each of which cover a population of approximately 150,000 to 200,000 people. Health expenditure in 2013 was 6.4% of GDP (CIA World Factbook, 2015), which ranks it 107th in the world. As well as public-health services, there are private facilities and traditional healthcare providers.

As at 2008 there were three national university hospitals, nine regional hospitals (*Centres Hospitaliers Régionales*), 63 district-health facilities, 35 medical-emergency centres (*Centre Médical*) and approximately 1,200 Centres of Health and Social Promotion (*Centre de Santé et Promotion Sociale*). The latter provide local communities with vaccinations and meet general medical needs as well as making referrals to district hospitals. Hospital-bed density in 2010 was 0.4 beds per 1,000 head of population and the density of physicians was 0.05 per 1,000 head of population (CIA World Factbook 2015; WHO, 2013, p.121). Burkina Faso's healthcare system is funded by the state as well as privately and through international aid. In 2010 Government expenditure on health was 58.5% of the total expenditure on health (WHO, 2015b, p.126).

A National Health Policy was adopted in 2000 (*La Politique Sanitaire Nationale*) (PNS). A National Health Development Plan (*le Plan National de Développement Sanitaire*) (PNDS) was approved for 2001-2010, the implementation of which made 'significant improvements in the coverage, quality, and usage of services' (Ministère de la Santé, 2011, p.iv). Despite these improvements, however, there continue to be concerns with the healthcare system in Burkina Faso. These include lack of universal access to services, inadequate provision of qualified staff and financial barriers to accessing healthcare. In order to address these, a further plan, PNDS 2011-2020, has been set up as

part of The Strategy for Accelerated Growth and Sustainable Development (*Stratégie de Croissance Accélérée et de Développement Durable*), which replaced the Poverty Reduction Strategy Paper that formed the framework for government policies from 2000 to 2010.

Life expectancy in Burkina Faso in 2012 was 58 years, which represents an increase of nine years over the period 2000 to 2012 (WHO, 2015b, p.2). The maternal mortality rate declined from 770 deaths per 100,000 live births in 1990 to 400 in 2013 (WHO, 2015b, p.1).

HEALTH AND THE NEW SUSTAINABLE

DEVELOPMENT GOALS

By 2015, Burkina Faso had made some progress towards reaching the MDGs:

GOAL 4: REDUCE CHILD MORTALITY

The under-five mortality rate declined from 202 in 1990 (per 1,000 live births) to 98 in 2013, and the infant (under one) mortality rate dropped from 103 in 1990 to 64 in 2013 (per 1,000 live births) (WHO, 2015c, p.45).

Malaria continues to be the main cause of death in children under five, accounting for 23% of deaths of under-fives in 2013 (WHO, 2015b, p.2). In an attempt to reduce this, in 2013 insecticide-treated bed nets were distributed to more than 95% of households nationwide (UNICEF, 2014, p.11). There was also an increase in immunisation against measles, achieving 82% coverage among one-year-olds in 2013, against a target of 90% (WHO, 2015c, p.26).

Malnutrition is still a major problem. It is estimated that almost half a million children under five will suffer from acute malnutrition in 2015 (European Commission, 2015, p.1). This is likely to have an effect on future child health and mortality.

GOAL 5: IMPROVE MATERNAL HEALTH

Burkina Faso achieved a 48% reduction in maternal mortality over the period 1990 to 2013, against the

MDG target of 75% (WHO, 2015c, p.26). Although the figure for maternal mortality per 100,000 live births for Burkina Faso dropped from 770 in 1990 to 400 in 2013, this is still more than double the MDG target of 192.5 (WHO, 2014, p.7). Antenatal care coverage (the number of women who received at least one visit) showed a slight drop from 95% in 2010 to 94% in 2013, but remained high. The percentage of women receiving at least four visits was much lower and remained stable at 34% over the same period (WHO, 2014, p.4). There was an increase in attended skilled delivery at birth from 53% in 2009 to 82% in 2012 (UNICEF, 2013b, p.11). However, in rural areas the proportion of births attended by skilled professionals was only 62%, compared to 94% in urban areas (WHO, 2015c, p.138).

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

Burkina Faso was one of 23 countries to achieve the MDG target for HIV/AIDS (African Health Observatory, undated, p.150). The prevalence of HIV/AIDS among Burkina Faso adults (aged 15 to 45) fell from 2.2% in 2001 to 0.9% in 2013 (WHO, 2014, p.7). Although the proportion of pregnant women tested for HIV increased from 30% in 2009 to 56% in 2014 (UNICEF, 2014, p.24), the percentage of the young-adult population (aged 15 to 24) with comprehensive and correct knowledge of HIV/AIDS remained low at 31% for females and 36% for males (WHO, 2014, p.5). 62% of females and 27% of males (aged 15 to 49) used condoms during higher-risk sex (WHO, 2014, p.5).

2015-2030 – CHALLENGES AND OPPORTUNITIES

The MDGs have now been replaced by the SDGs, which have a deadline for achievement of 2030. The full set of SDGs is available at <http://28toomany.org/fgm-research/research/>.

In addition to Goal 5.3 (*Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation*), which makes specific reference to the elimination of FGM by 2030, several other SDGs have relevance for

women and girls who have experienced or are likely to experience FGM, in particular those related to education, health and gender equality; for example:

Goal 3 (*Ensure healthy lives and promote well-being for all at all ages*) aims to

- (3.2) End preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1,000 live births

and achieve

- (3.7) Universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Both these SDGs fit well with Burkina Faso's National Health Policy (PNS) for 2011-2020. This has eight key strategic aims. Of these, improved coverage and financial accessibility will be particularly important to the elimination of FGM as they represent the barriers most often encountered by Burkinabé women (Pathfinder International, 2015).



Fig. 20: Young girl receiving vaccination in Burkina Faso (World Health Organization)

WOMEN'S HEALTH

The reproductive and sexual health of girls and women is affected by a number of factors such as their age when married; access to family planning and contraceptive advice; antenatal, obstetric and postnatal care; access to treatment for sexually transmitted infections; and the prevention of unsafe abortions.

According to a UNICEF report (2015) 52% of Burkinabé are married before the age of 18, and 10% before the age of 15. The rate of early marriage remains highest in rural areas where, in traditional ceremonies, girls as young as ten may be married. The majority of women in rural areas are married before the age of 19 (Amnesty International, 2009, p.13). More than half of these marriages lead to early pregnancies, which leave both young mothers and their children at significant risk of health problems – births to women aged 15 to 19 have the highest risk of infant and child mortality as well as a higher risk of maternal mortality (World Bank, 2011, p.2).

REPRODUCTIVE HEALTHCARE

Birth spacing is an important aspect of family planning, and a space of less than 24 months between births is considered a short birth interval that is likely to be detrimental to both the mother's and the child's health. In Burkina Faso the median birth interval is 35.9 months; however, this is much lower for younger mothers, at 28.5 months among girls aged 15 to 19 (UNFPA, 2013a). Although Burkina Faso's infant mortality rate declined from 103 per 1,000 live births in 1990 to 64 in 2013, and the under-five mortality rate fell from 202 deaths per 1,000 live births in 1990 to 98 in 2013 (WHO, 2015c, p.45), this still represented 64,000 deaths for children under five in 2013.

Although the fertility rate in Burkina Faso is falling, it still has one of the highest fertility rates in the world at 5.6 births per woman in 2013 (WHO, 2015d, p.45). This is higher in rural areas than urban areas and significantly higher for girls who are uneducated as opposed to those who have at

least secondary education (UNFPA, 2013a). It is estimated that there were 105,000 abortions in Burkina Faso in 2012. 43% of these resulted in health complications, with a higher risk for women in rural areas (Bankole *et al*, 2013, p.18). Of those who had complications in poorer, rural areas, one in five received no medical treatment (Bankole *et al*, 2013, pp.18,33).

One of the biggest problems leading to unwanted pregnancies in Burkina Faso is the low use of contraception. Although use doubled from 1993 to 2010, only 16% of married women of childbearing age used a contraceptive method in 2010 (Bankole *et al*, 2013, p.8).

For many women in Burkina Faso barriers to healthcare are not only structural (for example, poor facilities and poor training for healthcare providers) but also cultural. Men are often responsible for healthcare-spending decisions (74.9% of women in 2010 stated that their husband was the key decision-maker for healthcare spending); there are social pressures to marry and bear children at a young age; and mothers-in-law, as well as co-wives, in the case of polygamous marriages, may have influence or authority over young married women, particularly in rural areas (Pathfinder International, 2015, p.2).



Fig. 21: Women who have had FGM receive medical advice and support from Voix des Femmes at their purpose-built centre (CBF) (© Voix des Femmes)

REPRODUCTIVE HEALTH COMPLICATIONS

In 2006 the WHO published a study of six African countries, including Burkina Faso, which showed the negative health effects of FGM. It concluded that women who had undergone FGM had higher rates of complications during childbirth, including Caesarean section, postpartum haemorrhage, episiotomy and prolonged hospitalisation (WHO, 2006, pp.2-7). Another study of factors associated with FGM in Burkina Faso in 2010 (Inungu & Tou, 2013, p.23) showed that difficulty at delivery was the main complication of FGM (30%) with excessive bleeding the second-most-common complication (22%). While there is no documented proof that FGM is a direct cause of obstetric fistula, there is evidence that women who undergo FGM are more likely to suffer long and complicated deliveries, obstetric lacerations and obstetric haemorrhages (Berg & Underland, 2013, p.12).

Women who have undergone Type III FGM are considerably more likely to suffer adverse health effects, as are their babies. Longer-term health risks of FGM include infertility, urinary retention and infection and haematocolpos (filling of the vagina with menstrual blood) (Whitehorn, Ayonrinde and Maingay, 2002, p.162). New-borns also suffer from the effects of FGM, with a higher rate of infant resuscitation and perinatal death (WHO, 2006, pp.2-7).

In addition to the negative health-impacts of FGM, it has been shown that the women who have undergone FGM are more likely to experience pain during sexual intercourse and reduction in sexual satisfaction (Berg & Underland, 2013, p.1). A study of the psychological implications of FGM showed that it is associated with various degrees of psychological morbidity, including loss of trust, lack of bodily well-being, PTSD and depression, as well as experiencing a sense of betrayal and feelings of anger, guilt, shame and inadequacy during sexual intercourse (Whitehorn, Ayonrinde & Maingay, 2002, pp.165-167).

Reconstructive surgery for victims of FGM has been offered in Burkina Faso since 2006 and several surgeons are trained in the procedure. Prior to this, in 2001, the Government introduced a more general genital repair surgery (Sambira, 2013). In 2014 Clitoraid, a US-based charity, endeavoured to open a hospital in Burkina Faso dedicated to offering free reconstructive surgery to victims of FGM. Their attempts were quashed when the hospital was closed by the Ministry of Health amid accusations of religious conflicts and administrative failings after operating for just four days and treating only 29 women (Lloyd-Roberts, 2014).

FGM AND THE HEALTHCARE SYSTEM

FGM in Burkina Faso is performed by traditional 'circumcisers' in over 95% of cases, with little difference between rural and urban areas, but it

is understood that FGM carried out by medical personnel is slowly becoming more common (UNFPA, 2013b, p.2; WHO, 2011, p.5). As well as the health risks of FGM, the cost of obstetric care due to the practice is significant, accounting for up to 1% of Government spending on health for women aged 15 to 45 (WHO, 2011, p.7).

One of the negative consequences of laws against FGM being introduced in Burkina Faso is evidence that FGM is increasingly being performed on young babies instead of older girls so that cutters and parents may avoid detection and possible prosecution. During the first three months of 2008 there were 70 reported cases of newborns nationwide being admitted to hospital for emergency treatment after FGM had gone wrong (IRIN News, 2009). According to 2010 figures, 60% of women who had undergone FGM were cut before the age of five (UNFPA, 2013b, p.2).

GASCODE

GASCODE (*Groupe d'Appui en Santé, Communication et Développement*) was established in the late 1990s by 14 members of the medical profession, including doctors, midwives, health counsellors, nurses and social workers. Their aim is to bring communities together to change social norms and attitudes to FGM, and to help people understand the law. They integrate their work on FGM with an holistic approach to child protection as well as sexual health and reproduction, hygiene, and the promotion of women's rights, income generation and literacy.

GASCODE identifies and trains community volunteers (both men and women) to run educational discussion sessions. As a main implementing partner of the UNJP, GASCODE has trained and provided technical and financial support and supervision to nearly 160 associations and groups and 150 community volunteers in seven provinces of Burkina Faso. In 2009 it was awarded 'Knight of the Burkinabé Order of Merit' for its contribution to promoting the health and rights of women and children.



Fig. 22: Women participating in GASCODE's FGM awareness training in Burkina Faso (© GASCODE)

EDUCATION

Literacy rates remain low in Burkina Faso due to a range of socio-economic challenges. The adult literacy rate in Burkina Faso for 2008 to 2012 was 28.7% (UNICEF, 2015). The youth literacy rate (age 15 to 24) from 2009 to 2013 was 47% for males and 33% for females (UNICEF, 2015).

Burkina Faso’s school system comprises six years at primary level, starting at age six and completing at age 11 with a primary-school leaving certificate. This is followed by three years of junior secondary school, and then three years of upper secondary school, which results in a leaving degree (Kouraogo, 2010, p.14). Although the law establishes free education until the age of 16, this only covers tuition. Students are required to pay for uniforms and school supplies such as books and this can be a major financial challenge for many families. The shortage of teachers and lack of schools in rural areas is another limitation on children’s access to education in Burkina Faso (US Department of Labor, 2014, p.2).

There are very few private schools in Burkina Faso. Those that are available are international schools

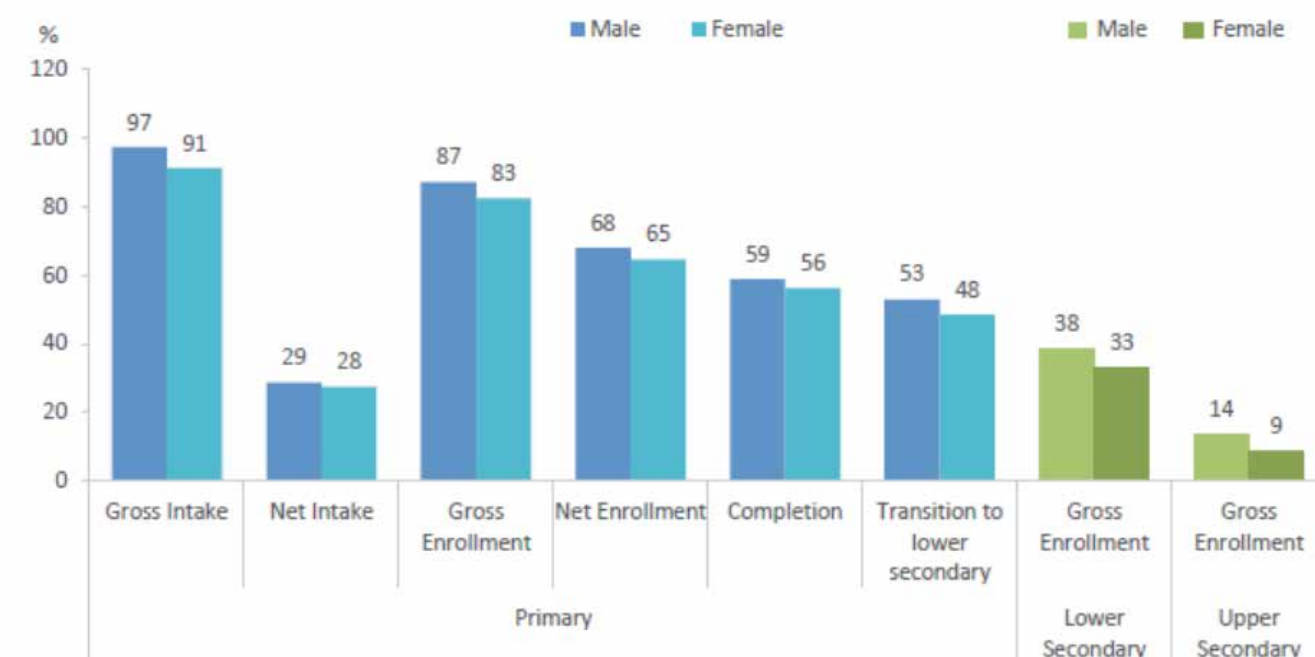
in the main cities, which are mostly attended by expatriates (Expat Quotes, undated) or are run by international charities (SOS Children’s Villages, undated).

Public schools within Burkina Faso do not provide religious instruction, although some secondary schools are managed by Muslim or Christian organisations. The Government does not fund religious schools or require them to pay taxes. It does monitor the curricula of religious schools to ensure that they provide a full academic curriculum in line with state policies, but does ‘not seek to influence religious curricula’ (US DOS, 2011, p.3).

ENROLMENT AND ATTENDANCE

Although the enrolment rate in primary education is 85% for girls and boys combined (including both over- and under-age students), it decreases to 36% in lower secondary and of those students less than half go on to higher secondary school, as shown in Figure 23 below (World Bank, 2014, p.2).

There is a high percentage of children who are out of school: 47% of boys and 50% of girls of primary school age do not attend. At secondary level



Data sources: UNESCO Institute for Statistics (UIS), EPDC calculation based on UIS data (see Data Table for year)

Fig. 23: Student intake and flow from primary to secondary schools (World Bank, 2014, p.2)

nearly 66% of female and 60% of male youths are out of school (World Bank, 2014, p.1). The greatest disparity between numbers of children who do not attend primary school regularly can be seen between the poorest and the richest children: 82% of children of secondary-school age in the poorest fifth of households do not attend compared to 40% of secondary-school-aged children in the richest fifth of households (World Bank, 2014, p.1).

Another factor reducing the numbers of children attending school regularly in Burkina Faso is the use of child labour in agriculture and mining, as shown in Table 1 below :

Working children, ages 5 to 14 (% and population):	42.1 (2,116,752)
School attendance, ages 5 to 14 (%):	41.9
Children combining work and school, ages 7 to 14 (%):	21.7
Primary completion rate (%):	57.6

Table 1: Statistics on children’s work and education in Burkina Faso (US Department of Labor, 2014, p.1)

A recent boom in gold mining, in particular, has lured many children out of school to dangerous jobs such as crushing stones and sieving dust. These children are mainly from rural areas, and some are as young as six. The discovery in September 2011, for instance, of a new vein of gold at the Pousghin site led to an estimated 20,000 children leaving school in the middle of the new school term (Terre des Hommes, 2011). The US Department of Labor (2014, p.1) claims that in 2006 47.7% of boys and 43% of girls aged five to 17 were engaged in child labour in Burkina Faso. NGO Terres Des Hommes has been working with the Government and parents to curb the negative effects that mining is having on education and attendance rates (IRIN News, undated).

Approximately 56% of young people aged 15 to 24 have had no formal education and 16% have an incomplete primary education; therefore, 72% of 15- to 24-year-olds do not have a complete primary education (World Bank, 2014, p.1).



Fig. 24: Burkinabé girls at Wayalghin Primary School in Ouagadougou (Olivier Badoh [photographer]/Global Partnership for Education)

GENDER PARITY

In 2001, with the aim of achieving its MDG targets, the Government introduced a ten-year plan for the development of its education system. This sought to raise the primary-school enrolment rate to 70% by 2010 and gave particular emphasis to reducing gender and regional disparities (Kouraogo, 2010, p.15). An inter-ministerial working party was set up in 2006 to discuss and draft further reforms to the education system (p.16). As a result, increased construction of schools, recruitment of teachers and improved access to educational resources has led to a reduction in gender and regional disparities, and there was a reported decrease in repetition and dropout rates between 2001 and 2007 (p.22).

Figure 23 above shows, however, that there is still a lower level of participation by girls at all stages of the education system, with the widest gap occurring at enrolment for higher secondary school. There are major differences in education rates between women living in towns and in the countryside. Almost twice as many girls in rural areas receive no education (79%) as girls in urban areas (41%) (DHS 2010, p.27). The gap widens at primary-school completion with three times as many girls living in urban areas completing primary education (6%) as girls in rural areas (2%) (DHS 2010, p.27).

EDUCATION AND THE NEW SUSTAINABLE DEVELOPMENT GOALS

Burkina Faso has made good progress towards the former MDGs, ranking highest in MDG acceleration within West Africa (UNECA, 2014, p.9). The Government has established a development strategy to allow for accelerated economic growth and poverty reduction. This has contributed to a more than 25% reduction in poverty over a six-year period (p.3).

In working towards the MDG Goal 2: *Achieve Universal Primary Education*, 'Burkina Faso expanded its elementary education at more than twice the rate of Western historical experience, and is even far above the faster education expansions of all other developing countries in recent decades' (W. Easterly in UNECA, 2015, p.10). Burkina Faso's highest rate of progress has been achieved in relation to primary education: the enrolment rate has increased from 36.7% in 2000 to 66.8% in 2013 (UNECA, 2015, p.9). In reaching towards its goal of universal education, Burkina Faso has almost reached parity in primary education. Burkina Faso now places an additional 30 to 40 girls into primary enrolment for every 100 boys (UNECA, 2015, p.17).

2015-2030 – CHALLENGES AND OPPORTUNITIES

The MDGs have been followed by the SDGs, which have a deadline for achievement of 2030. The full set of SDGs is available at <http://28toomany.org/fgm-research/research/>.

In addition to Goal 5.3 (*Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation*), which makes specific reference to the elimination of FGM by 2030, several other SDGs have relevance for women and girls who have experienced, or are likely to experience, FGM – in particular Goal 4, which relates to education:

Goal 4: *Ensure inclusive and equitable quality education and promote life-long learning opportunities for all.*

The targets for Goal 4 make specific reference to ensuring girls and other vulnerable people receive equitable early-childhood development, inclusive and effective schooling at all levels, and vocational training and university education; they also include aspirations for adult women and men to receive equal skills training to achieve literacy and numeracy and enable them to take up decent jobs and start businesses.

Of particular importance in relation to the elimination of FGM is Target 4.7:

By 2030 ensure all learners acquire knowledge and skills needed to promote sustainable development, including among others through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship, and appreciation of cultural diversity and of culture's contribution to sustainable development.

FGM is a violation of human rights, and progress towards achievement of this target will be supported by the subject's inclusion in the school curriculum, building on the work undertaken on this to date.



Fig. 25: Goal 4 of the new SDGs is crucial to the future of young girls in Burkina Faso (Photographer: Steve Evans)

EDUCATION AND FGM

Education can play an important role in overcoming and changing attitudes to cultural practices; for example, if it leads to more women refusing to allow their daughters to be cut, or more men marrying women who have not undergone FGM (GIZ, 2013, p.1).

In Burkina Faso, the CNLPE implemented a pilot training-scheme for teachers that incorporated FGM into the curriculum (WHO, undated, p.2). This pilot scheme was commissioned by the Federal Ministry of Burkina Faso under the Sexual Health and Human Rights programme. The pilot scheme enabled teachers to facilitate a reflective process among boys and girls, allowing them to question the harmful practice. In participating schools, FGM education took place across several subjects (for example, in natural sciences and philosophy) to expose children to a consistent message about the harmful nature of FGM (GIZ, 2013, p.2) and promote wider discussions about their gender roles at home and in society. Using communicative and participatory-learning techniques, this long-term approach within the education system has the potential to lead to substantial change, especially among girls, enabling them to realise their right to health and physical integrity (GIZ, 2013, p.2).

In 2003 the two Ministries of Education in charge of primary and secondary education agreed to extend the integration of FGM education across all schools. From 2007 to 2009 teacher-training material was developed and FGM was recognised as a theme to be included in the revised national curriculum. *Deutsche Gesellschaft für Internationale Zusammenarbeit* (GIZ) continues to work alongside the Government on this and pilot the changes across the country. The number of schools now offering FGM education continues to increase. The aim is for it to be available in all schools as soon as possible (GIZ, 2013, p.4).

RELIGION

Burkina Faso is a religiously diverse country. In July 2013 the United States Department of State (p.1) estimated that of a population of 17.8 million, Muslims made up approximately 61% (mainly Sunni); Roman Catholics, 19%; Protestants, 4%; and those subscribing exclusively to indigenous beliefs, 15%. These figures are approximate, as many Muslims and Christians report adhering simultaneously to some aspect of indigenous beliefs (US DOS, 2013, p.1). 'Indigenous beliefs' describes an array of mainly monotheistic, traditional, precolonial, West-African religions, which may also be called 'animism' (Hayford and Trinitapoli, 2011, p.254). Since the 1960s there has been a demographic transition in Burkina Faso away from these traditional beliefs and towards Islam and Christianity (Ouedraogo and Ripama, 2009, p.96).

Islam dominates the northern, eastern and western border-regions of Burkina Faso, and there is a concentration of Christians in the centre of the country. Those holding indigenous beliefs are spread across the country but are especially represented in rural communities (US DOS, 2013, p.1), where they comprise 19.3% of the population, compared to only 2% of the population in urban areas (Ouedraogo and Ripama, 2009, p.94). Unlike other African countries such as Kenya and Nigeria, there is little correlation between religion and ethnicity. Most major ethnic groups have at least a substantial minority of Muslims (Hayford and Trinitapoli, 2011, p.254).

Religious tensions in Burkina Faso appear to be minimal. The Constitution states that the country is secular, and laws protect the right of individuals to choose, change, and practise their religions (US DOS, 2013, pp.1-2). These laws are generally well-enforced. While in recent years there have been some reports of discrimination based on religious affiliation, belief or practice, these instances have been denounced by local communities and 'resolved peacefully' (p.3).

RELIGION AND FGM

In Burkina Faso it appears, from available data, that although FGM prevalence is highest among Muslims (81.4%), it is also widespread among other religions (Table 2).

RELIGION	FGM PREVALENCE
Muslim	81.4%
Traditional/Animist	75.5%
Catholic	66.1%
Protestant	60.0%
No religion	62.1%

Table 2: Prevalence of FGM among women aged 15 to 49 according to their religion (DHS 2010, p.291)

In a 2015 study Chikhungu and Madise (p.6) compared DHS data from 1999 to 2010 and found that the percentage of women who reported being cut had decreased across all religions (figure 26 shows the figures by religion for girls aged 15 to 19) and the percentage of women who would like the practice of FGM to stop increased across all religions. DHS 2010 (p.298) also asked both women and men if they thought FGM was a religious requirement. Table 3 shows that nearly a third of those practising traditional/animist beliefs and approximately a fifth of the Muslim community felt that FGM is required by religion.

RELIGION	WOMEN (aged 15-49)	MEN (aged 15-59)
Traditional/Animist	30.2%	29.8%
Muslim	21.8%	18.9%
Catholic	5.4%	2.6%
Protestant	4.1%	1.8%
No religion	13.0%	n/a

Table 3: Percentage of women (aged 15 to 49) and men (aged 15 to 59) in Burkina Faso who believe FGM is required by religion (DHS 2010, p.298)

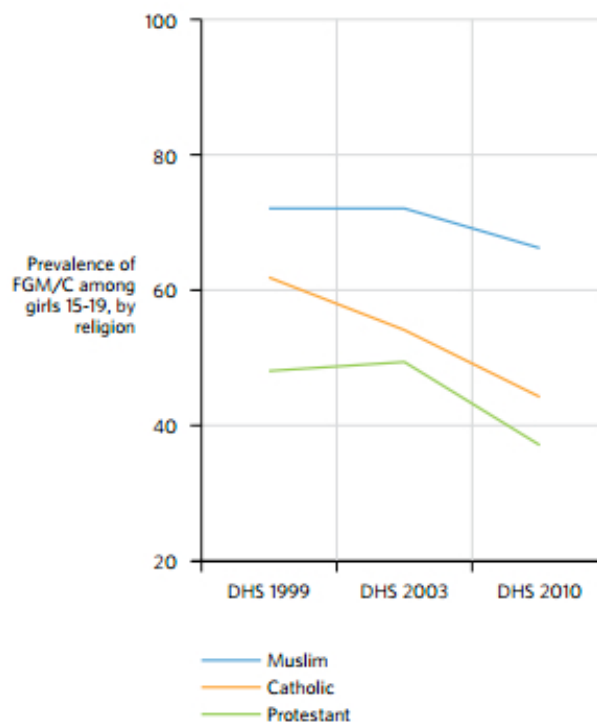


Fig. 26: Percentage of FGM among girls aged 15 to 19, by religion, 2014 (UNFPA, 2015, p.37)

Data from DHS 2010 (p.298) also suggests there are differences of opinion depending on place of residence and level of education; for instance, 18.1% of women and girls in rural areas believe FGM to be a religious requirement compared to 13.4% in Ouagadougou. 19.3% of women and girls with no education also believe this, compared to 9.1% who have achieved secondary or further education.

Although FGM is not explicitly required by any religious scriptures, studies and available data therefore suggest that, next to age, religion is the most significant demographic variable associated with FGM in Burkina Faso (Karmaker *et al*, 2011, p.7). That said, the link between religion and FGM is neither clearly defined nor universal. While religion is significant to the prevalence of FGM, it is not an absolute predictor (Hayford and Trinitapoli, 2011, p.269).

The importance of engaging religious leaders in the national effort to address FGM is a recurring

theme in the work of the CNLPE and NGOs throughout Burkina Faso. In ethnic groups such as the Dioula, life expectancy is little more than 45 years and hence there is a great respect for the elderly, 'especially if a man is an Islamic scholar' (Joshua Project, undated). (I)NTACT and Voix des Femmes identify local religious and spiritual leaders in the areas where they work. They are invited to seminars and discussion groups to address the issues surrounding FGM and subsequently take the message of abandonment out to their communities.

While religion appears to be an important factor in determining the risk of FGM, interaction between variables such as education, ethnicity, and socio-economic status should not be discounted. Educational and economic opportunities have long been obtained via religious channels. For example, in Burkina Faso Catholic schools provided a path to social mobility in the 19th and early 20th century, as Catholicism was the religion of the colonial government in Burkina Faso at the time (Hayford and Trinitapoli, 2011, p.254). Having some education is correlated with a lower prevalence of FGM, which may account in part for the lower prevalence of FGM among Burkinabé Catholics (Karmaker *et al*, 2011, p.6-7). It is important, therefore, to keep interactions with other socio-economic factors in mind when considering the relationship between religion and FGM.



Fig. 27: Traditional and religious leaders engaged in FGM-awareness work, November 2013 (© AWEPA)

MEDIA

PRESS FREEDOM

Burkina Faso is ranked 46th out of 180 countries in the Reporters Without Borders 2015 World Press Freedom Index (2015a). All media in Burkina Faso are under the supervision of the Ministry of Communications, which is responsible for developing and implementing Government policy on information and communication. The Superior Council of Communication (SCC) is a semi-autonomous body under the Office of the President. Its task is to monitor the content of radio and television programmes, newspapers and internet sites to ensure compliance with professional ethics standards and government policy. In June 2012 the Constitution was amended to enable the SCC to summon journalists and issue warnings for violations such as alleged libel, disturbing the peace, inciting violence or threatening state security (US DOS, 2012, p.9). Since then, there have been reports of journalists being subjected to harassment and arrested (BBC News, 2014) but these cases remain rare (Freedom House, 2015).

As a result, although freedom of speech is protected by the Constitution, many journalists practice self-censorship (Freedom House, 2015; US DOS, 2012, p.9). The arrest and imprisonment of two editors in 2012 and 2014 and the murder of editor Norbert Zongo in 1998 have made many others wary of criticising the Government or covering controversial issues (Freedom House, 2015).

In May 2015 the SCC announced there would be a three-month ban on any political coverage in the run-up to elections, which were due to be held in October 2015 (Reporters Without Borders, 2015b). This type of ban is contrary to Article 8 of the Constitution and the Information Code of 1993, which guarantees freedom of expression, information and the press (Freedom House, 2015). In addition, during the attempted coup in September 2015 by officers of the Regiment

of Presidential Security, several newspapers and radio and television stations were forcibly shut down (Reporters Without Borders, 2015c).

MAIN NEWS OUTLETS IN BURKINA FASO

Radio is the most popular media (BBC News, 2014). The high rate of illiteracy in the country is one reason for this. Only 9.4% of the population can access the internet (Freedom House, 2015) as the cost of a broadband subscription is greater than the average yearly income (BBC News, 2014). Radio and television outlets are the main form of news transmission; there are more than 200 stations nationwide (Freedom House, 2015). There has been a rise in the number of community radio stations and social issues have been addressed in local languages (Freedom House, 2015), making information and news available to a wider audience.

Television outlets include Television du Burkina (RTB), BBC, and Canal 3.

Radio stations include AM 2, FM 26, Shortwave 3, Radio Burkina, Radio Pulsar Radio Salankoloto, Horizon FM and Radio La Voix du Paysan, Voice of America and Radio France International.

The main newspaper and press outlets are Sidwaya, L'Observateur Paalga, Le Pays, L'Indépendant, Le Journal du Jeudi, San Finna, L'Hebdomadaire du Burkina, L'Événement, and L'Opinion and Agence d'Information du Burkina.

ACCESS TO MEDIA

The use of telecommunications is hindered by the low penetration and reliability of electricity, even in major cities. According to data collected by the UN Statistics Division (2013) only 2.1% of households had a computer in 2010. The number of mobile phones rose rapidly from just over 1 million in 2006 (CIA World Factbook, 2008) to 12.5 million in 2015 (CIA World Factbook, 2015). Internet access increased from 80,000 users in 2006 to over 643,000 users in 2014 (International Telecommunications Union, 2014).

In 2011 55% of women and 61% of men between the ages 15 and 19 accessed information through at least one media platform (UN Statistics Division, 2013). The DHS 2010 findings (pp.39-40) on access to media are set out in Table 4.

EXPOSURE TO MEDIA AT LEAST ONCE A WEEK	FEMALE %	MALE %
Reads a newspaper	4.9	9.9
Watches television	20.2	27.5
Listens to radio	45.2	66.6
All three media	3	6
No Media	48.1	27.7

Table 4: Exposure to media in Burkina Faso by gender (DHS 2010, pp.39-40)

Table 4 shows that men are more likely than women to be exposed to the media. Nearly half of women and just over a quarter of men are not exposed to any media. Only 6% of men and 3% of women are exposed at least once a week to all three of the media platforms considered (newspaper, television and radio). Of the three media platforms radio is the most used, followed by television. Men reported more frequently than women that they read newspapers. DHS 2010 (p.41) shows a significant difference between rural and urban areas: 57% of women living in rural areas are not exposed to any media, compared to 25% of women living in urban areas.

Education is another important factor in the population's exposure to media. Both men and women with higher levels of education have better access: 22% of women and 27% of men educated to secondary and higher levels access three media platforms regularly, compared with only 3% of women and 3% of men with primary-level education. Among those with no education, 56% of women and 33% of men are not exposed to any form of media (DHS 2010, p.41). Wealth too has an influence: of those living in households in the richest quintile, 12% of women and 19% of men regularly access three media platforms a week; in contrast, the figure for the poorest households is less than 1% for both women and men (DHS 2010, p.41).

MEDIA AND ANTI-FGM CAMPAIGNS

The media, and radio in particular, provides a very important channel for anti-FGM campaigns in Burkina Faso. One significant programme is Savane FM's regular radio talk-show, on which FGM is discussed and broadcast across Ouagadougou in the local language, Mooré. This programme reaches five million people – about a third of Burkina Faso's population (Juggapah, 2014). NGOs such as GASCODE and (I)NTACT, together with their grassroots partners, also regularly organise and host programmes discussing FGM on local community radio stations. In addition, they often use film in their community work to promote discussion on the harmful effects of FGM.

The use of music as a tool to promote the anti-FGM message is also growing in Burkina Faso. The rapper known as Smockey is an example of how men are taking an important role in grassroots activism against FGM. His recent song 'Tomber la Lame' (Drop the Blade) presents an anti-FGM message through its poetic yet graphic lyrics.



Fig. 28: NGOs like Voix des Femmes use media such as films during their FGM awareness training (© Voix des Femmes)

ATTITUDES AND KNOWLEDGE RELATING

TO FGM

Burkina Faso is classed as a 'moderately high prevalence country' by UNICEF (2013a, p.27). 76% of 15- to 49-year-old women reported having undergone FGM (UNICEF, 2013a, p.27). The most recent DHS survey data available for 2010 shows that knowledge of FGM is almost universal throughout Burkina Faso, with over 99% of women and 98% of men having heard of the practice (DHS 2010, p.290).

Attitudes towards FGM also appear fairly uniform across the age groups. 87.4% of women aged 15 to 49 who have had FGM express the view that it should be stopped, 11.7% are in favour of its continuation and 0.8% are unsure (DHS 2010, p.299). Among women who have not had FGM, 97.6% are against its continuation. Variation by age is small but it is worth noting that highest support for continuing the practice is among the youngest girls (10.3% aged 15 to 19 were in favour) and the older women (11.7% aged 45 to 49 were in favour). Among men the pattern is similar, with 87% aged 15 to 49 believing FGM should stop, 10% in favour of its continuation and 3% unsure (DHS 2010, p.299). Again, a slightly higher level of support for the continuation of the practice is noted in the youngest age group surveyed (12.2% for ages 15 to 19) and older men (11% for ages 45 to 49).

While the prevalence of FGM remains high in Burkina Faso, it does appear that attitudes towards the practice have changed over the last 15 years. Statistical analysis compiled by UNICEF shows that, while the DHS reported a 21% support for the continuation of FGM among women aged 15 to 49 in 1998-1999, this fell to 17% in 2003, to 11% in the MICS dated 2006, and to 9% in 2010 (UNICEF, 2013c, p.3). This downward trend in support does therefore suggest a shift in attitudes among women. The same report noted that among women and girls aged 15 to 49 some 52% believe that there are no benefits to undergoing FGM (UNICEF, 2013c, p.3).

It appears, as in many other countries, that the prevalence of FGM is higher in rural areas (78.4%) than urban areas (68.7%) (DHS 2010, p.291). As discussed elsewhere in this report, FGM prevalence varies between ethnic groups but this variation is not necessarily reflected in their attitudes to the practice. For instance, the highest prevalence of FGM is found among the Sénoufo (87%), the Fulani (84%) and the Lobi and Bissa (both at 83%) (DHS 2010, p.291). As might be expected, support for the continuation of FGM is highest among the Sénoufo (at 20% for women and 13% for men) and the Fulani (at 19% for women and 22% for men) but among the Lobi and Bissa peoples this support falls to 4% and 5% respectively for women and 6% and 12% respectively for men (DHS 2010, p.299).

Other socio-economic factors can influence attitudes to FGM and these need to be considered too. Figure 29 suggests that women and girls with a higher level of education are more likely to understand the negative effects of FGM and thus favour its abandonment. Only 3% of women (aged 15 to 49) who have completed secondary or higher education are in favour of FGM continuing, compared to 11% of those who have received no education (DHS 2010, p.300). UNICEF also reports that of those girls aged 0 to 14 who have undergone FGM (as reported by their mothers), 15% of their mothers have had no education and 2% have had secondary or higher education (UNICEF, 2013c, p.2). While level of education does appear to impact on attitudes towards the abandonment of FGM, DHS 2010 figures (p.300) suggest that level of wealth does not have so much influence. A similar percentage of women from the poorest wealth-quintile feel that the practice should be abandoned (88%) compared to the richest quintile (91%). 11% of the poorest women express support for its continuation compared to 8% of the richest.

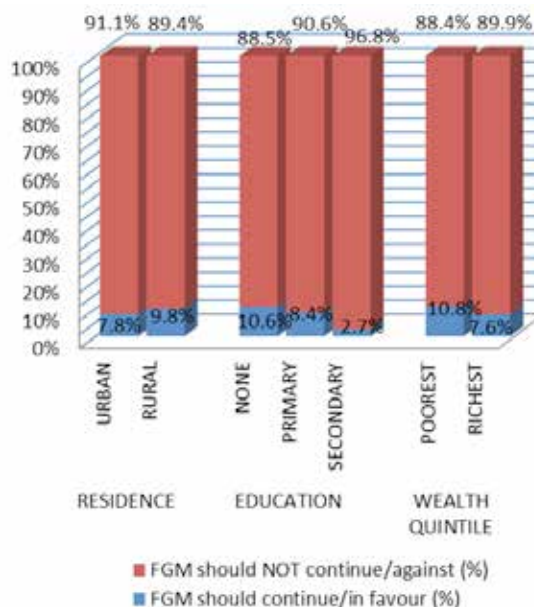


Fig. 29: Attitudes of women aged 15 to 49 according to residence, education and wealth indicators (DHS 2010, p.300)

In previous reports 28 Too Many has highlighted the issue of availability and reliability of data on FGM. We noted in our report on Senegal (June 2015, p.40), for example, that ‘UNICEF (2013) acknowledges that answers in formal surveys regarding questions about continuing FGM are opinions held at only one point in time.’ The reliability of surveys and the data collected from them can be limited, as they tend to be based on women’s and men’s personal reports and not medical or clinical data (Chikhungu and Madise, 2015, p.9).

Since the law criminalising FGM was passed in 1996 the reliability of these surveys has been brought further into question, as women may deny they have undergone the procedure for fear of incriminating family members or excluding themselves from their community. The WHO has also identified the likelihood of underreporting in regard to FGM in many African countries for the same reason. Women may also be unaware that they have undergone FGM if it was done in infancy or early childhood (WHO in Elmusharaf et al, 2006, p.3).

Data analysed by Chikhungu and Madise (2015, p.5) shows an increase in FGM being performed on girls up to five years of age from 34.2% in 1999 to 69% in 2010. This may also be due to the new law: if the girl is a baby or small child they will not be able to articulate what has happened to them, so there are likely to be fewer reports of it taking place and therefore fewer criminal prosecutions of parents and excisors.

Overall, the analysis by Chikhungu and Madise seems to indicate a shift in attitudes towards favouring the end of FGM. However, FGM remains prevalent, which suggests that the criminalisation of FGM may have influenced people to be more secretive about their attitudes towards the continuation of the practice for fear of repercussions (Chikhungu and Madise, 2015, pp.5-9).



Fig. 30: Evidence from Burkina Faso suggests FGM is being performed on even younger girls and babies (Global Environment Facility)

REASONS FOR PRACTISING FGM AND ITS PERCEIVED BENEFITS

FGM is a social norm – a deeply-rooted cultural tradition and a behavioural expectation that is often reinforced by community or peer pressure, and failure to conform carries the threat of stigma, shunning or even eviction. While it has been reported that 52% of women aged 15 to 49 in Burkina Faso perceive no benefits from the practice of FGM (UNICEF, 2013c, p.3), there nevertheless remains deeply entrenched reasons

for its continuation and these are always complex and varied across the country and between different groups.

COMMUNITY/SOCIAL ACCEPTANCE

Growing up in a culture where it is seen as the norm to have undergone FGM, and where FGM has only recently been deemed unlawful, women may tend to look towards the older generation for guidance. This dependence on elders, including local traditional and religious leaders, can make it difficult to break away from the practice, which is also strongly tied to social acceptance and a sense of community. In some cases all the women from previous generations will have undergone FGM. To feel a sense of community young girls may feel pressured into undergoing FGM without realising its full repercussions, or they may choose to ignore the repercussions to gain social acceptance within their community (UNFPA, 2011). UNICEF (UNICEF, 2013c, p.3) reports that 24% of women and girls (aged 15 to 49) who have heard of FGM cite 'social acceptance' as the reason for a girl to undergo the procedure. As previously discussed, the prevalence of FGM varies between the different ethnic groups with higher levels found in the communities of the Sénoufo, Fulani, Lobi and Bissa peoples (over 80%) compared to the Touareg (22%) (DHS 2010, p.291)

CLEANLINESS/HYGIENE

In Burkina Faso UNICEF reports that 6% of women and girls aged 15 to 49 believe that undergoing FGM maintains cleanliness and hygiene (UNICEF, 2013c, p.3); therefore, there does not seem to be a strong link between the practice of FGM and a belief that it is better for one's hygiene and health.

FIDELITY/VIRGINITY

Another reason often given for continuing FGM is the preservation of virginity and the prevention of promiscuity in women before marriage. However, UNICEF again reports statistics that show that in Burkina Faso only 4% of women and girls aged 15 to 49 believe this is a specific benefit of FGM (UNICEF, 2013c, p.3).

MARRIAGE PROSPECTS

Sometimes it is expected of the potential bride to have undergone FGM before she may be considered marriageable (UNFPA, 2011). This links back to the important role social acceptance plays in FGM's continuation: to be a part of the community, women must marry and have children to perpetuate the community, and they must undergo FGM in order to marry. Although marriageability may have been one of the key factors for the initial spread of FGM among communities, current survey results may suggest that this is no longer the case. In Burkina Faso only 3% of women (aged 15 to 49) cite better marriage prospects as a benefit of FGM (UNICEF, 2013a, p.3). However, as Mackie notes (in UNICEF, 2013a, pp.66-68), the preservation of virginity 'may be indirectly related to marriage prospects in some settings'. Additionally, the concept of social acceptance, the most commonly perceived benefit in Burkina Faso (UNICEF, 2013, p.67), may encompass better marriage prospects.

RELIGIOUS REQUIREMENT

On average in Burkina Faso 17% of women and 15% of men (aged 15 to 49) who have heard of FGM believe that it is a religious requirement. Among women and girls who have had FGM, the percentage of those who hold this belief is slightly higher, at 21%; only 7% of those who are uncut hold this belief (DHS 2010, p.298). There are also variations in belief depending on socio-economic factors. For example, among the Muslim population 22% of women and 19% of men consider FGM to be a religious requirement. The figure reaches a high of 30% among men and women with traditional/animist beliefs and lows of between 2 and 5% among Catholic and Protestant men and women (p.298). Beliefs vary between the ethnic groups in Burkina Faso; for example, among the frequently-practising Lobi communities some 41% of women believe FGM to be a religious requirement but only 4% of the men believe it to be so (p.298). FGM and religion is discussed further elsewhere in this report.



Fig. 31: Young girl in traditional dress, Sahel region of Burkina Faso (Photographer: Adam Jones)

LAWS RELATING TO FGM

INTERNATIONAL AND REGIONAL TREATIES

For information on international and African regional laws relating to FGM please refer to the [law factsheet](#) on our website.

A majority of the international human rights conventions and treaties related to the practice of FGM have been signed and ratified by Burkina Faso. The ratification of these conventions places a legal obligation on Burkina Faso to ensure that FGM, as an international human-rights violation, is eradicated by putting certain provisions in place.

Burkina Faso has ratified or signed up to the following conventions and treaties:

- Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984 (ratified in 1999) (Optional Protocol signature only, 2005)
- International Covenant on Civil and Political Rights, 1966 (ratified in 1999)
- International Covenant on Economic, Social and Cultural Rights, 1966 (ratified in 1999)
- Convention on the Elimination of all Forms of Discrimination Against Women, 1979 (CEDAW) (ratified in 1987)
- Convention on the Rights of the Child, 1990 (ratified in 1990)
- Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict, 2000 (ratified in 2007)
- Universal Declaration of Human Rights, 1948 (UDHR) (Burkina Faso's Constitution 1991 adopts the language used in its preamble to embody the principles of UDHR, acknowledging the equality of all without discrimination [Bayala and Gaanders in Gaanders and Valasek, 2011, p.63].)

Burkina Faso has signed up to the following regional charters which, like the international treaties, require certain provisions to be put in place to enact them:

- African Charter on Human and Peoples' Rights (the Banjul Charter), 1981
- African Charter on the Rights and Welfare of the Child 1990 (calls upon all States to take appropriate measures to eliminate harmful social and cultural practices [Art. 22])
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol), 2003 (ratified in 2005 – calls upon States to take measures to eliminate FGM and other traditional practices that are harmful [Art. 2(2)]).

NATIONAL LAWS

AGE OF SUFFRAGE, CONSENT AND MARRIAGE

Age of Suffrage:

The age of suffrage is 18 (CIA World Factbook, 2015) and, according to Article 33 of the Constitution, 'Direct suffrage is always universal, equal and secret.'

Age of Consent:

There is no specific law relating to the age of consent to sexual relations.

Age of Marriage:

The Code on the Individual and the Family (1989) states that the legal age for marriage is 17 for women and 20 for men. However, civil courts can authorise exceptions for women from the age of 15 and for men from the age of 18 (Art. 238).

THE CONSTITUTION

The Constitution does not directly prohibit FGM but it does affirm the human right to physical integrity (Art. 2) and the right to health (Art. 26). The Constitution also clearly states the importance of equality between men and women (Art. 1).

NATIONAL LAWS AGAINST FGM

The Penal Code of Burkina Faso was amended in 1996 to prohibit FGM (Office of the Senior Coordinator of International Women's Issues, 2001). Section 2 of The Penal Code, titled *Des mutilations génitales féminines (FGM)*, states at Article 380 that

[a]nyone who harms the female genital organs by total ablation, excision, infibulation, desensitisation or any other means shall be punishable by six months to three years' imprisonment and a fine ranging from CFA francs 150,000 to 900,000 or by one of these two punishments only. Should this result in death, the punishment shall be five to ten years' imprisonment (translation by the Inter-Parliamentary Union).

Article 381 states, 'The maximum punishment shall be meted out if the guilty party is a member of the medical or paramedical profession' (translation by the Inter-Parliamentary Union). The court may also ban the culprit from practising his or her profession for a duration not exceeding five years. Article 382 states, 'Any person who is aware of acts as defined by Article 380 and who fails to notify the competent authorities shall be punishable by a fine ranging from CFA francs 50,000 to 100,000' (translation by the Inter-Parliamentary Union).

LEGAL SYSTEM AND LAW ENFORCEMENT

Burkina Faso's legal system is based on the French civil law system and customary law (International Business Publications, 2014, p.14).

At the forefront of the campaign against FGM is the CNLPE. The CNLPE was first set up in May 1990 and gained a permanent secretariat in 1997, which now oversees and carries out its action plans to implement the law, including the National Action Plan. The Committee liaises with the 13 ministries, women's-rights and other NGOs, religious and community leaders, law enforcement officials and the judiciary (FuturePolicy.org, 2014).



Fig. 32: Traditional leaders participate in community FGM awareness training run by GASCODE (© GASCODE)

The CNLPE oversees all actions against FGM at a countrywide level through the mobilisation of resources, publications and data to monitor and evaluate activity. For example, the Committee lobbied and succeeded in getting the Government to identify FGM as a public health priority. It also conducts intensive training sessions about FGM and the law at grassroots level and tailors sessions for different professional groups, from religious leaders to the press and media. Following on from this training, groups develop different strategies towards the eradication of FGM. For example, the Islamic Association developed a national committee to organise awareness campaigns (Office of the Senior Coordinator of International Women's Issues, 2001).

The CNLPE has established a 24-hour telephone hotline, known as 'SOS Excision', which is dedicated to FGM. Anyone who suspects a girl is in danger of FGM can call the number anonymously. The police will then be notified and will try to intervene and help. The UNJP has supported the CNLPE since 2009, working to promote the law and its enforcement (Office of the Senior Coordinator of International Women's Issues, 2001).

There is no definitive evidence that the practice of FGM has gone further underground since the law was implemented, although available data indicates that 60% of incidents of FGM are carried out on girls aged five or younger (DHS 2010,

p.293). It has been suggested that FGM is being carried out more frequently at a younger age as it is less likely that a younger child will speak out or raise suspicions in relation to criminal activities (Chikhungu and Madise, 2015, p.6). Furthermore, problems have arisen from the geographical placement of Burkina Faso, which, in its land-locked position, may enable those who are set on pursuing the practice to cross the nearest border to carry out FGM (UNFPA, 2011). There are NGOs currently working in cross-border communities to tackle this problem; for example, (I)NTACT and local partners in the south of the country.

Since the law has been in place, there have been many convictions resulting in the imprisonment or fining of excisors and their accomplices. In practice the current sentence of imprisonment has ranged from one to ten months, with some prison sentences being suspended (Office of the Senior Coordinator of International Women's Issues, 2001).

Despite the difficulties surrounding prosecution, such as strong cultural ties and judges'/magistrates' reluctance to deprive children of their parents' care by imprisoning them, there has been a gradual increase in prosecutions. Between 1997 and 2005 94 individuals were sentenced compared to the period 2005 to 2009, when 686 individuals were convicted (40 excisors and 646 parents). In 2009 authorities responded to 230 individual cases of FGM (UNFPA, 2011). In 2014 there were also two public hearings: one case followed the cutting of 14 girls; the other case resulted in two excisors and 21 accomplices each receiving up to 12 months' imprisonment (UNFPA-UNICEF, 2015, p.43).

There is no current replacement for the National Action Plan 2009-2013. However, UNFPA and UNICEF have noted that the development of a new National Action Plan to promote the elimination of FGM will shortly commence (UNFPA, 2011). It is hoped that, following the forthcoming elections, the new Government will make this a priority.

Burkina Faso has signed up to the SDGs.

STRATEGIES TO END FGM AND

ORGANISATIONAL PROFILES

BACKGROUND

In 1990 the Government of Burkina Faso established the CNLPE as the institutional framework for coordinating resources and actions to eradicate FGM in Burkina Faso. As the IAC representative for Burkina Faso the CNLPE has been responsible for undertaking research and raising awareness of the harm of FGM at national and local levels for the past 25 years. This work, with the support of the former first lady, Madame Chantal Compaore, contributed to Burkina Faso becoming the first African country in 1996 to pass a national law against FGM.

The CNLPE is also responsible for enforcing the law on FGM and introducing education on FGM into the school curriculum. An important early initiative from 1990 was the establishment of the 'SOS Excision' telephone hotline, to which anonymous calls can be made if someone suspects a girl is in danger of FGM.

GOVERNMENT POLICY AND SUPPORT

The CNLPE is under the administrative supervision of the Ministry of Social Action and National Solidarity. It comprises a General Assembly composed of representatives of Government ministries, women's associations, professional associations, traditional and religious authorities, and other community leaders. Its work is coordinated by a permanent secretariat and supported by 45 provincial, departmental and village-level committees and other local associations.

The CNLPE has engaged public authorities in the fight against FGM by showing how they can take account of FGM in public-health priorities, economic policies and public investment programmes. In 2000 it introduced a national day against excision which is now held on 18 May each year. In 2004 funding for activities to eliminate

FGM was integrated into the national budget and in 2005 a reproductive-health law was introduced, outlawing harmful practices (UNICEF 2013a, p.12). The Government adopted a National Action Plan to eliminate FGM for 2009-2013. The CNLPE has also facilitated the training of doctors in dealing with the harmful physical effects of FGM.

During 2012 and 2013 the National Assembly collaborated with the Association of European Parliamentarians with Africa (AWEPA) on a number of initiatives, bringing together Government representatives and NGOs at workshops to reaffirm commitments to enforce the national law and agree 'Key Parliamentary Actions' for MPs to take forward (AWEPA 2014a&b). Government representatives also travelled out to the province of Yatenga, in the north of Burkina Faso near Mali, where FGM prevalence remains high, to discuss the cross-border issue with local community and religious leaders and the need for further action.



Fig. 33: National Parliamentary Workshop on FGM Abandonment 2012 (© AWEPA)

ANTI-FGM INITIATIVES NETWORKS

Burkina Faso has a strong network of NGOs working to end FGM under the supervision of the CNLPE, and from 2009 it became one of the 17 African countries currently in the UNJP. The main local implementing partners in the UNJP are GASCODE and Mwangaza Action. They have been able to bring together 375 villages in their areas of intervention to date to publicly declare the abandonment of FGM.

OVERVIEW OF STRATEGIES TO END FGM

A broad range of interventions and strategies have been used by different types of organisations to eradicate FGM in Burkina Faso. More information can be found on our [Overview of Strategies to end FGM Factsheet](#). Often a combination of the interventions and strategies below are used:

TYPE OF STRATEGY	ABBREVIATION
Alternative Rites of Passage	ARP
Human Rights/Community Dialogue Programmes	HR/ CDP
Promotion of Girls' Education to Oppose FGM	E
Educating Traditional Excisors and Offering Alternative Income	EX
Addressing Health Complications of FGM	H
Health Risk/ Harmful Traditional Practice	HTP
Legal	L
Media Influence	M
Working with Men and Boys	MB
Religious-Oriented	R
Supporting Girls Escaping from FGM/Child Marriage	SG

Table 5: Strategies used by organisations to promote the abandonment of FGM

INTERNATIONAL ORGANISATIONS

ITALIAN ASSOCIATION FOR WOMEN IN DEVELOPMENT (AIDOS)

www.aidos.it

Strategies: HTP / HR / E / M

AIDOS is an Italian NGO that has been working for the rights of women in several African countries since 1981. In Burkina Faso it has provided financial, technical and organisational support, partnering with Mwangaza Action, Voix des Femmes and the CNLPE to raise awareness and provide information to stop FGM. In 2007 the funding of the CBF in association with Voix des

Femmes provided a key resource to support the local community. AIDOS also coordinates through the working group STREAM (Sharing Technologies and Resources for Engaged and Active Media) an international ‘Stop FGM/C!’ campaign to improve involvement of the media in countries such as Burkina Faso.

(AIDOS, 2006; International campaign for the abandonment of female genital mutilation/cutting, 2010)



Fig. 34: Designed and funded by AIDOS, the CBF is a focal point for the community, providing vital information about FGM and support services for women and girls (RASCA Production – screen capture)

DEUTSCHE GESELLSCHAFT FÜR INTERNATIONALE ZUSAMMENARBEIT (GIZ)

Strategies: HR / CDP / E / HTP / L
www.giz.de

Since 2007 GIZ has implemented a joint German-Burkinabé programme addressing human rights and sexual health in Burkina Faso known as PROSAD (*Le Programme Santé Sexuelle, Droits Humains*). FGM is addressed through GIZ’s work to promote women’s and girls’ rights and the prevention of gender-based violence. GIZ works at the national and local level, with intervention activities concentrated in the south-west and east of the country. Firstly, it uses a community-dialogue approach to raise awareness, targeting both women and men, young people and local leaders. GIZ’s research has confirmed that this approach continues to be successful in ‘encouraging a deep and honest dialogue’ (GIZ, 2015) between key decision-makers (i.e. heads of families) and those at risk of FGM. Secondly,

since 2013 GIZ has also been working to include FGM awareness in both primary and secondary schools in Burkina Faso. To achieve this GIZ has worked with others at the national level to redraft the school curriculum to include FGM and identify six leading regions to initially implement it for the 2015-2016 academic year. Finally, GIZ also supports the community judicial councils that are put in place to protect women’s and girls’ rights and offer support to victims of violence. Activities utilise guides and photographs of FGM and include training and discussion groups on violence against women and reproductive health.

(GIZ, undated & 2015)

INTER-AFRICAN COMMITTEE ON TRADITIONAL PRACTICES (IAC)

Strategies: HTP / CDP / R / EX
www.iac-ciaf.net

The IAC is an umbrella body with national chapters in 29 African countries and it has been working on policy programmes to stop FGM for the last 28 years. The headquarters of the IAC is in Addis Ababa, Ethiopia, and it has a liaison office in Geneva. The IAC collaborates with a number of international organisations, including its partners UNFPA, WHO and UNICEF.

IAC programmes throughout Africa include training for professionals, women’s and men’s groups, peer educators and legal bodies. It undertakes information and sensitisation campaigns, targeting groups such as religious leaders and traditional rulers, and provides training and credit to excircumcisers, utilising them as agents for change. The CNLPE is the IAC national committee member for Burkina Faso, based in Ouagadougou.

(IAC, 2009)

(I)NTACT MÄDCHENHILFE

Strategies: HR / CDP / EX / H / HTP / M / R
www.intact-ev.de

(I)NTACT is a German-based NGO that has been working extensively in Burkina Faso since 1993. In partnership with grassroots organisations, it provides financial and technical support to awareness campaigns around the issue of FGM. (I)NTACT's local coordinators provide theoretical and practical training to community representatives prior to the launch of awareness campaigns and then support and monitor them during implementation and afterwards. A variety of approaches are used to ensure that all members of the community are fully informed about the negative consequences of FGM, including holding community discussions and workshops for circumcisers, using theatre and film and sending social workers to visit families. As well as educating the circumcisers, in some projects (I)NTACT has supported them to find alternative sources of income. They also maintain contact with them afterwards to ensure that they do not return to cutting (over 100 have been reported to have abandoned their work).

(I)NTACT also places a heavy emphasis on the importance of working with religious leaders. Those leaders are invited to project seminars and subsequently can take the information out to their own communities. This approach has been found to be highly effective in Burkina Faso (some 250 religious leaders have now been sensitised against FGM).

To ensure sustainability, (I)NTACT maintains contact with communities after the end of projects and ensures local representatives supervise families with girls at risk. There still remains the problem of cross-border movements to carry out FGM. In response, (I)NTACT began a cross-border project in early 2014 in partnership with Association des Jeunes de Léo (AJDL) and further partners in Ghana and Togo. The project, which is run in the south of the country, has raised awareness in some 170

villages, working alongside former circumcisers and supporting over 70 girls who have been cut. The project is due to continue until the end of 2016.

((I)NTACT Mädchenhilfe, 2014 & 2015)



Fig. 35: (I)NTACT, with local partners AJDL, hold public discussions on FGM (© (I)NTACT)

PLAN INTERNATIONAL

Strategies: HR / CDP/ E / H / HTP
www.plan-international.org

Plan International works throughout Burkina Faso to protect children against all forms of violence and in particular to ensure that the rights of girls to physical integrity and an education are recognised and respected. Plan works alongside groups at all levels, from Government to children and young people, to tackle sexual abuse, trafficking, child labour, FGM and child marriage. Activities include establishing child-protection units, school-governance groups and vocational training to support girls forced into early marriages.

(Plan International, undated)

SAVE THE CHILDREN

Strategies: HR / CDP / E / H / HTP
www.savethechildren.net

Save the Children works in 120 countries across the world and began programmes in Dori, Burkina Faso in 1977. It partners with a number of grassroots organisations to provide education and health services to 81 communities in Bazega province,

south of Ouagadougou. These programmes particularly focus on girls’ rights, promoting school enrolment and improving maternal and child health and HIV/AIDS prevention. Save the Children also works at the national and local level to promote the eradication of FGM in Burkina Faso (alongside NGOs such as Voix des Femmes).

(Save the Children, 2015a&b)

UNICEF/UNFPA

Strategies: HR / CDP / H / HTP / R / M
www.unicef.org
www.unfpa.org

Burkina Faso is one of the 17 countries forming part of the UNJP. The UNJP strategy includes lobbying and advocating at both the national and local level, organising awareness-raising activities in the community (targeting traditional and religious leaders) as well as strengthening the coordination and monitoring activities of the CNLPE. The two main implementing partners in Burkina Faso are GASCODE and Mwangaza Action (see profiles below). Utilising a community-dialogue approach to tackling FGM, these partners have now brought together representatives of some 375 villages to declare abandonment of FGM in public ceremonies.

UNFPA-UNICEF have supported work in Burkina Faso to include FGM in antenatal and neonatal care in the health districts of Kaya and Zorgho (in the North and Central Plateau regions). They have also trained 40 medical staff from 11 centres in the Centre, Central Plateau and Centre-North regions to undertake surgical repairs of the effects of FGM (272 procedures were carried out in 2011). In the areas bordering Mali the UNJP has supported partners in the broadcasting of community-radio programmes to raise awareness of issues surrounding FGM.

(UNICEF, undated; UNFPA, undated; UNFPA-UNICEF, undated)

NATIONAL AND LOCAL ORGANISATIONS

ASSOCIATION D’APPUI ET D’EVEIL PUGSADA (ADEP)

Strategies: HR / CDP / E / H / HTP / M / SG
www.pugsada.org

ADEP was established in 1995 with the objective of helping young girls (*pugsada* in the national Mooré language) to understand their rights. Its aims are to promote girls’ education, provide them with information on sexual and reproductive health, help them gain independence, and fight against all forms of gender-based violence (including FGM). ADEP organises activities to help parents understand and respect the rights of their daughters and the impact of FGM on their physical and psychological health.

ADEP’s advocacy of the eradication of FGM takes place at both the national and local level and it works with a number of partners and funding agencies. Its programme strategies include educational talks and discussion groups, radio and TV broadcasts, and the use of film screenings and theatre forums in the community. ADEP also provides counselling services for girls experiencing difficulties in their family lives.

(Association d’Appui et d’Eveil Pugsada, undated)

ASSOCIATION POUR LA PROMOTION DE LA JEUNESSE AFRICAINE ET LE DÉVELOPPEMENT (APJAD)

Strategies: HR / CDP / E / MB

APJAD promotes the well-being and development of young people in Burkina Faso and was the first youth association to become involved alongside the CNLPE at the national level to campaign for the eradication of FGM.

Utilising a ‘peer educator’ approach, APJAD began a project in 2000 titled *Jeunesse en campagne contre l’excision* (‘Young people campaign against FGM’) in the Orodara and Korrigan areas. For its awareness-raising, advocacy and education work

in those communities, APJAD addressed girls and boys aged between seven and 24, its priority target group. Influential adults such as community leaders and local administrative bodies were also involved. APJAD uses a range of techniques to engage the young community, including theatre forums, cultural nights (with music and dancing), film screenings and the distribution of books and t-shirts. It has also established anti-FGM clubs that are overseen by the peer educators.

APJAD now has a well-established training and outreach team and continues to work on FGM issues with young people.

(Population Council and Secrétariat Permanent du Comité National de Lutte contre la Pratique de l'Excision, 2006)

ASSOCIATION KHOOLESMEN

Strategies: HR / CDP / EX / H / HTP / SG
asskhood.e-monsite.com

Association Khoolesmen is one of the grassroots organisations currently working in partnership with (I)NTACT to tackle FGM in the Seno province in the northern Sahel region of Burkina Faso. The Association, set up in 1994, focuses on child protection and the socio-economic advancement of women and girls. Its activities include the provision of information and education in communities regarding FGM; community dialogue programmes; support for women and girls who have undergone FGM; and retraining and microcredit initiatives for former circumcisers. The Association also addresses early and forced marriages and obstetric fistulae through its work.

(Association Khoolesmen, undated)

ASSOCIATION MAÏA

Strategies: HR / CDP / E / H / HTP / MB / R / SG
www.associationmaia.org

Association Maïa was created in the Bobo-Dioulasso area of Burkina Faso in 1994 and has worked as a nationally recognised NGO in the area of women's

and girl's rights since 1998. Work began between 2003 and 2006 with a sexual-health programme for women in Bobo and the surrounding villages, in partnership with the French Movement for Family Planning. Facilitators ran support groups on a number of themes, including women's rights and FGM. Feedback from this programme suggested that the community would benefit further from the inclusion of men. Subsequently, the second programme has proved very popular as it has aimed to be more inclusive, introducing men as facilitators in community-dialogue workshops and the participation of local traditional and religious leaders in advocacy work. A film screening followed by an audience discussion has been a particularly well-received tool.

(Association Maïa, undated & 2015)



Fig. 36: FGM awareness groups run by Association Maïa include both men and women (© Association Maïa)

LE COMITÉ NATIONAL DE LUTTE CONTRE LA PRATIQUE DE L'EXCISION (CNLPE)

Strategies: HTP / E / EX / H / L / MB / R

Based in Ouagadougou, the CNLPE is the national committee member of the IAC and represents the institutional framework for the eradication of FGM in Burkina Faso. Under the administrative supervision of the Ministry of Social Action and National Solidarity, the CNLPE is made up of:

- the General Assembly, including representatives of Government ministries,

women's associations, traditional and religious authorities and NGOs; and

- the permanent secretariat, which coordinates and enforces the decisions of the General Assembly.

Committees at the regional and village level, including traditional and religious authorities, provide support.

The CNLPE is responsible for coordinating actions and resources to eradicate FGM across the whole of Burkina Faso. Its Action Plan details its aim to achieve this through consultation; research; awareness-raising activities in different sections of the community, including circumcisers and FGM survivors; enforcement of the law on FGM; increased education on FGM in the school curriculum; and monitoring and evaluating. A key initiative developed and run by CNLPE has been the 'SOS Excision' telephone hotline to which anonymous calls can be made if someone suspects a girl is in danger of FGM. This information is then forwarded to local police, who try to intervene.

(IRIN News, 2005; MASSN.GOV.BF, 2012)

GROUPE D'APPUI EN SANTÉ, COMMUNICATION ET DÉVELOPPEMENT (GASCODE)

Strategies: HR / CDP / EX / HTP / M / MB / R

GASCODE was founded in 1997 by a group of medical professionals to provide training and support for NGOs and partner associations in various areas of development, including women's and girls' rights, reproductive health and FGM awareness. The group has an office in Ouagadougou, two centres in Ziniaré and Guiloungou and a centre for distressed children at Siglé. GASCODE is a main implementing partner of the UNJP and a member of the CNLPE network, and utilises a community-based approach to tackling FGM.

Its activities include advocacy and sensitisation work with traditional and religious leaders (some

260 have contributed to FGM projects to date, including in the town of Tenkodogo in June 2015), which has led to public declarations of abandonment of FGM in 95 villages. GASCODE also aims to educate and include former circumcisers in this abandonment process. Commitments made as a result of this work are closely monitored. The main areas of intervention are in the Sahel, Centre, Centre-East, East, Boucle du Mouhoun and Central Plateau regions.

GASCODE also gives educational talks and training to members of other associations and local communities (for example, Ziniaré), so that they in turn can become facilitators and peer educators. Awareness is then spread through various channels, including workshops, film screenings and interactive theatre performances, and programmes on local community radio.

(Agence d'Information du Burkina, 2015; Department for International Development, 2014; GASCODE, 2015; Kobre, Yaro and Dan-Koma M., 2008)

MWANGAZA ACTION

Strategies: HR / CDP / E / H / HTP / MB / R
www.mwangaza-action.org

Mwangaza Action has been working in Burkina Faso since the mid-1990s to advocate for women's and girls' rights and to strengthen the capacity of communities in areas including reproductive healthcare and informal education. It has partnered with a range of organisations to implement community-based programmes that include activities to tackle FGM and, alongside GASCODE, it is a main implementing partner of the current UNJP and a member of the CNLPE network.

Between 2000 and 2003 Mwangaza Action also partnered with Tostan (a human-rights-based NGO, www.tostan.org) to replicate in Burkina Faso their community-based education programme to tackle FGM. Using a model first developed in

Senegal, 23 villages in the districts of Béré and Bindé in Burkina Faso were chosen to participate and, although there were organisational problems along the way, the outcome was positive in the promotion of reproductive health and women's rights. The programme concluded with all 23 villages making a public declaration to abandon FGM.

Other partner projects include work in 2012 funded by UNICEF to tackle child marriage and FGM alongside the CNLPE in the Centre-East and Sahel regions. A holistic approach was taken whereby facilitators lived and worked within the communities to carry out awareness-raising activities. Since 2007 Mwangaza Action has also worked alongside a number of other local NGOs, including APJAD, ADEP and AFD, funding micro-projects to extend and develop best practice in the abandonment of FGM in the areas of Kourinion, Soaw, Koungoussi and Ouagadougou.

(Mwangaza Action, 2015; Population Council, Mwangaza Action Association and TOSTAN, 2003)

VOIX DES FEMMES

Strategies: HTP / HR / CDP / EX / H / L / MB / R / SG



Fig.37: Voix des Femmes activities at the CBF allow for open discussion around the harm of FGM among all age groups (© Voix des Femmes)

Voix des Femmes was established in 2000 with a focus on the protection and promotion of

women's and children's rights. It is one of the leading NGOs in Burkina Faso working to end FGM and undertakes a wide range of activities to educate and advocate, aiming to bring an end to violence against women and girls across seven regions of the country. Voix des Femmes works in partnership with organisations including Government departments, other members of the CNLPE/IAC, schools, health professionals and international NGOs (for example, funding partners including GIZ/PROSAD).

Its activities to end FGM include advocacy and awareness training via seminars and workshops, theatre, radio and TV productions; educational activities with children and adolescents; and various health and psychotherapy services run at the CBF on the outskirts of Ouagadougou (see page 7). Voix des Femmes includes all sectors of the community in its work on FGM, engaging local traditional and religious leaders, and educating and retraining the circumcisers (with funding support from the IAC). Together with its monitoring and support for girls at risk of FGM, and health and legal services at the CBF for survivors of violence (including FGM), the holistic approach developed by Voix des Femmes has been successfully received in the communities where it works.

(Voix des Femmes, 2015)

CHALLENGES FACED BY ANTI-FGM

INITIATIVES

Challenges fall into two categories: firstly, strategic issues – those that are embedded in the structure of Burkinabé society, representing tradition and social norms; and secondly, practical aspects of encouraging more individuals and communities to change their behaviour and delivering the kind of support needed by those who go against the social norms.

The strategic challenges can be further divided into three types:

- the pervasiveness of cultural and social norms that support continuation of FGM;
- systemic failure of authorities to enforce the law in a way that prevents the practice being driven underground; and
- poor physical infrastructure (lack of roads, electricity, telecoms, schools and properly equipped clinics) which makes it difficult to outreach and work effectively in many rural communities where FGM is most prevalent.

As social acceptance was the most cited perceived benefit of FGM by Burkinabé women and girls (24%), and boys and men (10%), it is clear that changing social and cultural norms and behaviour is critical to eliminating the practice (UNICEF 2013a, pp.67&68). The evidence suggests that there has been change across the generations, with mothers reporting that fewer daughters are being cut. However, there is the alternative possibility that, to avoid legal repercussions, girls are being cut at a younger age and not reported, or they are being taken across borders into neighbouring countries where the laws are less stringently enforced. Identifying and addressing these possibilities remain a huge challenge.

Burkina Faso should be credited with being the first African country to outlaw FGM, setting severe punishments for those who perform the procedure. However, the existence of a law can

drive a practice underground unless the law is accepted and upheld by the majority of people it is designed to serve and protect. As has been shown by NGOs such as GASCODE and Mwangaza Action, who work at a community level with women and men, adherence to the law and changing social norms is most likely to be achieved through education in schools with young people, training sessions in communities led by traditional and religious leaders, and the development of peer educators.



Fig. 38: A former excisor shows the tools she used to use at a public declaration of FGM abandonment in the village of Napamboumbou (© GASCODE)

But reaching remote villages where FGM is most prevalent, and getting information to them, is not easy if there are no proper roads or if telecoms and newspapers are rarely available. A report by the UNJP makes the point that visiting villages with social workers and the gendarmerie to raise awareness is ‘hampered by the high cost of petrol when they try to follow up on a case’ (UNFPA-UNICEF, 2011, p.19).

Having achieved success in communities where public declarations of abandonment of FGM have been made by circumcisers, NGOs face the challenge of keeping up the momentum and ensuring these people do not renege their pledge. The practical challenges to anti-FGM initiatives include:

- providing continued support to communities that have started the abandonment process;

- identifying key local religious leaders in communities and engaging them for the long-term in programmes;
- continuing and increasing enforcement of the law, and making protection available to those women and men who want to save their daughters from being cut;
- providing care to women who have already undergone FGM and have limited access to healthcare;
- lack of medical studies in Burkina Faso about the problems caused by FGM, or gynaecological observation to support the self-reported figures of FGM prevalence; and
- the need for surveys gathering data on FGM prevalence and abandonment to take into account the illegality of the procedure, and the effect this might have on 'truthful reporting', possibly pushing it further underground and across borders.



Fig. 39: Voix des Femmes continue to raise awareness – talking with women at a market in Burkina Faso (© Voix des Femmes)

CONCLUSIONS

Current available evidence suggests the girls and women most vulnerable to undergoing FGM in Burkina Faso are those who are poor, uneducated, and living in rural areas. Ethnicity and region of residence may also influence whether or not they are cut. Based on mothers reporting fewer girls being cut there would appear to be a decline in the practice across generations. Conversely, there may be significant under-reporting due to the illegality of the procedure.

Government and NGOs have been working in Burkina Faso for the past two decades to eliminate FGM, supported by the media putting out information about its harmful effects and anti-FGM messages. These concerted efforts at educating the populace have led to many communities and circumcisers publicly pledging abandonment of the practice.

28 Too Many recognises that each country where FGM exists requires individualised plans of action for elimination to be successful. Drawing on the successes described earlier in this report, we propose the following general ways forward, many of which are applicable within the wider scope of international policy and regulation and some that are specific to Burkina Faso.

ADOPTING CULTURALLY RELEVANT PROGRAMMES

Communities in which FGM is found often have different customs surrounding the practice and express different reasons for performing FGM. Those designing programmes to tackle FGM need to be aware of these differences, deploying strategies to address the issues within each community and build support to stop FGM. Since its inception the CNLPE has coordinated community-led actions and resourcing to eradicate FGM across the whole of Burkina Faso. Mwangaza Action and GASCODE have also worked on this basis, as implementing partners of the UNJP.

LONG-TERM FUNDING

Programmes and research studies concerned with the elimination of FGM require long-term funding to be effective. Continued publicity of current FGM practices at a global level, particularly through the UN and WHO, is crucial for ensuring that NGOs and charities are given support and resources in the long term. Prioritising charitable aid and grant funding is inherently challenging and programmes for ending FGM are given less attention than those related to health and poverty crises. In Burkina Faso long-term funding is needed at grassroots level for organisations promoting women’s rights and girls’ education and for initiatives such as the SOS telephone hotline, to ensure its operative efficiency.

FGM AND THE SUSTAINABLE DEVELOPMENT GOALS

The inclusion in the SDGs of a specific target to eliminate FGM conveys the significant negative impact FGM makes on humanity. The prevention of FGM is thereby associated with the eradication of extreme poverty and hunger, the promotion of universal primary education and gender equality, the reduction of child mortality, the improvement of maternal health and the fight against HIV/AIDS. It is important therefore to highlight FGM in the context of these when creating grant proposals and communicating anti-FGM initiatives to a wider audience. There has been a momentum for change, with the UN’s global ban on FGM in December 2012 and the UN Commission on the Status of Women 57th session, which focused on violence against women and girls, including FGM. This momentum to eliminate FGM and violence against women can be continued within the framework of the SDGs, which has global support.

FGM AND EDUCATION

Education is a central issue in the elimination of FGM. The lack of basic education is a root cause of the perpetuation of social stigmas surrounding FGM as they relate to health, sexuality and women’s rights. FGM hinders girls’ ability to obtain

basic education, which in turn prevents them from pursuing higher education and employment opportunities. This lack of education also directly relates to issues surrounding child marriage. The CNLPE has successfully led the way in advocating for the inclusion of a module on FGM in the school curriculum, and the training of teachers on its harmful effects. We recommend that organisations continue to provide programmes related to education for boys and girls and that the Government makes efforts to comprehensively report on education conditions.

FGM, MEDICAL CARE AND HEALTH EDUCATION

More resources and education are required across the health systems in Burkina Faso, and there needs to be better access to healthcare, especially in rural areas. Health providers need to be better trained on the complications of FGM and provided with resources to support girls and women who have undergone FGM, in order to address both their physical and psychological issues. Voix des Femmes is providing vital health support to women and girls in the community at their CBF, and Association Khoolesmen has used a community-dialogue approach to encourage discussion on the health hazards associated with early marriage and obstetric fistulae.

FGM, ADVOCACY AND LOBBYING

National advocacy and lobbying will be essential to ensure future governments continue to support anti-FGM programmes and initiatives, that progress towards the elimination of FGM in Burkina Faso is maintained after the forthcoming election and that a new National Action Plan is developed and introduced. Support is also required from international partners and donors for the development of Burkina Faso’s health and education sectors, as well as for local initiatives that tackle FGM. This is essential, as rural areas remain the most difficult to reach and need the investment of time and money into advocacy and lobbying work to make a difference to girls most at risk of FGM and bring about a decline in prevalence across the whole of Burkina Faso.



Fig. 40: Girl en route to Bani in the Sahel region of Burkina Faso (Photographer: Adam Jones)

FGM AND THE LAW

Enforcement of the anti-FGM law in Burkina Faso must be upheld and further strengthened. Education and training is required for all those responsible for upholding the law. Consideration should also be given to measures to protect those who are at risk or are seeking to protect their daughters from FGM. The SOS Helpline is a key initiative in offering this protection.

FGM IN THE MEDIA

The media has proved 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, particularly in rural communities where many do not have regular access to the media. We also recommend the development of projects that more generally promote women’s access to the media. The use of diverse forms of media, and radio in particular, together with film screenings and interactive theatre, are proving to be successful tools in Burkina Faso and are included in the work of many NGOs, including Voix des Femmes, GASCODE and (I)NTACT.

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. FBOs 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. In Burkina Faso, given the trusted position that religious leaders have throughout society, it is essential that they are engaged in anti-FGM programmes, speak out against the practice and encourage its abandonment. Several NGOs are working closely with local traditional and religious leaders to achieve this (alongside their grassroots partners), including Voix des Femmes and (I)NTACT.

FGM AND MEN

Several NGOs (including Association Maïa and Voix des Femmes) have highlighted how important it is to engage with boys and men as well as girls and women when conveying the negative impacts of FGM. Association Maïa maintains that in many instances men who have participated in training sessions on FGM in their own community have gone on to take the message out to men in other communities.

COMMUNICATION AND COLLABORATIVE PROJECTS

There are a number of successful anti-FGM programmes currently operating in Burkina Faso, with the majority of the progress beginning at the grassroots level. We recommend continued effort to communicate this work more publicly and encourage collaborative projects. The fight against FGM will be strengthened by networks of organisations working against FGM (and more broadly for women’s and girls’ rights); integrating anti-FGM messages into other development programmes; sharing best practice, success stories, operations research, training manuals, support materials and advocacy tools; and providing links/referrals to other organisations.

FURTHER RESEARCH

We recommend that studies be undertaken in the following areas, and that existing survey methodologies should take into account the potential extent of misleading reporting, to ensure

a clearer picture is given of the real FGM situation in Burkina Faso.

- Gathering more-complete data on what is working and changing in FGM programming and implementing complementary methodologies would be beneficial.
- Consistency in both the order of questions in surveys and the age cohort of girls and women discussed would allow for analyses of trends between datasets.
- The best way to collect reliable data on an illegal practice remains to be determined. This problem needs to be addressed at global and grassroots levels. The issue of cross-border activity between Burkina Faso and its neighbours also needs further investigation.
- Given the significant work being done to end FGM in Burkina Faso, there is a lack of medical reports on the impact of FGM and how the situation may be changing. This needs to be addressed to ensure appropriate support is provided to survivors of FGM, who often have complex and specialist needs.
- Further research on the impact of religious leaders' involvement in the work to end FGM may be beneficial for future programming.



Fig. 41: Ms Coulibaly, President of Association Yenimahan, working on anti-FGM programmes in Mohoun and Kossi. Raising awareness alongside her, the former excisor who cut her (© (I)NTACT)

APPENDIX I – LIST OF INTERNATIONAL AND NATIONAL ORGANISATIONS CONTRIBUTING TO WOMEN’S AND CHILDREN’S RIGHTS IN BURKINA FASO

Amnesty International
 Appui Moral Matériel Intellectuel à l’Enfant (AMMIE)
 Association d’Appui et d’Eveil Pugsada (ADEP)
 Association Burkinabé pour la Survie de l’Enfance (ABSE)
 Association des Femmes Juristes du Burkina Faso (AFJ/BF)
 Association des Jeunes de Léo (AJDL)
 Association Khoolesmen
 Association Maïa
 Association of European Parliamentarians with Africa (AWEPA)
 Association pour la Promotion de la Jeunesse Africaine et le Développement (APJAD)
 Association Songmanegré Femmes pour le Développement (AFD)
 Association Soutong Nooma
 Association Yenimahan
 Christian Aid
 Christian Children’s Fund (Canada)
 Coalition Burkinabé pour les Droits de la Femme (CBDF)
 Le Comité National de Lutte contre la Pratique de l’Excision (CNLPE)
 Defence for Children International (DCI)
 (Deutsche) Gesellschaft für Internationale Zusammenarbeit (GIZ)
 Economic Community of West African States (ECOWAS)
 Entraide Féminine Burkinabé (EFB)
 Forum for African Women Educationalists (FAWE)
 Groupe d’Appui en Santé, Communication et Développement (GASCODE)
 (I)NTACT Mädchenhilfe
 Inter-African Committee (IAC)
 Italian Association for Women in Development (AIDOS)
 Kebayina Association of Women of Burkina
 Mouvement Burkinabé des Droits de l’Homme et des Peuples (MBDHP)
 Mwangaza Action
 Plan International

Promo-Femmes Développement Solidarité (PFDS)
 Réseau de Communication, d’Information et de Formation des Femmes dans les ONG au Burkina Faso (RECIF/ONG – BF)
 Save the Children
 SOS Children’s Villages International
 Terre des Homme
 United Nations Children’s Fund (UNICEF)
 United Nations Population Fund (UNFPA)
 USAID
 Voix des Femmes
 We Women
 Women in Law and Development in Africa (WiLDAF)
 Women Living Under Muslim Laws (WLUML)
 World Health Organisation (WHO)

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