



Baseline and Intervention Strategy Survey for the Eradication of Female Genital Mutilation in the Kurdistan Region of Iraq

2015

Intervention Strategy Baseline Survey 2015

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In 2015 Heartland Alliance International's Country Office in Iraq carried out the study "Baseline and Intervention Strategy Survey for the Eradication of FGM/C in the Kurdistan Region of Iraq (KR-I)" in consultation with lead researchers with expertise in the field of FGM/C research. The United Nations Children's Fund (UNICEF) and Kurdistan Regional Government (KRG) Ministry of Planning provided technical expertise.

The views expressed in this report are those of the author and do not necessarily reflect the official opinion of Heartland Alliance International.

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ABBREVIATIONS

BCC	Behavior change communication
FGM/C	Female genital mutilation/cutting
HAI	Heartland Alliance International
HCWA	High Council of Women Affairs
IEC	Information, education and communication
KAP	Knowledge, attitudes, and practices
KRG	Kurdistan Regional Government
KR-I	Kurdistan Region of Iraq
MICS4	Multiple indicator cluster survey 4
MOP	Ministry of Planning
OCHA	Office for the Coordination of Humanitarian Affairs
TBA	Traditional birth attendants
UNAMI	United Nations Assistance Mission for Iraq
UNDP	United Nations Development Program
UNECA	United Nations Economic Commission for Africa
UNESCO	United Nations Organization for Education, Science and Culture
UNFPA	United Nations Population Fund
UNHCHR	United Nations High Commissioner for Human Rights
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
UNV	United Nations Volunteers
WFP	World Food Program
WHO	World Health Organization

EXECUTIVE SUMMARY

The Kurdistan Regional Government (KRG), High Council of Women Affairs (HCWA), the KRG Ministry of Planning, Heartland Alliance International (HAI), and the United Nations Children’s Fund (UNICEF) present results from the Intervention Strategy Baseline Survey on Female Genital Mutilation and other forms of genital cutting (FGM/C) in the Kurdistan Region of Iraq (KR-I).

As defined by the World Health Organization (WHO), “FGM/C comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.” From a human rights perspective, FGM/C is considered an extreme form of discrimination against women as well as a violation of child rights when performed on minors, as it usually is.¹ The practice also violates the rights to health, security, and physical integrity of the person, the right to be free from torture and cruel, inhuman, or degrading treatment, and the right to life when the procedure results in death. As such, a wide range of international human rights and aid organizations are committed to eliminating FGM/C.

This report, based on analysis of survey results, describes the prevalence of FGM/C in the KR-I, with the goal of informing the design and development of an intervention strategy to eradicate FGM/C. The survey results shed light on the practice of FGM/C in the KR-I, as well as women’s understanding of FGM/C, their perceptions and motivations, and the role of social pressure and in decisions made about FGM/C. Moreover, this survey investigates the root causes of FGM/C, as well as women’s responses to awareness campaigns and the law against FGM/C. Survey responses confirm that religious, social, traditional, and cultural factors often reinforce misconceptions about FGM/C and are substantial obstacles to changing behaviors surrounding FGM/C. Illuminating the underlying barriers to reducing FGM/C will enable stakeholders to design targeted, evidence-based prevention programs going forward, including advocating for full implementation of Law No. 8: the Law Against Family Violence in the Kurdistan Region of Iraq (Anti-Domestic Violence Act), which prohibits FGM/C.

Published reports of FGM/C in the KR-I first emerged just over a decade ago, in 2004.² Since then several population studies using various methodologies have reported a prevalence of FGM/C ranging from 41%³ to 73%⁴ of the female population in the KR-I. This report surveyed aims to provide updated information on prevalence, knowledge, attitudes, and practices of FGM/C in the KR-I as well as provide recommendations for designing an effective campaign to eradicate the practice.

¹ UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNWOMEN, WHO (2008). Eliminating female genital mutilation: an interagency statement. Geneva: WHO.

²“Female Genital Mutilation in Iraqi-Kurdistan: An empirical study by WADI,” 2010, WADI - Association for Crisis Assistance and Development Co-operation

wadihttp://www.stopfgmkurdistan.org/study_fgm_iraqi_kurdistan_en.pdf

³ Iraqi Kurdistan: Law Banning FGM a Positive Step”16 July 2011, Human Rights Watch, <http://www.hrw.org/news/2011/07/25/iraqi-kurdistan-law-banning-fgm-positive-step>

⁴Female Genital Mutilation in Iraqi-Kurdistan: An Empirical Study

http://www.stopfgmkurdistan.org/study_fgm_iraqi_kurdistan_en.pdf

A sample of 5,990 mothers of girls aged 4 to 14 years from the four governorates of Erbil, Sulaymaniyah, Halabja, and Dohuk were surveyed for this analysis. While previous studies conducted in the KR-I have documented the overall practice and prevalence of FGM/C, this is the first study to focus on girls in this young age group. This group is of special interest to stakeholders working to eradicate FGM/C as it is the group of girls at current risk of becoming victim to FGM/C.

FINDINGS & RECOMMENDATIONS

Findings

Results from this study indicate a sharp decrease in FGM/C prevalence based on the comparison of FGM/C rates in mothers and daughters. This decrease may be connected to anti-FGM/C awareness activities conducted in the area in recent years and to the law banning FGM/C in the KR-I, passed in 2011, but this remains a speculative interpretation. Indeed, the study results may be unrelated to these anti-FGM/C efforts, as around half of the women reported they had never heard any anti-FGM/C message, and a similar number were not aware of the law. Further analysis is needed to examine a statistical association or causal relationship between these factors. What the survey does show unequivocally, however, is a need for greater awareness of FGM/C and the harms it causes women socially, psychologically and physically, and of the law banning its practice in the KR-I. More detailed findings are as follows:

Prevalence of FGM/C

- FGM/C in the KR-I has dramatically declined over the past generation.
 - Among the mothers surveyed, 44.8% reported undergoing FGM/C themselves compared to 10.7% of their daughters.
 - This dramatic decrease in FGM/C in the KR-I is found across all geographic, education, and income sub-groups, although substantial variations do exist in the degree to which the prevalence has declined.
 - FGM/C among daughters has the highest prevalence in Erbil (16.7%) and Sulaymaniyah (11.8%), and the lowest rates in Dohuk (4.1%) and Halabja (1.1%).
 - Erbil (67.6%) and Sulaymaniyah (60.3%) also have the highest rates of mothers who self-report undergoing FGM/C themselves.
 - FGM/C prevalence among daughters is correlated with the mother's level of education. On average, as a mother's level of education increases the likelihood of her daughter undergoing FGM/C decreases.
 - FGM/C among both daughters and mothers was more prevalent in rural areas than in urban areas, as has been found in previous studies.
- Biases inherent in the study design could contribute to prevalence being underreported, and some mothers still plan to cut their daughters. However, when mothers were asked about their plans to cut or not to cut their other daughters, only 4.3% stated that they intend to have FGM/C performed for their daughter (an additional 5.3% were unsure).

Practice of FGM/C

- In daughters, FGM/C was conducted at around age 5, with a mean of 4.7 years. Of girls who were cut, the vast majority (90.0%) were cut with a razor blade. Cutting usually happened at the girl's home (75.0%) rather than at the home of a relative or the home of the cutter (sometimes the same person) (21.1%).
- Traditional birth attendants (TBAs) conducted just over 65% of all reported cuttings. The next most common cutter was a female relative other than the mother herself.

Health Problems due to FGM/C

- Only 5.8% of the daughters who were cut were reported to negative health or psychological problems as a result. No single health complication was indicated by more than 2.0% of respondents. This rate is quite low compared with the mother's self-reported complication rate of 20.7%. Complication rates identified by previous studies are also higher than what was reported for the daughters in this survey.^{5,6} There is a strong likelihood that the complication rate is underreported either because mothers were unwilling to admit to surveyors that their daughters experienced harm or because longer term health complications (i.e. issues related to sexual health, menstruation, pregnancy/birth, etc.) had not yet manifested due to daughters' young ages.

Reasons for FGM/C

- The two most common reasons cited by mothers for forcing their daughters to undergo FGM/C were that FGM/C was a religious requirement (63.4%) and that FGM/C was part of their tradition (61.8%). Just over 24.0% said that FGM/C was done as a result of family pressure.
- Among mothers whose daughters had not undergone FGM/C, about 40.0% said that they did not force their daughters to be cut because FGM/C was not part of their tradition and 23.5% said that their religion forbade it.
- Respondents in some geographic areas were more likely to cite religion as the reason both for and against cutting their daughters. Respondents in Dohuk, where the FGM/C rates are lower, were the most likely to state that their religion forbids FGM/C; however, almost all Dohuk mothers who practiced FGM/C on their daughters cited religion as the reason for practicing FGM/C. This paradox could indicate inconsistency among religious leaders in how Islamic doctrine is being taught regarding FGM/C.

Influencers on FGM/C

- Results point to the importance of female family members as the main instigators of FGM/C. Mothers who decided to force their daughters undergo FGM/C cited close female family members as the main people who encouraged them to do so.

Attitudes regarding FGM/C

⁵ Female Genital Mutilation in Iraqi-Kurdistan: An empirical study by WADI - Association for Crisis Assistance and Development Co-operation, 2010

wadi http://www.stopfgmkurdistan.org/study_fgm_iraqi_kurdistan_en.pdf

⁶ UNICEF, "Preliminary Findings Report: Fourth Round of the Multiple Indicator Cluster Survey (MICS-4): Iraq -2011," page 31, 2011, http://www.childinfo.org/files/MICS4_Iraq_PreliminaryReport_Eng.pdf

- The majority of mothers surveyed had a critical attitude toward FGM, with 72.5% agreeing that FGM/C violates human rights.
- In general, only 14.0% of women surveyed believed that FGM/C was a religious requirement. This perception was slightly more common in rural areas (18.2%) than in urban areas (12.9%). However, among the 640 mothers who reported that their daughters underwent FGM/C, the majority (63%) believed FGM/C was a religious requirement.

Knowledge about FGM/C Health Risks

- Only 42.6% of mothers were aware of any health problems related to FGM/C.
- Awareness of FGM/C-related health problems varied significantly across governorates, with the highest awareness in Sulaymaniyah (61.6%), followed by Halabja (52.2%), Erbil (47.2%), and Dohuk (19.5%).

Awareness of Anti-FGM Campaigns

- Nearly two-thirds of respondents (63.0%) reported having heard an awareness campaign message citing the negative consequences of FGM/C. Of those, the vast majority (88.4%) were exposed to these campaigns through television, a trend that persists across all sub-groups.
- When it comes to the extent and medium of exposure to “stop-FGM/C” campaigns, Dohuk is a bit of an outlier compared to the other governorates. Just 34.4% of respondents in Dohuk report having heard “stop-FGM/C” messages, compared with 75.0% of respondents in each of the other three governorates. In addition, respondents in Dohuk are far less likely to have heard “stop-FGM/C” messages (56.1%) on TV than in the other governorates, where more than nine out of ten respondents cited TV as the source of these messages. On the other hand, respondents in Dohuk are much more likely to cite family (35.9%) and friends (40.6%) as sources of “stop-FGM/C” messages than in the other governorates, where 0.0% to 12.0% of respondents cite these two sources.
- A similar trend is seen in rural areas, where respondents are more likely to cite family and friends as sources of “stop-FGM/C” messages than in urban areas.

Law against FGM/C

- Just over 50% of respondents were aware that there was a law prohibiting FGM. The rate was much lower in Dohuk (19.7%) compared to each of the other three governorates (66.0%).
- The majority of mothers (67.5%) believed that greater awareness of and enforcement of the law would help reduce the practice of FGM/C.
- Mothers felt that the best way to strengthen the law was through information campaigns from the government using media (61.0%), better enforcement of the law (58.7%), increased vocal support from religious leaders (56.5%), education in schools (50.4%), and information campaigns by civil society organizations (47.3%).

Recommendations

- Increase Educational Campaigns. Equipping women with the correct information about the harms of FGM/C is essential to eradicate its practice. A comprehensive communication strategy should be developed using the findings of this study to address the specific gaps

in knowledge, dominant misconceptions, and underlying reasons that FGM/C is still practiced.

- Tailoring Awareness Campaigns. Educational campaigns need to specifically target the various groups and governorates where the prevalence of FGM/C is high, such as Erbil and Sulaymaniyah. Communication and awareness activities should be designed based on the needs, sensitivities, knowledge base, and capabilities of their target audiences, including gender, age group, educational status, and location.
- Effective Communication Channels. This study shows that mass media, specifically TV, is the most important source of information for FGM/C. Therefore, TV should be used as the central communication channel in a mass media campaign to disseminate information and messages about FGM/C. However, a comprehensive information campaign with a strong focus on TV, complemented by other communication channels such as radio, newspaper, internet, and social media, could be a powerful tool to further increase awareness and fill identified knowledge gaps.
- Increase Awareness about the Law Prohibiting FGM/C. This study found that only half of women were aware of the law prohibiting FGM/C, therefore it is important to increase awareness of the law through a public education campaign that includes messages denouncing FGM/C as an illegal practice and emphasizing the importance of reporting cases of FGM/C. Strongly promoting and enforcing the law against violence could help eradicate FGM/C. Concrete measures could include: (1) public prosecution of FGM/C cases to strengthen Law No.8 and emphasize the credibility of the law, and (2) training lawyers specifically to prosecute FGM/C cases to bring the perpetrators to justice.
- Engaging the Community to Eradicate FGM/C. This study found that a large percentage of respondents, particularly those that had their daughters cut, believed that FGM/C was a cultural tradition and/or a religious requirement. Therefore, religious figures are important partners in any government campaign to eliminate the practice of FGM/C. The Ministry of Religious Affairs also should be considered as a partner to reach religious leaders within the framework of law.

INTRODUCTION

Background

Many human rights actors, such as UNICEF and UN Women, as well as the KRG and the KRG's High Council of Women Affairs (HCWA) are working towards eradicating female genital mutilation and cutting (FGM/C) in the Kurdistan Region of Iraq (KR-I). Likewise, many international and local organizations working in the KR-I believe full eradication of this gross violation of women's and girls' rights must remain a priority.

The first published report of FGM/C in the region came from a 2004 study by the Association for Crisis Assistance and Development Co-operation (WADI),⁷ however it was not until 2009 that the Human Rights Report of the United Nations Assistance Mission for Iraq (UNAMI) included FGM/C as a serious human rights concern in the region.⁸ Over the past six years at least five separate studies of FGM/C have been conducted, including research by WADI and the Iraqi Women's association (PANA), the KRG Ministry of Health (MoH), and the High Council of Women Affairs (HCWA). Despite this, a lack of consensus regarding the prevalence of FGM/C persisted among government officials and the international, regional, and local communities, largely due to a lack of credible evidence.

A 2010 study by WADI reported an FGM/C prevalence rate of 73% in the KR-I, with some regions reporting a rate of more than 80%.⁹ A 2011 study, however, surveyed 5,000 women and girls and reported an FGM/C rate of 41%. More recently, the KRG General Directorate of Health published a report in 2013 based on a survey of 1,987 women and girls in the primary health care centers and the Maternity Teaching Hospital in Erbil city. Based on physical examinations, the researchers found an FGM/C prevalence rate of 58.5%; however the women self-reported a prevalence rate of 70.3%. .

Several of the previous studies also examined variations among rural and urban areas, as well as across governorates. The WADI survey reported an FGM/C prevalence of 78% among women of all ages in Sulaymaniyah and 63% in Erbil. The KRG Ministry of Human Rights (MoHR) conducted a study on FGM/C prevalence in the Chamchamal district in Sulaymaniyah, finding a prevalence rate of 41%.¹⁰ While there is some discrepancy in FGM/C prevalence rates between studies, findings do confirm that FGM/C is in fact widely practiced in the region. In 2010, the MoH surveyed women in Erbil and Sulaymaniyah, finding an overall prevalence rate of 41%.¹¹ Additional data collection is needed to resolve the discrepancies in the FGM/C prevalence rates cited in these studies.

In 2011, UNICEF and the KRG conducted the Multiple Indicator Cluster Survey round 4 (MICS-4)¹², which specifically included FGM/C as one of the indicators. This survey was more robust in terms of sampling methodology, as well as sample size and representativeness. Although the survey collected only very basic information on prevalence, the numbers were surprising: 54% of women aged 15 years

⁷ "Female Genital Mutilation in Iraqi-Kurdistan: An empirical study by WADI," 2010, WADI - Association for Crisis Assistance and Development Co-operation

wadihttp://www.stopfgmkurdistan.org/study_fgm_iraqi_kurdistan_en.pdf

⁸ United Nations Assistance Mission for Iraq (UNAMI) Human Rights Report 1 July – 31 December 2009, http://www.ohchr.org/Documents/Countries/IQ/UNAMI_Human_Rights_Report16_July_December_2009_EN.pdf

⁹ Female Genital Mutilation in Iraqi-Kurdistan: An empirical study by WADI - Association for Crisis Assistance and Development Co-operation, 2010

wadihttp://www.stopfgmkurdistan.org/study_fgm_iraqi_kurdistan_en.pdf

¹⁰ "They took me and told me nothing"-Female Genital Mutilation in Iraqi Kurdistan, June 2010, Human Rights Watch, <https://www.hrw.org/sites/default/files/reports/wrd0610webwcover.pdf>

¹¹ Iraqi Kurdistan: Law Banning FGM a Positive Step" 16 July 2011, Human Rights Watch, <http://www.hrw.org/news/2011/07/25/iraqi-kurdistan-law-banning-fgm-positive-step>

¹² UNICEF, "Preliminary Findings Report: Fourth Round of the Multiple Indicator Cluster Survey (MICS-4): Iraq - 2011," page 31, 2011, http://www.childinfo.org/files/MICS4_Iraq_PreliminaryReport_Eng.pdf

to 49 years suffered from FGM/C; while in Erbil the prevalence was 58%.¹³ The MICS-4 survey also showed a prevalence rate in Dohuk of only 1%, which contradicts earlier studies that placed the prevalence rate just under 10%.

MICS-4 also showed that women with no education were at a much higher risk of FGM/C than women with secondary or higher education. Women's approval of the continuation of the practice was highest among those with no formal education at 17%, while just 2% of those with secondary education or above approved. Approval of the practice was also more common among women who had suffered FGM/C themselves than among those who did not. Moreover, FGM/C was more prevalent among women in the second and poorest wealth quintiles than among those in the richest households. FGM/C prevalence was also higher among women aged 45-49 years than among younger women aged 15-19 years.

An October 2013 survey of 5,000 women and girls and found that, although 66% to 99% of women aged 25 and older were cut, the FGM/C rate among girls aged 6-10 years was 11% in Sulaymaniyah and nearly 0% in Garmiyan, suggesting a significant decrease in FGM in the region.¹⁴

Despite the discrepancies, this quantitative research provides important background evidence that the practice of FGM/C is widespread in the KR-I. However, additional information collected with rigorous methodology is needed to provide further insight to eradication campaigns.

To that end, in 2014, Heartland Alliance International (HAI) completed the first-ever Knowledge, Attitudes and Practices (KAP) survey in the greater Middle East and North Africa (MENA) Region that looks specifically at the prevalence and practice of FGM/C in the KR-I. The current study builds on this foundation to provide details of FGM/C practice that will help design programs to eradicate it in the region.

Awareness Raising Campaign to Eliminate FGM/C in the KR-I

Various campaigns have worked to increase awareness of FGM/C since it was first identified as a common practice in the KR-I. Efforts include awareness-raising and education campaigns geared specifically toward women and girls who have been cut or are most at risk of being cut. Government stakeholders as well as community and religious leaders have also been targeted to increase their knowledge of the health, psychological, social, and legal consequences of practicing FGM/C.

Most of these campaigns have been initiated by WADI and local Kurdish women's organizations. WADI mobile teams operate in remote villages in Kurdistan to provide rural women with counselling and health services. Through these interactions, WADI is able to facilitate discussions on FGM/C, thereby

¹³ UNICEF 2011, 31.

¹⁴ *Significant Decrease of Female Genital Mutilation (FGM) in Iraqi-Kurdistan, New Survey Data Shows,* 21 Oct. 2013, Wadi - WADI - Association for Crisis Assistance and Development Co-operation, <http://www.stopfgmkurdistan.org/html/english/updates/update018e.htm>

educating women on the harmful consequences of this practice.¹⁵ As a result, the FGM/C-Free Communities Program, in which village mayors sign a contract publicly declaring an end to the practice of FGM/C, has been initiated in at least seven villages.¹⁶ Education campaigns are disseminated through different media channels. For example, Radio “Denge Nwe”, a community-based radio station in Halabja, serves as a venue for women to share experiences and relevant news to raise awareness on the dangers of FGM/C.¹⁷ Advocacy work by religious leaders is also a central focus of the campaigns. For example, the Scientific Islamic Union expressed their support for eradicating FGM/C and works to educate the public that FGM/C practices have no religious backing in Islam.¹⁸

The fight to eliminate FGM/C took a major step forward in 2011 when the KRG banned FGM/C under the Law Against Domestic Violence Act,¹⁹ which is often referred to as the most advanced family violence law in the Middle East. Advocacy and awareness campaigns related to the law have almost certainly played an important role in advancing conversations about FGM/C and contributing to serious efforts to eliminate its practice. However, the results of this study indicate that awareness of the law desperately needs to be expanded. Part of the aim of this study is to provide baseline data that can be used to measure the impact of advocacy efforts to eliminate FGM/C in the KR-I going forward.

METHODOLOGY

The goal of this study was to survey a population of women about issues related to the prevalence and practice of FGM/C in order to better understand how to eradicate the practice. The research team conducted household surveys from April to December 2015 in the four governorates of Erbil, Sulaymaniyah, Halabja and Dohuk in Kurdistan Iraq.

The main objectives of the survey were to:

- Provide information on prevalence and geographic distribution of FGM/C among girls aged 4 to 14 years;
- Document current procedures and practices of FGM/C, sources of information about FGM/C in families and communities, and perceptions of FGM/C awareness campaigns and the law prohibiting FGM/C;
- Identify gaps in knowledge regarding health problems and other problems associated with FGM/C;
- Identify factors and/or people that contribute to the support and/or the opposition of FGM/C;

¹⁵ For further information, see ‘Mobile Women-Led Aid teams’, http://en.wadi-online.de/index.php?option=com_content&view=article&id=71&Itemid=19, accessed 12/04/2015.

¹⁶ For further information, see ‘FGM Free Communities Programme: http://en.wadi-online.de/index.php?option=com_content&view=article&id=1060&Itemid=16, accessed 12/04/2015.

¹⁷ See Radio “Dange New” – a Community Radio: http://en.wadi-online.de/index.php?option=com_content&view=article&id=24&Itemid=25, accessed 12/04/2015

¹⁸ See: “Discussing FGM at the Scientific Islamic Union”, accessed 12/04/2015.

¹⁹ Act No. 8: The Act of Combating Violence in the Kurdistan Region of Iraq http://www.ekrg.org/files/pdf/combat_domestic_violence_english.pdf

- Inform a comprehensive intervention strategy to combat FGM/C in the KR-I and provide a credible, evidence-based benchmark to measure reduction of FGM/C.

Target Population and Sampling

This survey sought to provide information about FGM/C for girls in the age group of 4 to 14 years in the four governorates of Erbil, Sulaymaniyah, Dohuk and Halabja.²⁰ There are two main standardized and internationally accepted methods for assessing FGM/C prevalence: 1) capture FGM/C rates by self-reports from women of reproductive age, usually 15 through 49 years, on whether they have undergone FGM/C, or 2) ask mothers about the FGM/C state of all their daughters, usually aged 4 through 14 years. There are several reasons why this study selected the latter method. First, this method provides more up-to-date information on current FGM/C practices because FGM/C is typically practiced upon girls 14 and younger. Data captured from mothers about the FGM/C of their daughters also appear to be more reliable than self-reports of women about their own FGM/C status due to the time passed since they underwent FGM/C.²¹ Daughters were not surveyed directly due to ethical, emotional, developmental, and cognitive concerns related to interviewing underage recipients of FGM/C. While the main focus of this survey was to assess the FGM/C state of daughters of ages 4 through 14 years, the FGM/C state of the mothers themselves was also investigated. This approach made it possible to identify trends of FGM/C across generations as well as to investigate progress toward FGM/C eradication.

A multi-stage cluster sampling methodology was applied to randomly selected representatives of the target populations in Erbil, Sulaymaniyah, Dohuk, and Halabja governorates. A household survey approach was used in interviewing women, and the final total sample size was n=5,990.²²

Female surveyors trained by the research team visited each household, identified the women in the household, and determined their eligibility for inclusion in the study using a standardized procedure. The questionnaire covered topics related to demographic composition, FGM/C prevalence, attitudes towards FGM/C including why it was or was not practiced within the family, and attitudes and myths related to FGM/C. The survey also gauged awareness of the law prohibiting FGM/C and exposure to messages from campaigns seeking to eradicate the practice. Respondents were also asked their opinions about how these messages and the law could best be supported within their communities.

Data were analyzed using STATA/IC 14.1 software to establish a baseline prevalence of FGM/C among girls aged 4 through 14 years, as well as among their mothers. Statistical methods used to analyze the data were mostly descriptive (i.e. measures of central tendency and dispersion); however some

²⁰ In the course of planning this survey, Halabja, formerly part of Sulaymaniyah, became a separate governorate and was therefore targeted as a separate unit within Sulaymaniyah.

²¹ United Nations Children's Fund (UNICEF) (2013). *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*. New York: UNICEF.

²² 240 individuals refused to participate in the survey, citing that they were busy, were very shy, had a fear of technology, were missing permission from their husband, did not know enough about FGM, or were unwilling to talk about it.

inferential statistics (i.e., measures of association) were also applied. Data analyses were conducted across the entire sample, as well as across sub-groups broken out by governorates, urban/rural locations, income groups, and levels of education.

Ethical Issues

Given the sensitive nature of the data collected through this study, the field team maintained strict adherence to ethical research standards. Surveys were confidential and anonymous to ensure participant protection. Procedures to ensure strict anonymity included the use of codes rather than names for identifying interviews, and requiring all persons related to the research to agree to strict confidentiality rules and practices. The data were gathered based on the voluntary participation of the respondents. The data collection process, including the survey proposal and the questionnaire, underwent a stringent ethical review to ensure that the study complied with academic ethical research standards. Professor Victoria Fontan, Director, Center for Peace and Human Security and Interim Chair of the Department of Politics and Public Policy at American University Dohuk Kurdistan, conducted the ethical review process on behalf of the Institutional Review Board of American University Dohuk Kurdistan.

Limitations of the Study

Despite careful preparation for every stage of the survey, such as the development of the standardized questionnaire, pre-testing in the field, adaptations, and rigorous training of supervisors and surveyors, methodological biases are inevitable in behavioral research studies based on self-reports from respondents. These include (1) social desirability bias, or the tendency to respond to questions in a socially acceptable direction regardless of actual attitudes or true behavior; (2) cognitive dissonance, or the difference between an opinion and attitude a person expresses and the related behavior; (3) the interviewer effect, in which respondents alter responses toward what they think the interviewer/surveyor favors based on subtle hints; and (4) the acquiescence effect, or the tendency to agree with any statement regardless of its content. These effects were mitigated as far as possible through precautions including intensive surveyor training and careful construction and order of questions. Nonetheless, biases cannot be completely avoided, and therefore must be carefully considered when analyzing and interpreting survey results.

Given these issues, there is a risk that the prevalence rates of FGM/C were underreported in this study. The respondents were aware that the surveyors worked for an international organization which works to promote women's rights', which may have exacerbated the biases described above. Furthermore, respondents may have feared the legal consequences of admitting their daughters underwent FGM/C due to the Law No. 8, which includes a section prohibiting FGM/C.

Electronic tablets were used for data collection in an effort to reduce data collection errors, however, this technology may have raised concerns and fear among some respondents. Finally, another limitation that could potentially impact prevalence rates is that the study represents a single snap shot in time. In other words, the prevalence rates for this survey sample may increase over time as the girls grow older.

RESULTS

Sample Demographics

Questionnaires were administered to a sample of 5,990 mothers in the following governorates: Dohuk (33.4%), Erbil (33.3%), Sulaymaniyah (31.8%) and Halabja (1.5%). Representative of the population distribution in each governorate, 61.1% of questionnaires were collected from urban regions and 38.9% from rural regions. Respondents had an average of 1.8 daughters, with almost 50% of the sample having just one daughter and over 98% of the sample having 4 or fewer daughters.

The figures below show a selection of demographic characteristics of the sample of respondents.

Figure 1. Education Level, Income, and Marital Status of Respondents (N = 5,990)

Age	15-24 years (4.6%)	25-34 years (43.5%)	35-44 years 46.9%	50+ years 4.9%
Education Level	None (48.2%)	Primary (28.7%)	Secondary (14.2%)	Post-Secondary (9%)
Income	Lowest Income (22.7%)	Second Lowest Income (49.8%)	Second Highest Income (2.0%)	Highest Income (25.6%)
Marital Status	Married (96.0%)	Divorced (0.85%)	Widowed (3.1%)	Single (0.07%)

Figure 2. Ethnic Background and Religious Affiliation of Respondents (N = 5,990)

Ethnicity	Kurd (96.5%)	Arab (1.5%)	Turkmen (1.0%)	Assyrian (0.5%)	Other (0.53%)
Religion	Sunni (96.4%)	Shi'i (0.8%)	Christian (1.2%)	Yezedi (1.2%)	Other (0.34%)

Of the 5,990 mothers surveyed, the majority (82.3%) were between the ages of 25 and 44.

The vast majority of respondents (96.5%) reported their ethnicity as Kurdish. Of the Kurdish respondents, 97% reported their religion as Islam-Sunni. In the sample overall, 96.4% reported Islam-Sunni. Although the non-Sunni respondents were few, they were spread across all ethnic groups, and the majority of non-Sunni respondents (75%) lived in Dohuk.

The proportions of the respondents across education levels reported in Figure 1 are similar across the governorates of Dohuk and Erbil. However, in Halabja and Sulaymaniyah respondents were slightly less likely to have no formal education (32.3% and 43.5% respectively) than to have a primary (40% and 31.4% respectively) and secondary education (17.8% and 19.5% respectively).

The number of people without education was much higher in the rural areas (62.8%) as compared with urban areas (38.8%). Likewise respondents in urban areas were slightly more likely to have a post-secondary education (9%) than in rural areas (3.5%).

The study defined a wealth index similar to the index from the Multiple Indicator Cluster Survey to categorize economic status (UN, 2011). Four categories were defined based on whether the household possessed a radio, bicycle and/or wrist watch, as follows:

- The household had no radio and no bicycle (22.7%);
- The household had either a radio or a bicycle (49.8%);
- The household had both a radio and a bicycle (2.0%); or
- The household had a radio and a bicycle and a wristwatch (25.6%).

Prevalence of FGM

An intergenerational Comparison among Mothers and Daughters

Overall, 10.7% of the 5,990 of mothers surveyed reported that their daughters underwent FGM/C, and 44.8% reported undergoing FGM/C themselves. This indicates a dramatic decrease in the prevalence rate of FGM/C over a single generation.

Mothers reported undergoing FGM/C at a mean age of 5.6 years, compared with the mean age of 4.7 years for their daughters. Since some mothers had daughters under the age of 4.7 it could be expected that the prevalence rate among daughters might rise within this sample over time. To estimate the potential increase we can consider that 4.3% of mothers reported that they intend to cut their daughters in the future and an additional 5.3% reported being unsure if they intend to cut their daughters in the future. These percentages are similar across the four governorates. If we believe that only those who reported that they intend to cut their daughters eventually do, the prevalence rate of FGM/C among daughters in this sample will increase from 10.7% to 15.0%. If those who reported being unsure also cut their daughters in the future the rate of FGM/C among daughters in this sample could almost double to 20.0%. While this would be an extremely substantial increase in the FGM/C prevalence rate among daughters, it would still indicate a strong decline in the practice of FGM/C from the mother's generation to the daughter's generation.

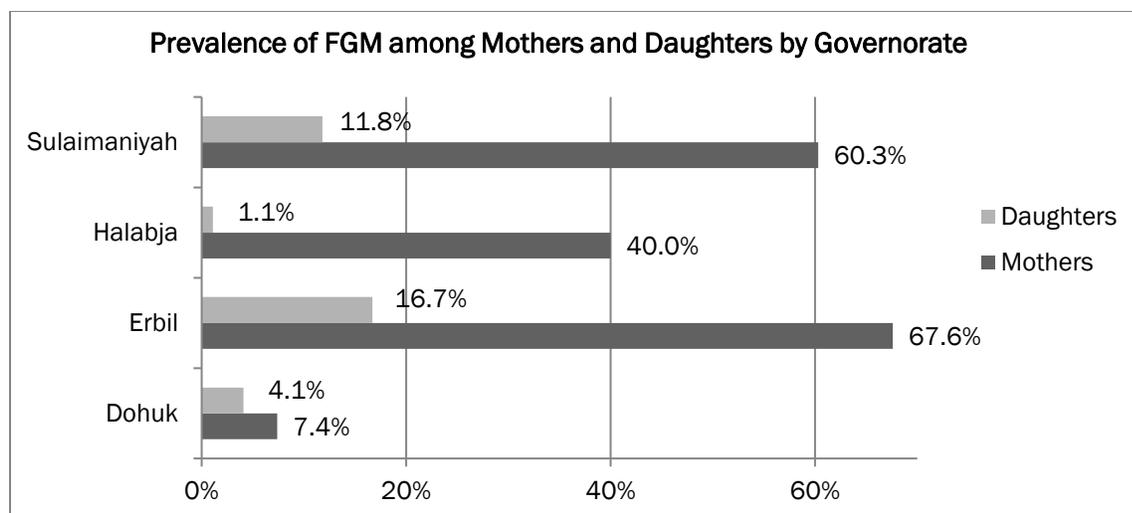
It is important to also note that the 10.7% FGM/C rate among daughters documented in this study is much lower than rates found in previous studies among older generations. These studies have reported the overall prevalence of FGM/C ranging from 41%²³ to 73%²⁴ of the female population in the KR-I, with the KAP-study (HAI/UNICEF, 2014) finding an FGM/C prevalence of 58.5% in an older age group of female respondents.

FGM/C rates vary substantially across sub-groups of the sample. Figure 3 shows the prevalence rates by governorate.

Figure 3. Prevalence of FGM among Mothers and Daughters by Governorate

²³ *Iraqi Kurdistan: Law Banning FGM a Positive Step* 16 July 2011, Human Rights Watch, <http://www.hrw.org/news/2011/07/25/iraqi-kurdistan-law-banning-fgm-positive-step>

²⁴ *Female Genital Mutilation in Iraqi-Kurdistan: An Empirical Study*
http://www.stopfgmkurdistan.org/study_fgm_iraqi_kurdistan_en.pdf



Overall, Erbil had the highest prevalence of FGM/C among both mothers and daughters, followed by Sulaimaniyah. Dohuk had a much lower prevalence rate for mothers and daughters, while in Halabja only one case of a daughter undergoing FGM/C was reported even though 40% of mothers were cut.

Figure 4 shows the number of daughters that each respondent reported undergoing FGM/C by governorate. The raw number of cases is reported in parentheses, which provides context for the number of cases reported by governorate.

Figure 4. Percent of Sample by Number of Daughters Undergoing FGM/C*

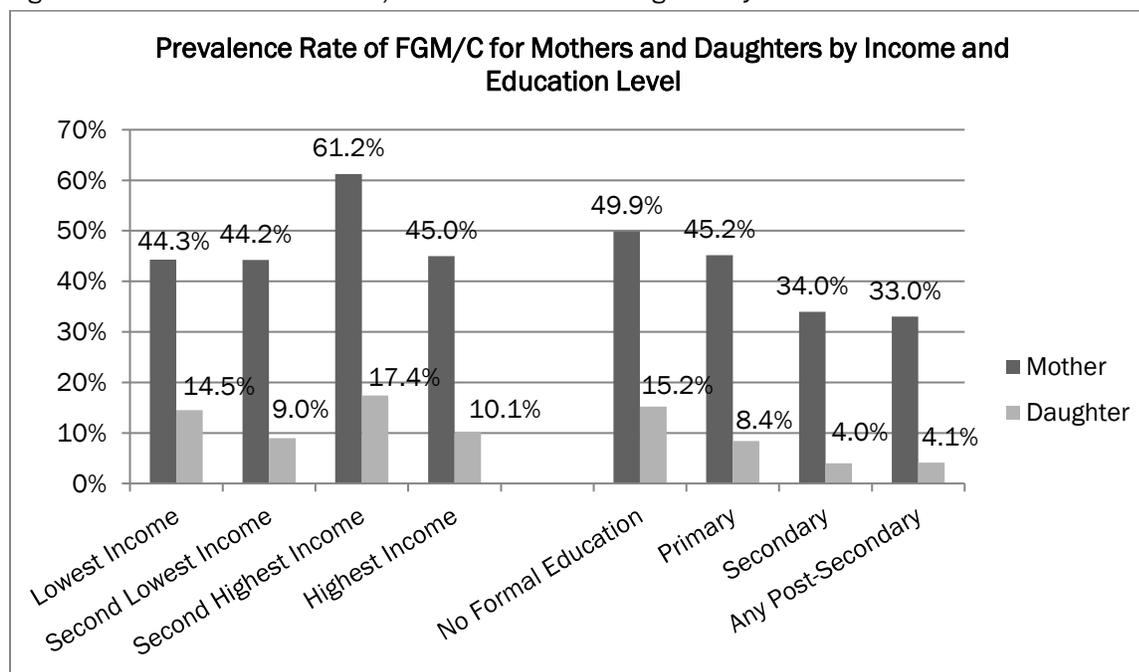
	No Daughters FGM/C	1 Daughter FGM/C	2 Daughters FGM/C	3 Daughters FGM/C	4 or 5 Daughters FGM/C
Total Sample (N = 640)	89.3% (5,350)	5.7% (343)	3.4% (205)	1.1% (64)	0.5% (28)
Dohuk (N = 225)	95.6% (1,919)	1.1% (21)	2.0% (39)	0.7% (14)	0.35% (7)
Erbil (N = 333)	83.3% (1,662)	9.5% (189)	5.0% (100)	1.5% (29)	0.8% (15)
Sulaymaniyah (N = 81)	88.2% (1,680)	6.9% (1,680)	3.5% (1,680)	1.1% (1,680)	0.3% (1,680)
Halabja (N = 1)	98.9% (89)	1.1% (1)	0.0% (0)	0.0% (0)	0.0% (0)

*Raw number in parentheses

FGM/C was more prevalent for both mothers and daughters in rural areas, where 16.1% of mothers reported that their daughters had been cut and 50.8% reported that they themselves were cut. This is compared to 7.2% of daughters and 40.9% of mothers self-reporting FGM/C in urban areas.

Figure 5 illustrates how FGM/C prevalence rates also vary by the approximate income and education level of the mothers.

Figure 5. Prevalence Rate of FGM/C for Mothers and Daughters by Income and Education Level



Prevalence rates of FGM/C have a linear and inverse relationship to the mothers' education levels. That is, as the level of education of the mother goes up the likelihood of being cut goes down among both daughters and mothers. The highest rates of FGM/C are among mothers that have no formal education (49.9% of mothers and 15.2% of daughters) and lowest among mothers that have at least some post-secondary education (33% of mothers and 4.1% of daughters).

Income, on the other hand, does not exhibit a linear relationship to FGM/C prevalence rates.²⁵ Rather, mothers and daughters in the second highest income group have the highest rates of FGM/C; however the trend begins to vary for mothers and daughters in other income groups. The next highest rate of FGM/C among daughters is found among the lowest income group, followed by the highest income group and then finally the second lowest income group. For mothers, the other three income groups have very similar prevalence rates between 44%-45%.

Prevalence in Other Female Family Members

When asked if any female family member was cut, 50.3% of respondents said yes, with a higher FGM/C rate reported in rural areas (55%) compared to urban areas (47.3%). By governorate, the reported rate of FGM/C of any female family member was highest in Erbil (72.1%), followed by Sulaymaniyah

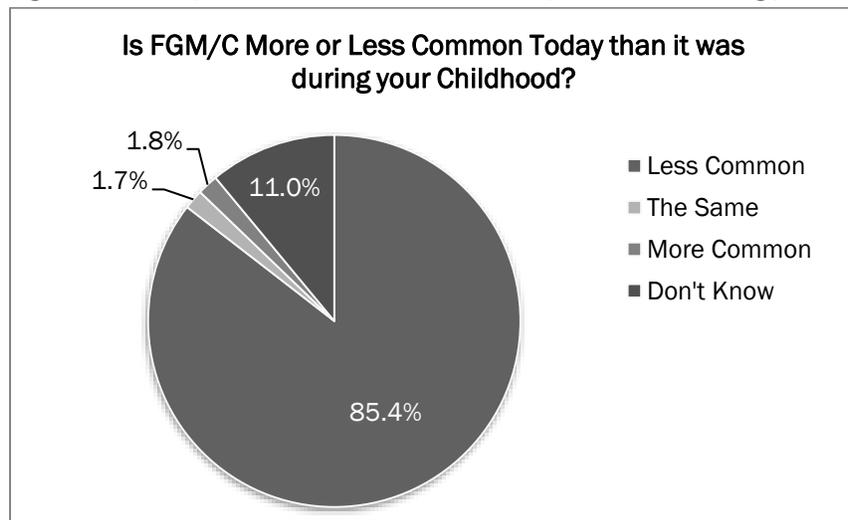
²⁵ Data analysis found a low correlation (0.119) between proxy indicators for income and education level. Based on the literature a higher correlation between these variables was expected, therefore income indicators should be interpreted with caution.

(67.8%), Halabja (48.9%), and Dohuk (12.1%). Of the total sample, 53.2% reported that either a mother or aunt was cut, while 44.3% reported that a sister or cousin was cut. These rates confirm the decline of FGM/C rates over time since the rate was highest with the respondents' mothers and/or aunts (53.2%) and similar among the mothers' peers (sisters and/or cousins) at 44.8% and 44.3% respectively.

Perceived Trends of FGM/C

The vast majority of women, 85.4%, felt that FGM/C has become less common in KR-I since their own childhood. Figure 6 shows respondents' attitudes about how the practice of FGM/C has changed over time.

Figure 6. Is FGM/C More or Less Common Today than it was during your Childhood?



This trend was perceived more or less similarly across governorates, with some slight differences. In Sulaymaniyah, Erbil, and Halabja, 96.7%, 92.4%, and 88.9% respectively, perceived the practice of FGM/C as declining. In Dohuk 67.6% thought FGM/C was declining, and more than a quarter, 25.3%, said that they didn't know. This result may be connected to the generally lower FGM/C rate in Dohuk, and consequently lower awareness about its practice. The percent of respondents believing that FGM/C was in decline was also similar across rural (87.4%) and urban (84.2%) areas.

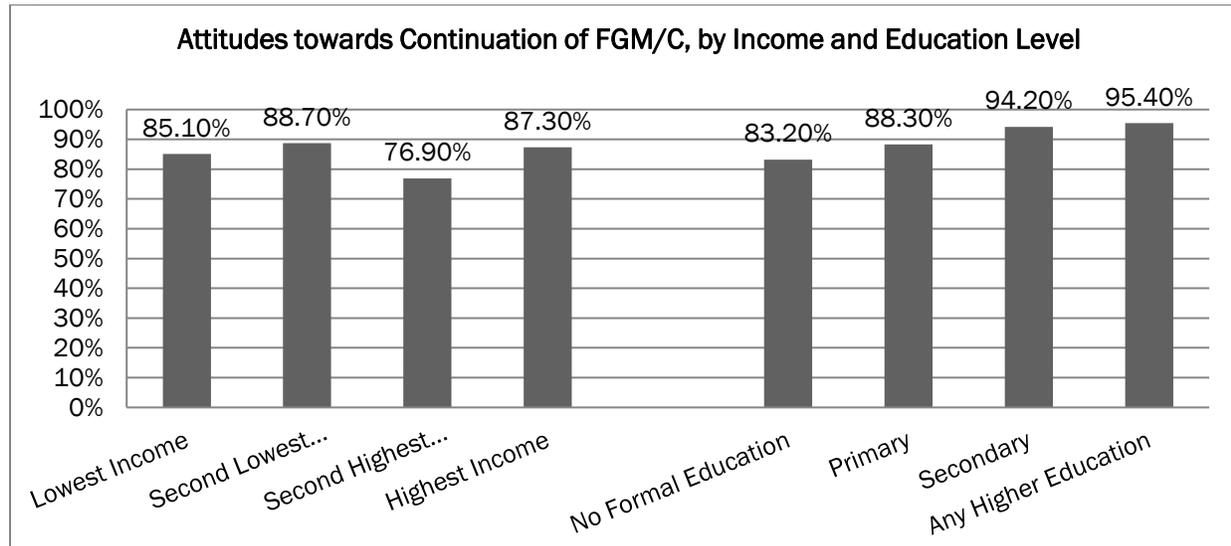
Attitudes toward FGM/C

When asked whether the practice of FGM/C should continue, the majority of women (87.3%) wanted the practice of FGM/C to stop. Across the four governorates, the percentage of respondents believing that FGM/C should end ranges from 94.4% in Halabja to 84.8% in Erbil. Similar differences in attitude are seen between those who believe FGM/C should end in rural (83%) and urban (90.1%) areas.

There were slightly more substantial differences in attitudes towards FGM/C among women across income groups and levels of education. Among women with different levels of education, those with at

least some formal education were much more likely to say that the practice of FGM/C should end. Attitudes across income groups mirror the actual prevalence of FGM/C across the income groups. In other words, the percentage of mothers who feel that the practice of FGM/C should end within a given income group corresponds to the percentage of mothers who did not force their daughters to undergo FGM/C. Figure 7 provides further details regarding these differences.

Figure 7. Attitudes towards Continuation of FGM/C, by Income and Education Level



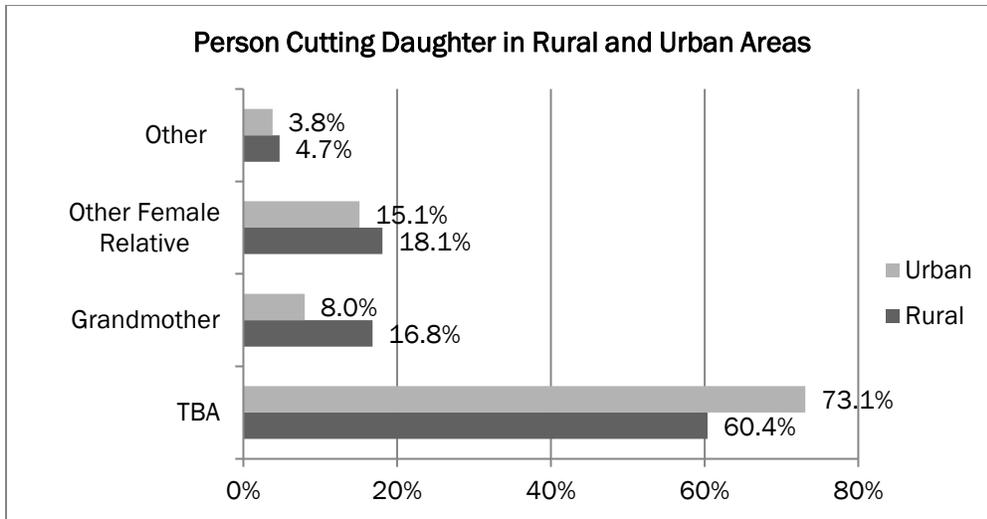
Characteristics of FGM/C

In order to understand why FGM/C occurs, respondents were asked about their motivations for having their daughters cut, as well as the practical aspects of the cutting such as where it is done, by whom, and with what.

How is FGM/C Carried Out?

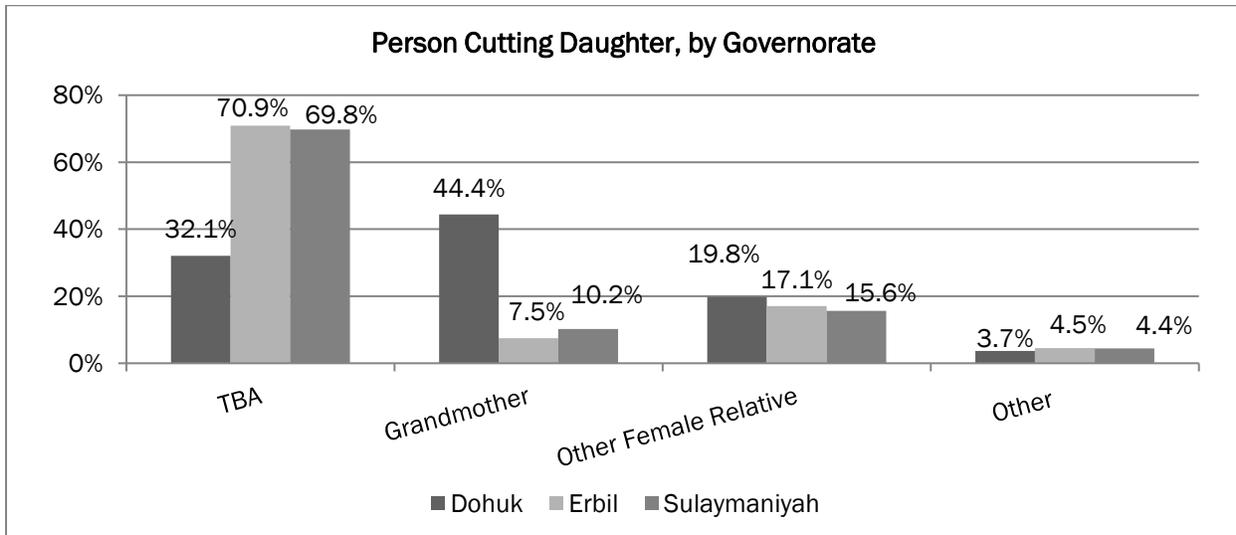
Of the 640 cases of mothers reporting that their daughter has undergone FGM/C, traditional birth attendants (TBAs) conducted 65.5% of the cuttings, grandmothers conducted 13.1% of cuttings, and other female relatives conducted 16.9% of cuttings. These percentages vary considerably across regions. Figure 8 shows the differences in who does the cutting by rural and urban areas. Grandmothers and other female relatives performed the FGM/C at higher levels in rural areas. TBAs, on the other hand, were more likely to conduct FGM/C in urban (73.1%) than rural (60.4%) areas.

Figure 8. Person Cutting Daughter in Urban and Rural Areas



Across the governorates, there are large differences in who is most likely to conduct FGM. Since just one case was reported in Halabja, it is not included in the comparison. Across all three of the other governorates, TBAs, grandmothers, and other female relatives were the main people to carry out FGM/C. Figure 9 below shows the way in which the rates of who conducts the cutting vary by governorate. Mothers, other male relatives, health staff, and self-reported “other” are included in the category “Other”.

Figure 9. Person Cutting Daughter by Governorate



In Dohuk, grandmothers (44.4%) were more likely to conduct FGM/C than in Erbil (7.5%) or Sulaymaniyah (10.2%). On the other hand, TBAs are much more likely to conduct FGM/C in Erbil (70.9%) and Sulaymaniyah (69.8%) as compared to Dohuk (32.1%).

In terms of the tools used to carry out FGM/C, 90% of cuttings were performed with razor blades. Scalpel had the next highest percentage (5.5%), followed by scissors (2.8%), “other” (1.3%), and knife (0.5%). Similar patterns hold up across the governorates and urban/rural location.

Daughters were most likely to be cut (75.6%) in their homes, while 21.9% underwent FGM/C at the house of a relative or the person conducting the cutting, and just 1.1% took place in a health facility. Nine cases (1.4%) reported other locations. Based on the qualitative information within the survey, it appears that in one case FGM/C was conducted in a ditch and in another case in the woods.

Health Problems Related to FGM/C

Health Problems of Daughters

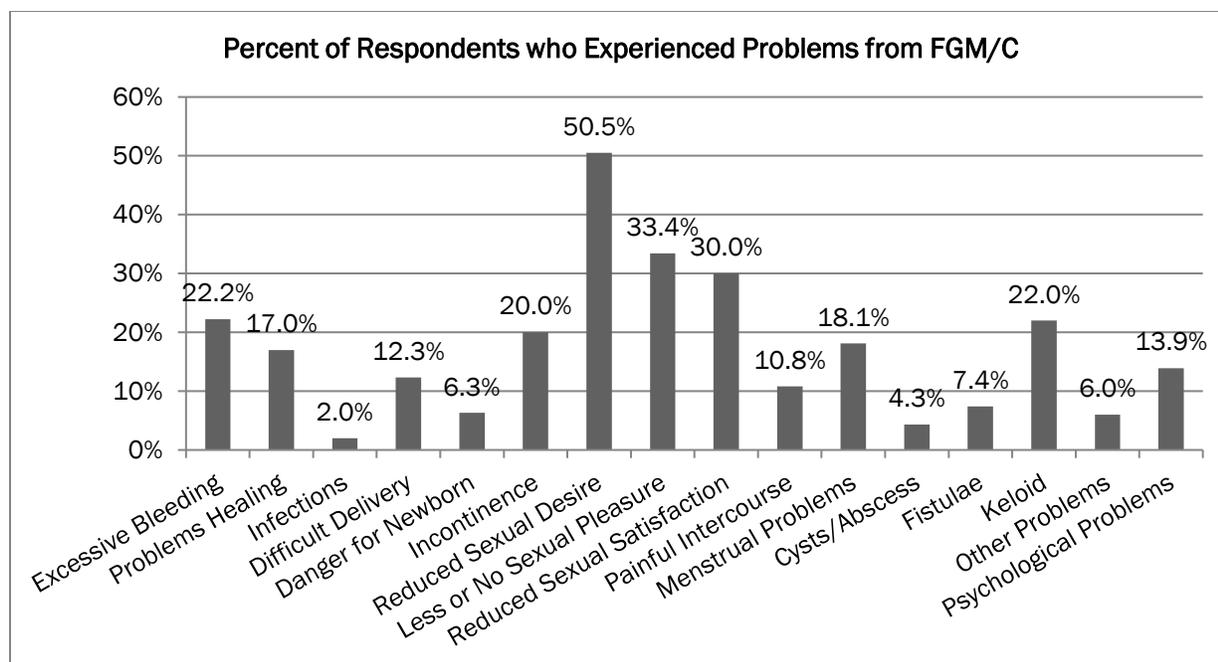
Of the 640 mothers who reported their daughters were cut, 5.8% reported that their daughters experienced health problems related to FGM/C. An additional 5.3% said that they could not remember if their daughters experienced complications. The most frequent complications reported were excessive bleeding, difficulties with wounds healing, urination difficulties, keloids, and psychological problems, however no one single complication was reported by more than 2.0% of the 640 cases.

The overall reporting of complications is low compared to the complication rates mothers reported related to their own FGM/C (see below). It is also low when compared to complication rates reported in previous studies of older FGM/C populations. Indeed, the complication rate for daughters in this study was likely underreported due to several factors, such as the mothers’ lack of awareness of their daughters’ complications, mothers’ unwillingness to admit to the surveyors that their daughters experienced complications, and because longer term health complications (i.e. issues related to sexual health, menstruation, pregnancy/birth, etc.) have not yet manifested due to daughters’ young ages. Mothers did seek medical help in 23 of the 37 of cases (62.2%) where daughters suffered complications. Unavailability of female doctors in local health facilities, the help being too expensive, and being afraid of violating the law were the three reasons most often given in the 14 cases where mothers reported not seeking medical assistance.

Health Problems of Mothers

Among the 2,680 mothers who reported undergoing FGM/C themselves, 20.7% reported health and psychological problems as a result, with an additional 11% saying that they did not remember. Figure 10 displays detailed information regarding the type of complication faced for the 554 respondents who reported experiencing complications.

Figure 10. Percent of Respondents who Experienced Problems from FGM/C



The vast majority of women reported sexual health problems, including reduced sexual desire (50.5%), less or no sexual pleasure (33.4%), and reduced sexual satisfaction (30.0%). Other medical problems reported were excessive bleeding (22.2%), keloids (22.0%), difficulty urinating (20.0%), menstrual problems (18.1%), and failure to heal (17.0%). Psychological problems were reported by 13.8% of those reporting complications, with fear reported most often, and depression and problems trusting other people reported less often.

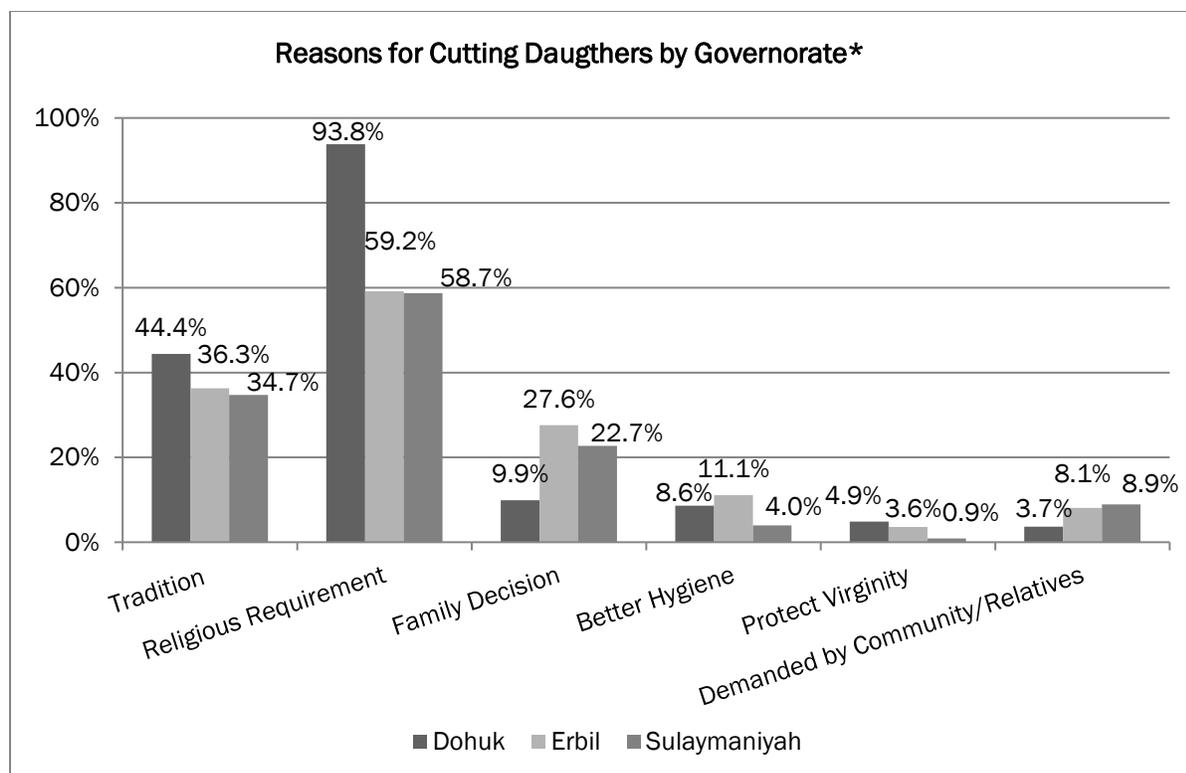
Motivations for FGM/C Decision-Making

Mothers' Reasons for FGM/C of Daughters

The 640 mothers who responded that their daughters were subjected to FGM/C were also asked an open-ended question about why they chose FGM/C. The vast majority said it was a religious requirement (63.3%) or that it was their tradition (61.7%). The next most common reason given was that it was a family decision (23.6%), and very few cite health-related reasons or other conceptions such as protecting their daughter's virginity (3.5%), increasing their chances of marriage (2.5%), better hygiene (8.3%), or community demands (7.9%).

Over 65% of the respondents in rural areas believe that FGM/C is a religious requirement, whereas the majority of urban respondents (almost 64%) say that the practice of FGM/C continues because it is part of their tradition. The motivations behind FGM/C varied substantial across governorates, as indicated in Figure 11 below. Halabja is not included in the graph because only one respondent reported that their daughter underwent FGM in that governorate.

Figure 11. Reasons for Cutting Daughters by Governorate*



* Other reasons given include Increase Chance of Marriage, Male's Sexual Pleasure, Ensure Faithfulness, Cannot Say, and Other. No category had more than 3% of respondents.

Religion is by far the largest influencer for FGM/C in Dohuk, with 93.8% of mothers who had their daughters cut citing it, although it is still strong in the other two governorates, with almost 60% of respondents who had their daughters cut also reporting it is a religious requirement. Pressure from the family was less relevant in Dohuk (9.9%) compared to nearly a quarter of cases reported in the other two governorates.

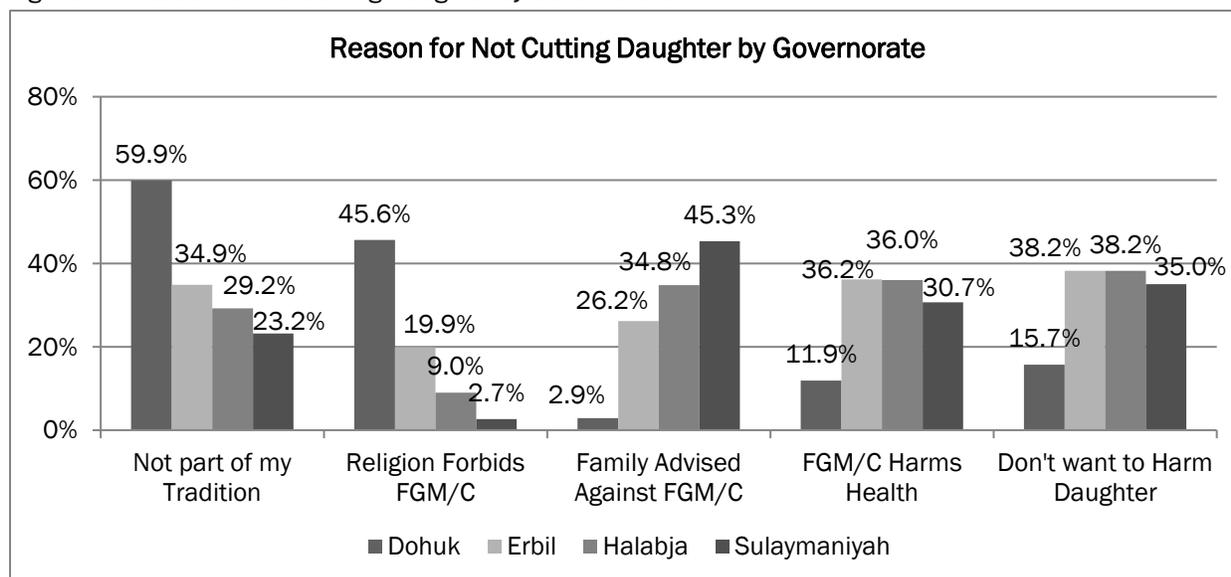
Mothers' Reasons for non-FGM/C of Daughters

Of the 3,550 mothers who decided not to force their daughters to undergo FGM/C, just over 40% said that they made this decision because FGM/C is not part of their tradition, and 23.5% said that their religion actually prohibits the practice. These responses are interesting given that the two reasons most cited for abstaining from FGM/C are the same as the top reasons cited for having daughters undergo FGM/C. Other reasons for abstaining from FG/C include a desire to avoid harming their daughter (29.1%), the belief that FGM/C resulted in harmful health outcomes (25.8%), and being advised not to cut their daughters by their families (24%). A small number of respondents reported deciding not to cut their daughter because their daughter was too young, they received advice from religious leaders, they received advice from health workers, and a self-reported "other."

These reasons did not differ significantly across rural and urban areas, but there are substantial differences across the four governorates (Figure 12). Interestingly, in Dohuk, religion and tradition were the two top reasons that respondents gave to justify cutting their daughters; however of those

Dohuk residents who did not cut their daughters, they are also the top justifications. In Erbil and Halabja, not wanting to harm their daughters were the top reasons reported for not cutting daughters, while in Sulaymaniyah advice from the family was the most frequently cited reason for not conducting FGM/C.

Figure 12. Reason for not Cutting Daughter by Governorate



The correlation between mothers and daughters both undergoing FGM/C is moderate ($r=.355$). Figure 13 below shows the likelihood of a daughter being cut if her mother is also cut. Of the 640 mothers who report that their daughters were cut, 95.8% of the mothers themselves were also cut.

Figure 13. Cross-tabulation of Mothers and Daughters Undergoing FGM/C

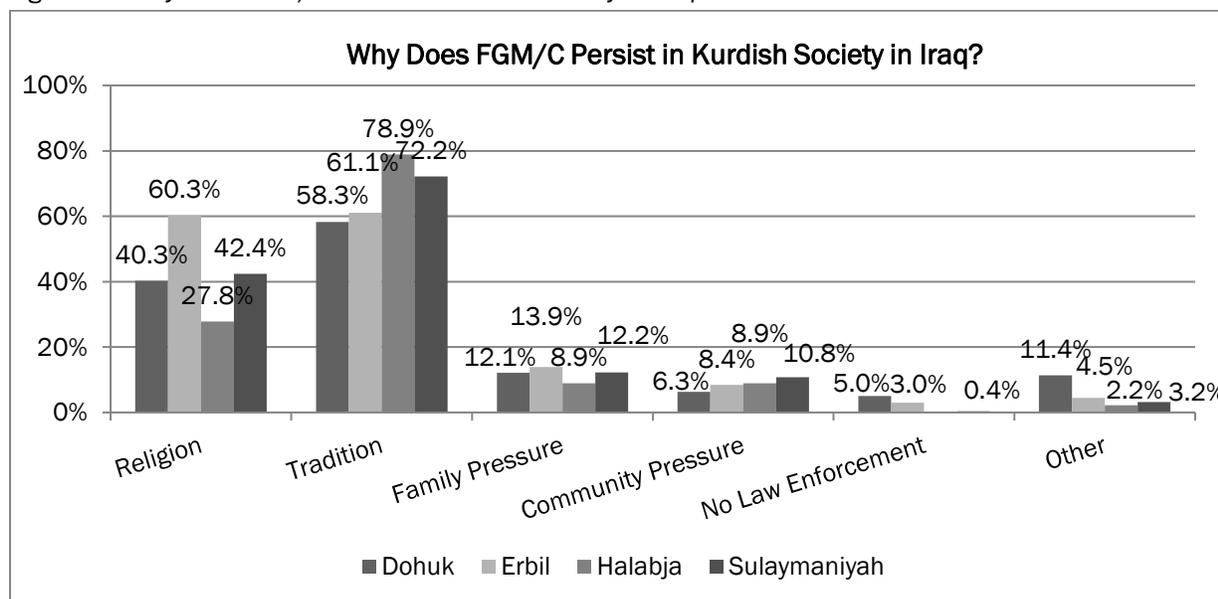
	Mother Underwent FGM/C	Mother Did Not Undergo FGM/C
Daughter Underwent FGM/C	22.9% (613)	0.8% (27)
Daughter Did Not Undergo FGM/C	77.1% (2,067)	99.2% (3,280)

Mothers' Perceptions of Causes of FGM/C

The data reported above explains why mothers say they did not cut their own daughters. However, the respondents were also asked their opinion, more generally, as to why the practice of FGM/C still exists in Kurdish society. By and large the two most given reasons were that FGM/C is part of tradition (63.9%) or that it was related to religious beliefs (47.4%). Some respondents also cited family pressure (12.7%), community pressure (8.5%), and a lack of law enforcement (2.8%).

These percentages remain constant across both rural and urban locations but do fluctuate across governorates. Figure 14 shows the differences in respondents' opinions as to why the practice of FGM/C still exists in Kurdish society.

Figure 14. Why Does FGM/C Persist in Kurdish Society in Iraq?



Education also seems to influence the mothers' perception of causes for the continuing practice of FGM/C. Fifty-six percent of mothers with no formal education cited religion as the primary cause, while only 31.9% of mothers with Bachelor degrees said the same. Conversely, as education level increases mothers are more likely to cite tradition as a reason for the continuing practice, with 62.8% of those with no formal education and 70.6% of those with post-secondary education.

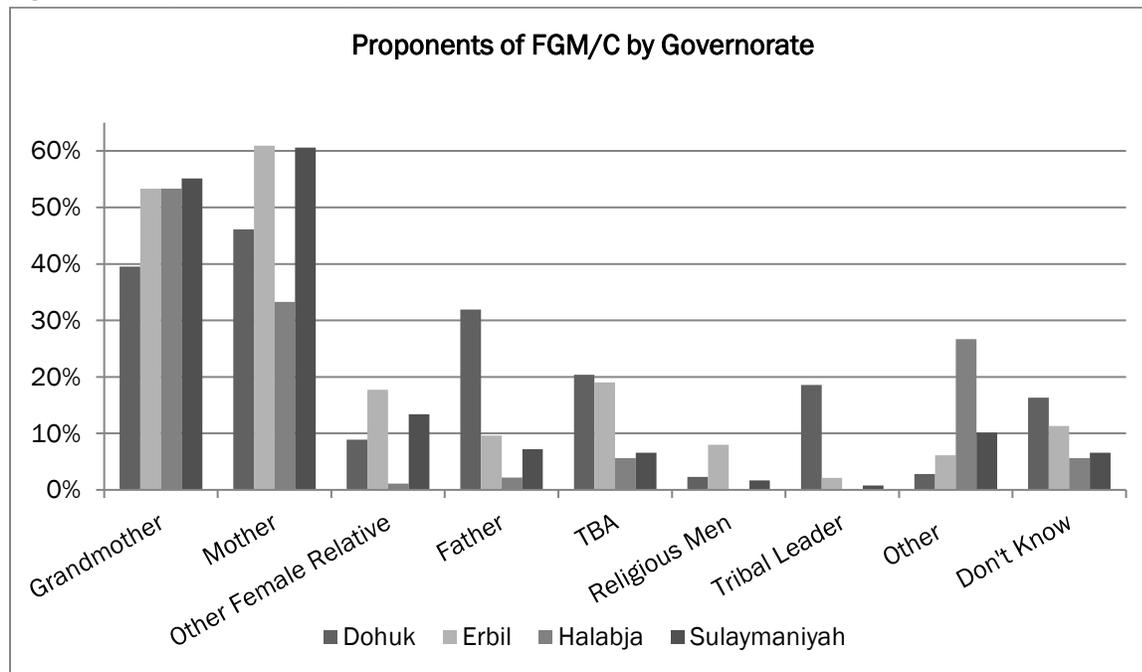
Perpetuators of the Practice of FGM/C

Proponents of Maintaining the Practice of FGM/C

Respondents were asked who the main proponents of continuing FGM/C were. Overall, close female family members were most often seen as the main supporters of FGM/C. Over half (55.4%) of the respondents named their own mothers as the main proponents of FGM/C, while 49.3% mentioned grandmothers. Fathers were cited much less often (16.2%), similar to TBAs (14.5%), and female relatives such as aunts (13.1%). Each of the other categories – which included nurses, religious men, tribal leaders, community leaders, and other/don't know – were cited by 7.0% or fewer of the respondents.

This trend generally holds up across both urban and rural areas, where close female relatives are seen as the main supporters of FGM/C in the community. TBAs are seen as more active supporters of the practice in rural (20%) as opposed to urban (12.3%) areas. Differences across governorates are slightly more pronounced. Figure 15 shows which actors are seen as the main supporters of FGM/C within each of the four governorates.

Figure 15. Proponents of FGM/C by Governorate



In Dohuk, the respondents' mothers were perceived as the main supporter of FGM/C (46.1%), followed closely by their grandmother (39.5%). This pattern is also true for Erbil (60.9% and 53.3% respectively) and Sulaymaniyah (60.6% and 55.1% respectively). In Halabja, however, respondents were more likely to identify their grandmothers (53.3%) as opposed to their mothers (33.3%), indicating the declining nature of the practice over generations. In Dohuk, 31.9% of respondents cited their fathers, which is a much larger percentage than other governorates (the next closest is 9.6% in Erbil). Similarly, tribal leaders in Dohuk were reported as FGM/C supporters by 18.6% of women compared with just 2.1% in Erbil, 0.8% in Sulaymaniyah and none in Halabja.

Higher levels of education are correlated with a lower likelihood of indicating their mother or grandmother as a main supporter; however this category still hovers around 50.0%. Education also has a negative correlation with the belief that fathers were main supporters. Those with post-secondary education were slightly more likely to indicate tribal leaders (10.9%) and other female relatives (18.3%) than those with no formal education (6.6% and 12.5% respectively).

Influencers of FGM/C in Practice

The mothers were asked who tried to convince them to cut their daughters, regardless of whether they were finally cut or not. Almost three-quarter of mothers (72.4%) stated that they were not encouraged by anyone. The most frequently mentioned encouragers were mothers-in-law (10.2%), the respondents' own mothers (7.9%), and grandmothers (7.6%). Male family members were also named, but much less often, with only 2.9% citing husbands and 2.5% naming their own fathers. These results indicate that female family members are significantly more influential in a mother's decision to cut her daughter. There were no substantial differences among the governorates.

This pattern also holds up when we look just at the 640 cases where mothers report their daughters ultimately were forced to undergo FGM/C. Figure 16 shows the main people to influence a family's decision to cut their daughter among families where daughters were cut. Within this smaller sample of 640 respondents, there are substantial differences in who was identified as encouraging respondents' daughters to be cut across governorates (Figure 17).

Figure 16. Who Encouraged FGM/C among Families where Daughter is Cut?

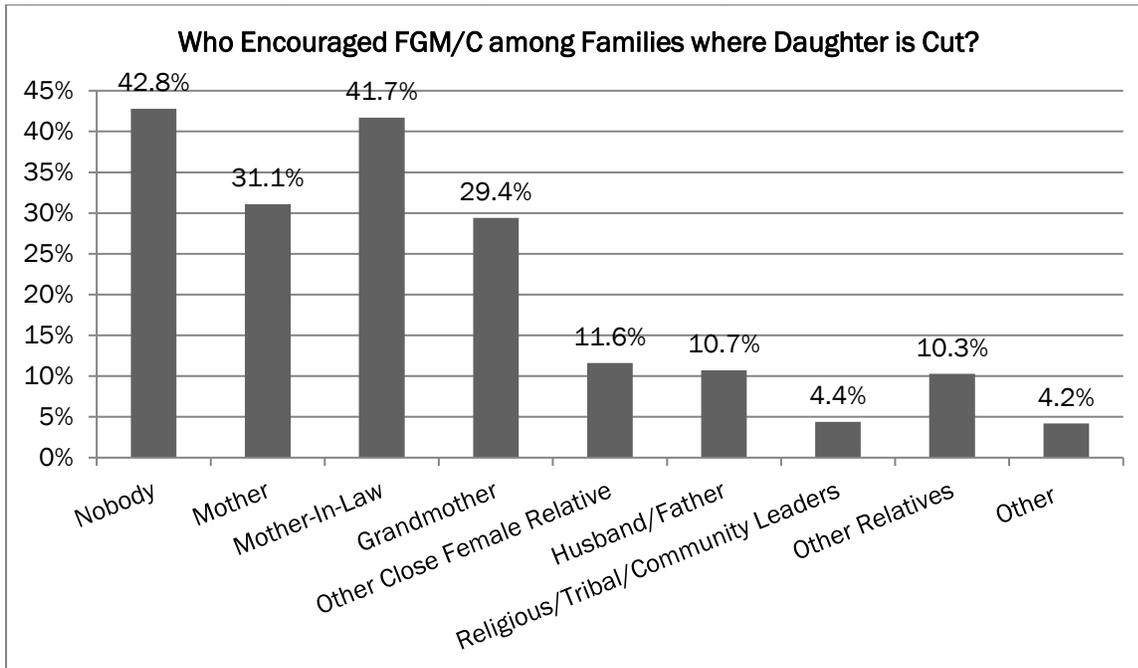
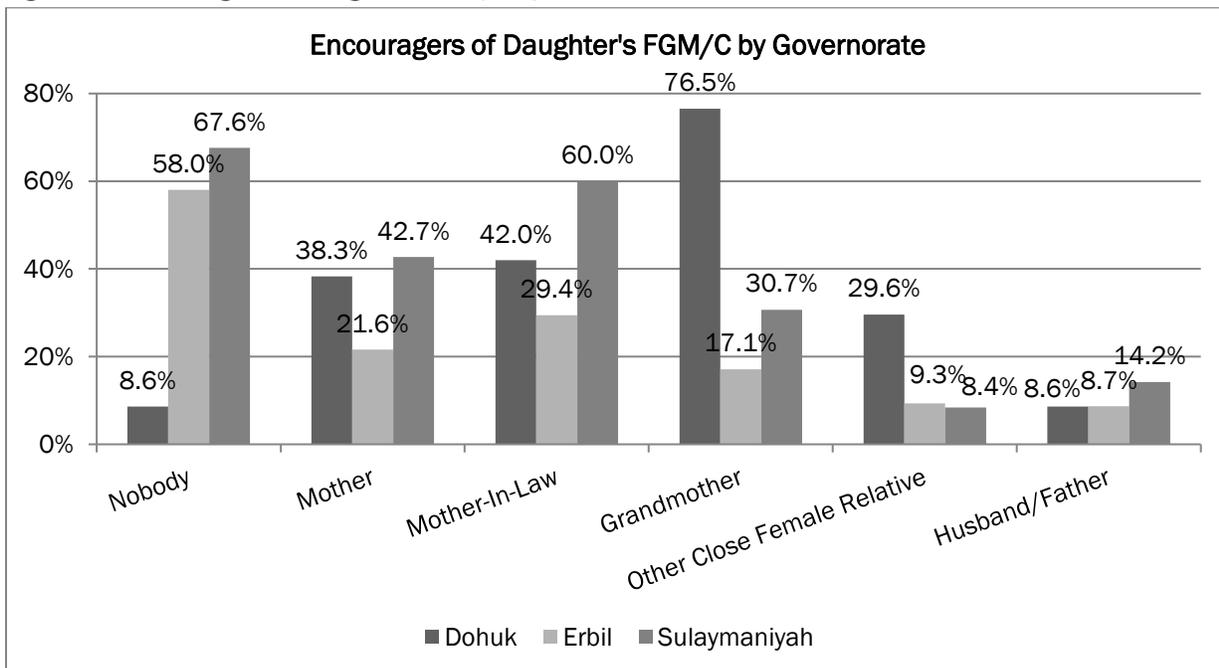


Figure 17. Encouragers of Daughter's FGM/C by Governorate



While 58% of respondents in Erbil and 67.6% in Sulaymaniyah said that they were not encouraged by anyone to cut their daughters, only 8.6% in Dohuk said the same. In Dohuk, the majority of respondents were encouraged by their grandmother (76.5%) followed by their mother-in-law (42%) and mother (38.3%). While respondents in the other governorates were more likely to say no one encouraged them, when they did they were most likely to point to their mother-in-law.

What is clear from these statistics is that the respondents are much less likely to identify male relatives and males in the community as the main actors encouraging (or pressuring) the daughters to undergo FGM/C.

Social Pressures and FGM/C

To further assess the social pressure exerted by family and relatives, the mothers were asked if there were different opinions in the family over whether to cut or not to cut the daughter. Overall, the vast majority of mothers (84%) reported no controversy. Discussions and different opinions about FGM/C were more common in rural areas, where 14.2% of mothers reported different perspectives compared to 8.9% of urban mothers. Family disagreement is slightly more common in Erbil (14.6%) and Sulaymaniyah (12.1%) than in Dohuk (6.6%) and Halabja (2.2%). In addition, the likelihood of family disagreement decreases as respondents' level of education goes up, which may be due in part to the fact that FGM/C is less likely at higher levels of education.

One note of caution in interpreting the prevalence of differing opinions about the FGM/C decision is that it could be underreported due to post-compliance as a psychological effect based on the mothers' need to reduce cognitive dissonance between their own and their families' decisions.

Knowledge about FGM/C-related Issues

FGM/C-related Health Problems

In general, knowledge about the harmful effects of FGM/C was limited. More than half of mothers (57.4%) were not aware of any health problems related to FGM/C. Awareness of FGM/C-related health problems was highest in Sulaymaniyah at 61.6%, followed by 52.2% in Halabja and 47.2% in Erbil. In Dohuk, only 19.5% were aware of the potential harms of FGM/C. Urban respondents were only slightly more likely to have heard of health problems associated with FGM/C compared to rural respondents (44% and 40.4% respectively). Awareness of health problems is positively correlated with level of education in that as respondents' level of education increases they are also more likely to be aware of FGM/C-related health issues. For example, 36.2% of respondents with no formal education report being aware of health problems related to FGM/C compared to 62% of respondents with at least some post-secondary education.

The known health complications that were most commonly reported related to sexual health. Almost two-thirds of women (62.6%) reported that FGM/C can reduce sexual desire, and over one third (35.3%) were aware that FGM/C may reduce sexual satisfaction or result in less or no sexual pleasure during intercourse (37.9%). Other medical complications cited by respondents who had heard of complications included excess bleedings (50.5%) and urinary issues (14.2%). These general patterns

hold up across the four governorates, although percentages vary. When asked about what psychological problems were related to FGM/C, respondents most frequently mentioned fear, depression, low self-esteem, and lack of feelings. A few mothers mentioned marital problems and that FGM/C can lead to divorce, however overall only 1.7% of the sample had heard of any type of psychological problem.

Consequences of FGM/C on Health

To further assess respondents' overall knowledge of issues related to FGM/C, they were read a series of statements and asked to rank their opinions on a scale from strongly agree to strongly disagree.

The answers to these questions, in general, indicate that the health consequences of FGM/C are not known by the majority of mothers in the overall survey sample. Figure 18 presents the results for the health-related questions answered by the total sample.

Figure 18. Respondent Knowledge of FGM/C-related Health Issues

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
FGM/C is beneficial for the health of the women	1.5%	7.1%	11.2%	45.5%	34.7%
FGM/C causes difficulties and complications in labor	4.0%	15.1%	33.1%	29.3%	18.5%
FGM/C is necessary for better female hygiene	1.8%	8.5%	9.9%	47.7%	32.0%
FGM/C promotes fertility and pregnancy	0.8%	2.6%	17.6%	49.3%	29.7%
FGM/C causes health and psychological problems for women	18.2%	32.3%	17.4%	21.4%	10.9%

To summarize the results above, 80.9% of women did not think that FGM/C could cause difficulties in labor, answering either “strongly disagree,” “disagree,” or “don’t know.” Almost half of the female respondents (49.7%) were not aware that FGM/C could cause health and psychological problems. On the other hand, the majority of respondents did not believe the myths that FGM/C improves fertility and chances for pregnancy, nor that it is better for female hygiene.

In summary, the survey documented remarkable gaps in knowledge about the health effects and harms of FGM, even among those who were aware that the practice has some adverse health effects. Awareness was especially low about potential problems and complications in childbirth.

Common Misconceptions about FGM/C

Respondents were also asked a series of questions to assess the degree to which they believed common misconceptions about the roles of women in society who are not cut. Overall, the results presented in Figure 21 below indicate that these misconceptions are not commonly held in the current sample.

Figure 19. Respondent Knowledge of Common Misconceptions about FGM/C

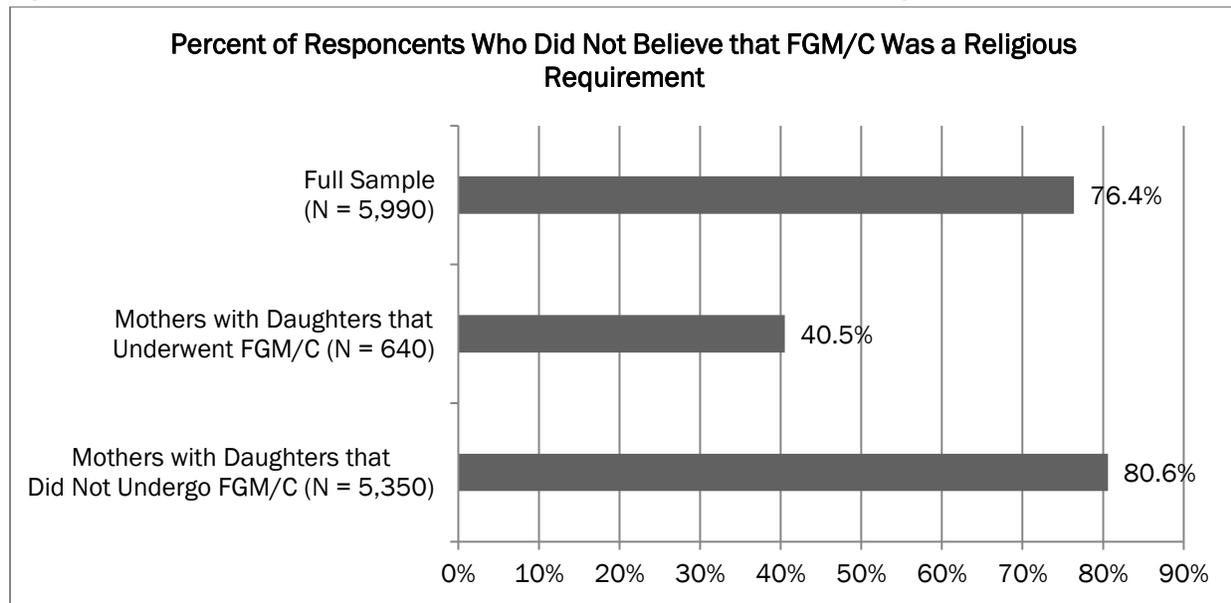
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
FGM/C increases a woman's chance of marriage	1.0%	2.8%	9.7%	52.8%	33.8%
FGM/C prevents sex before/outside of marriage	6.47%	7.1%	10.1%	47.6%	28.9%
FGM/C ensures female purity	1.5%	5.2%	10.5%	47.7%	35.1%
FGM/C is a religious requirement	4.0%	11.0%	8.7%	38.7%	37.7%
FGM/C is against human rights	33.3%	39.2%	8.4%	10.6%	8.5%
Women who are not cut will be excluded from the community	0.4%	1.2%	6.0%	53.4	39%
Food prepared by women where are not cut is forbidden	2.1%	5.3%	5.3%	47.1%	40.3%

Overall, the statistics presented above indicate that the vast majority of respondents disagree with common misconceptions. The notion that women who do not undergo FGM/C could be excluded from the community drew the strongest disagreement at 92.4%. However misconceptions such as “FGM/C increases women’s chance of marriage”, “FGM/C ensures purity”, “FGM/C prevents sex outside of or before marriage”, and “food prepared by uncircumcised women is forbidden,” were also strongly disbelieved. Slight differences can be seen across the four governorates, as well as rural and urban areas. For example, over three-quarters (76.5%) of respondents in urban areas thought that FGM/C violates human rights compared to just over two thirds (66.1%) in rural areas. Both percentages, however, are high, and overall adhere to the general pattern of respondents not believing what were thought to be commonly held misconceptions.

Whether or not respondents believed that FGM/C is a religious requirement varied depending on whether the mothers had forced their daughters to undergo FGM/C. Among the full sample of 5,990 respondents, over three quarters of the respondents (76.4%) did not believe that FGM/C was a religious requirement (and an additional 8.7% neither agreed nor disagreed). Even though the vast

majority of respondents across the full sample did not see FGM/C as a religious requirement, this percentage drops significantly among those respondents who report that their daughters underwent FGM/C. Just over 40% of the 640 mothers who had their daughters cut did not believe that FGM/C was a religious requirement. This important distinction about whether or not FGM/C is a religious requirement is illustrated in Figure 20.

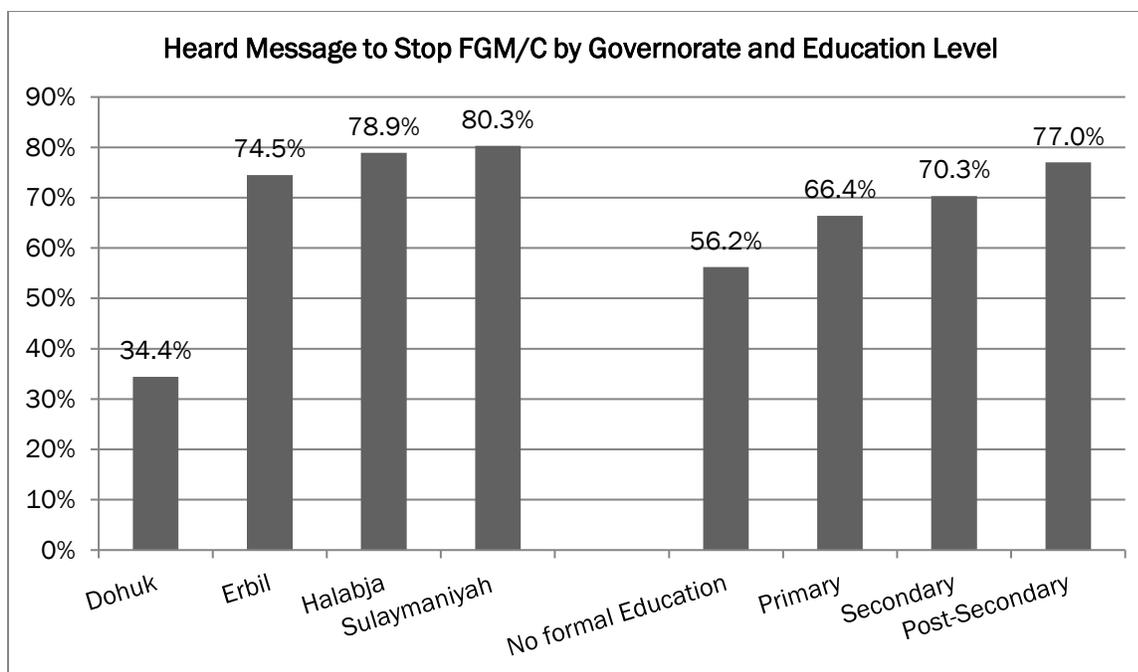
Figure 20. Percent of Respondents Who Did Not Believe that FGM/C Was a Religious Requirement



Awareness of FGM/C Eradication Campaigns

FGM/C awareness campaigns have developed messages to educate the public about FGM/C and eradicate the practice. These messages have been heard by almost two-thirds of respondents (63.0%), a rate that remains consistent across urban (62.9%) and rural (63.3%) areas. Exposure to eradication campaigns, however, does differ substantially across the four governorates and depending on the respondent's level of education (Figure 21).

Figure 21. Heard Message to Stop FGM/C by Governorate and Education Level



Approximately 75% to 80% of respondents in Erbil, Halabja, and Sulaymaniyah report having heard messages from an FGM/C eradication campaign, compared to only 34.4% of the population in Dohuk. Interestingly, Dohuk has a relatively low prevalence rate of FGM/C among the younger generation according to this survey (81 of 2,000 or 4.1%).

The likelihood that a respondent heard a message increases significantly as their education level increases, from just over half (56.2%) of respondents with no formal education to just over three quarters (77.0%) of respondents with some post-secondary education. This may be related to increased literacy rates making it possible to consume these messages as well as the likelihood of being exposed to messages in school.

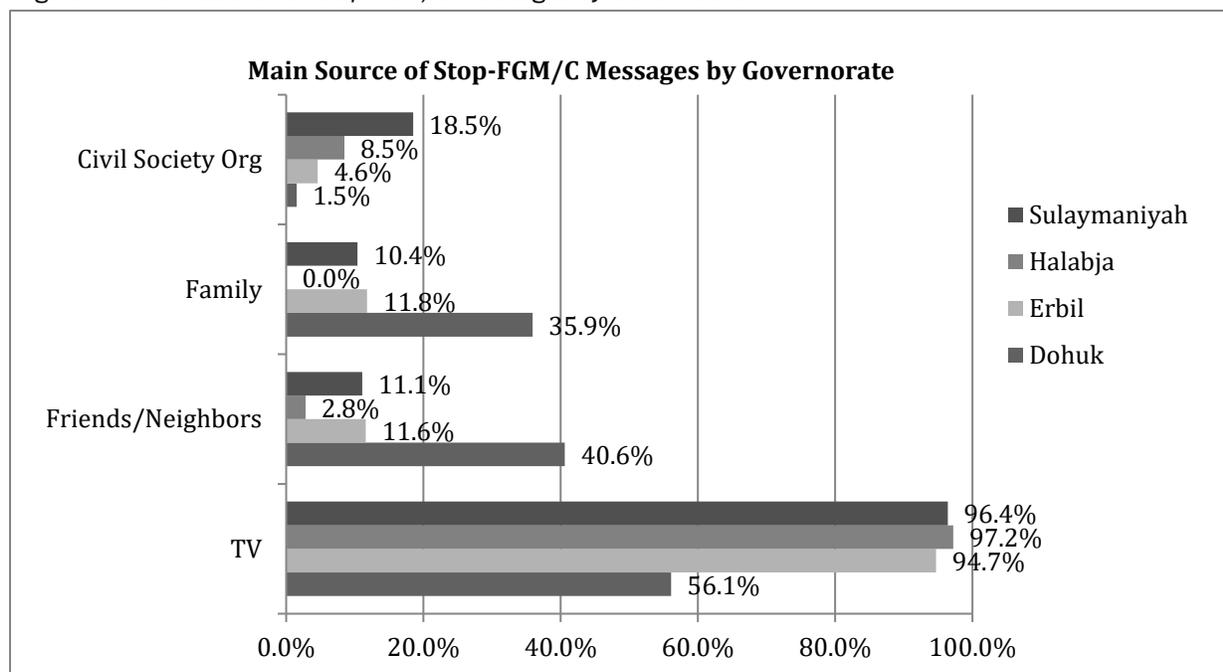
Source of Eradication Message

To design effective eradication campaigns it is important to analyze the source of the message heard by respondents. The data show two main sources of these messages: mass media and close social networks. By far, the largest percentage of respondents report being exposed to stop-FGM/C campaigns through television (88.4%), compared to only 4.5% through newspapers, and 6.0% through radio. Leaflets, brochures, billboards, and posters were indicated by less than 4.0% of respondents as the source of the FGM/C eradication messages. Stop-FGM/C messages were also spread among families and social networks, with friends and neighbors reported as sources at 14.7%, and family and relatives at 13.4%. Among civil society institutions, NGOs were the most cited source of anti-FGM/C messages at 9.4%. TBAs, health or social workers, mobile units, and teachers were reported by less than 3.0% of all respondents.

These trends hold across respondents in urban and rural areas, as well as across various education levels and income groups. Among all of these subgroups, well over 80% of the respondents reported

hearing messages on TV, followed by family, friends, and neighbors as the next most frequent sources of stop-FGM/C messages. While the types of sources that provide the greatest exposure to messages about FGM/C remain the same across the four governorates (TV and family/friends/neighbors), the relative penetration of these information sources did vary, as shown in Figure 22.

Figure 22. Main Source of Stop-FGM/C Messages by Governorate



As compared to the other governorates, Dohuk appears to be a bit of an outlier. For example, respondents in Dohuk were far less likely to hear messages from FGM/C eradication campaigns on TV as compared to the other governorates. On the other hand, respondents in Dohuk were much more likely to hear messages from family, or friends and neighbors (35.9% and 40.6% respectively) than in the other governorates where the percentages are below 12.0%. Civil society organizations appear to be more active in disseminating these messages successfully in Sulaymaniyah, where 18.5% of respondents report hearing messages against FGM/C from this source.

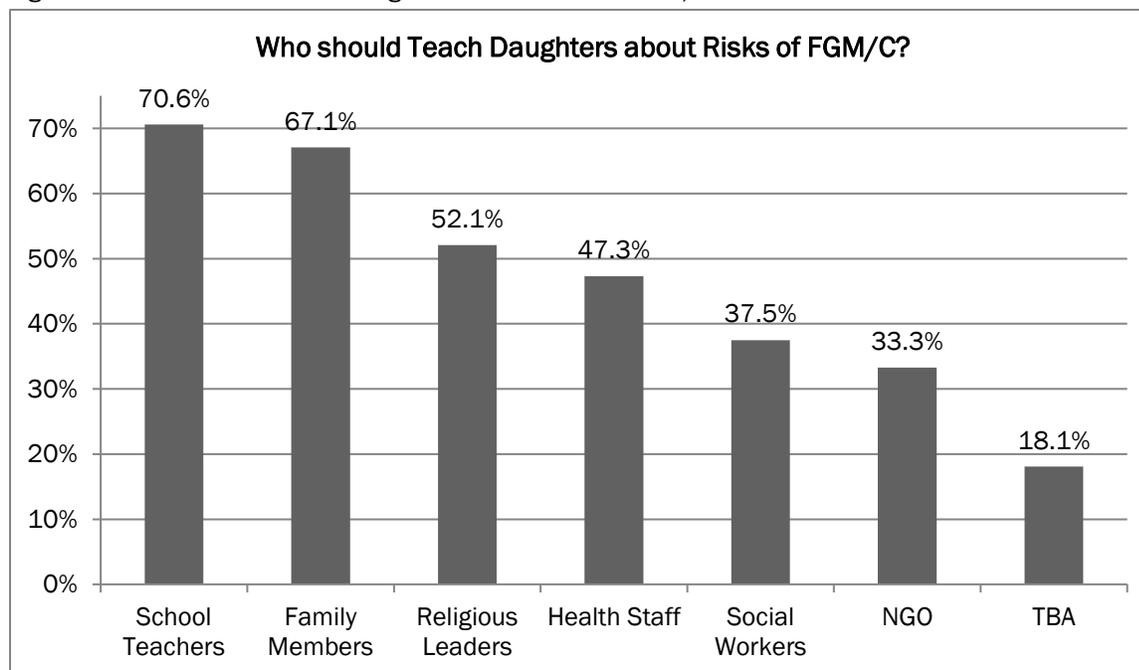
Willingness for Education on FGM/C

The population's openness to hear messages from a stop-FGM/C campaign impacts the effectiveness of the campaign. Among the sample surveyed, the vast majority (73.3%) reported they would welcome the education of their daughters about FGM/C and its risks, with an additional 7.3% being unsure, and 19.4% saying they would not approve of such education. Approximately 74.0% of rural respondents and 73.0% of urban respondents were also in favor of educating daughters about risks, and the support among all income groups was between 73% and 76%. Higher education increased the likelihood of approval for educating girls about FGM/C risks, ranging from 72.3% of respondents with no formal education approving to approval by 84.8% of those with a B.A. or higher. The governorate of Dohuk had by far the lowest support for teaching daughters about the harms of FGM/C (53.2%) as

compared with Erbil (79.3%), Halabja (88.9%), and Sulaymaniyah (87.2%). These results are consistent with the other indicators of the lower FGM/C rate and lower awareness of FGM/C in Dohuk.

Many potential educators for teaching daughters about risks associated with FGM/C were identified by the mothers surveyed. It is important to understand which actors the population feels are most appropriate for delivering this message when designing an effective eradication campaign. Figure 23 shows the main educators identified by the 4,388 out of 5,990 respondents who felt that their daughters should be taught the risks.

Figure 23. Who should Teach Daughters about Risks of FGM/C?



Differences between rural and urban respondents were small. For example, rural mothers were slightly more likely to feel that religious leaders should be teachers (55.5%) compared to urban mothers (49.9%), whereas urban mothers were more likely to identify school teachers as the best educators for FGM/C risks (71.7%) compared to rural respondents (68.8%). Larger variations exist across the four governorates. Respondents in Dohuk, Erbil, and Halabja were all most likely to identify family as the most appropriate educator for daughters, whereas respondents in Sulaymaniyah were most likely to identify school teachers for this role. Figure 24 shows the most popular educators identified by governorate.

Figure 24. Who Should Teach Daughters the Risks of FGM/C (Total N = 4,388)

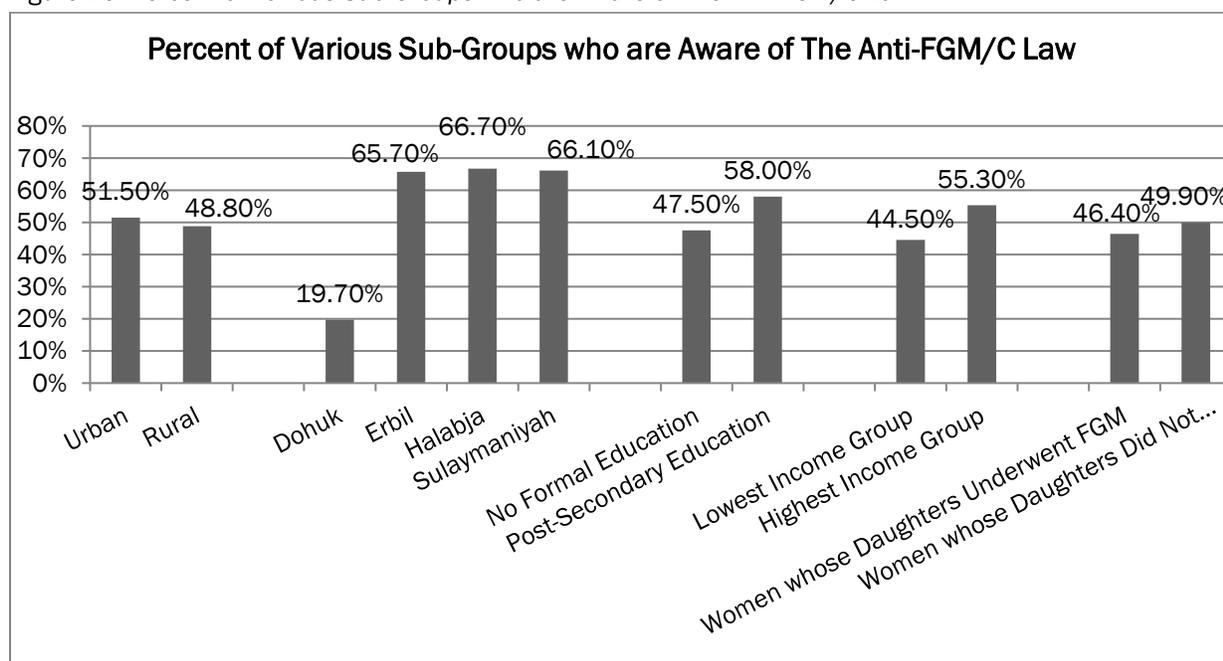
	Dohuk	Erbil	Halabja	Sulaymaniyah
Family	63.4%	72.8%	82.5%	63.2%

School Teacher	63.2%	64.3%	87.5%	80.6%
Social Worker	29.0%	42.4%	62.5%	37.2%
Religious Leader	51.1%	65.4%	62.5%	39.5%
Health Staff	43.0%	48.4%	67.5%	48.0%
NGO	30.4%	43.8%	65.0%	52.9%
TBA	5.7%	24.3%	43.8%	19.0%

Knowledge and Attitudes about Law and FGM/C

Act No. 8: The Law Against Domestic Violence in the Kurdistan Region of Iraq²⁶ includes an article which makes FGM/C illegal in the KR-I. However, the results of this survey show that knowledge of this law is somewhat limited. Of the total sample, just over half (50.4%) of the mothers had heard of this law. Figure 25 shows the percent of various sub-samples that are aware of the existence of this law.

Figure 25. Percent of Various Sub-Groups who are Aware of The Anti-FGM/C Law



As Figure 25 indicates, Dohuk is an outlier with only 19.7% of respondents being aware of the anti-FGM/C law compared to the other three governorates where about 66% of respondents knew that a law existed.

Those with some post-secondary education were more likely to report hearing about the law via civil society organizations (26.0%) compared to respondents with no formal education (7.4%). They were also more likely to hear about the law via their social network such as family (15.5%) and friends/neighbors (18.3%) as compared to those with no formal education (8.5% and 8.1%

²⁶Act No. 8: The Act of Combating Violence in the Kurdistan Region of Iraq
http://www.ekrg.org/files/pdf/combat_domestic_violence_english.pdf

respectively). However, between 95.0% and 97.0% of respondents at all levels of education who had heard about the law did so on television.

Television was also the most popular source of information about the law across all governorates, however its prevalence is slightly lower in Dohuk (85.2%) as compared to the other governorates where rates were 97.0% or higher. In Sulaymaniyah civil society organizations were more relevant as sources of information than in other governorates.

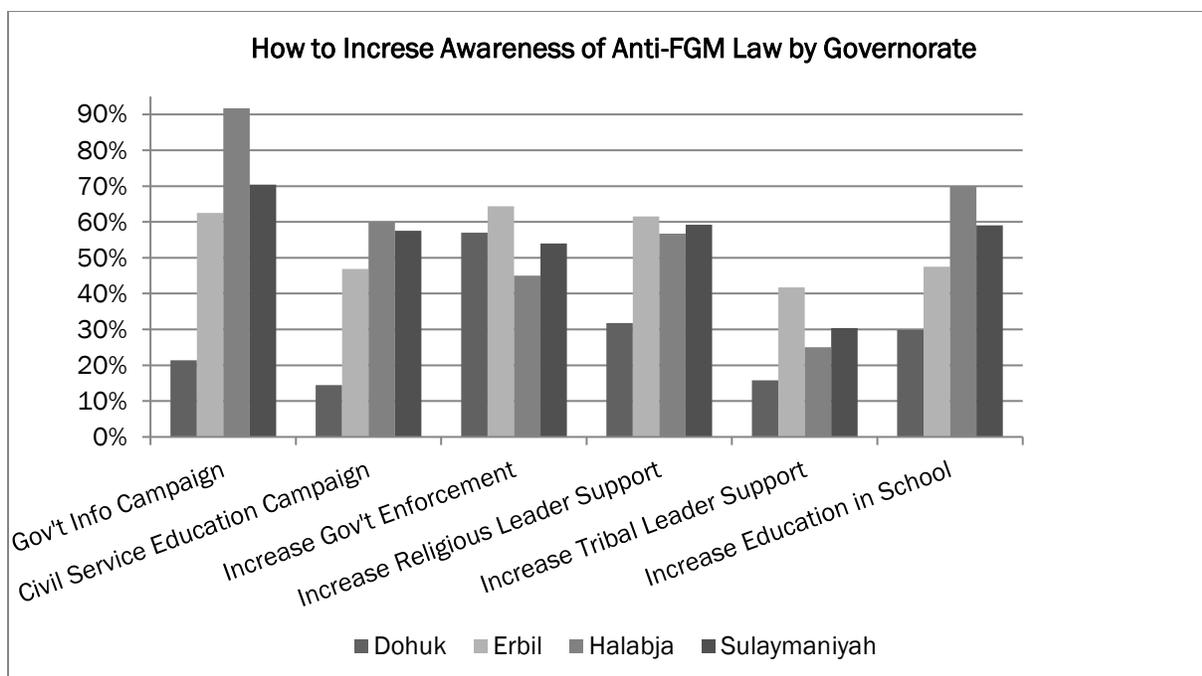
More than two-thirds of mothers who had heard about the law (67.5%) believed that citizens would adhere to it, while 16.8% were not sure, and 15.7% said they thought that people would not adhere to the law. The percent of respondents across urban/rural areas, income groups, governorates, and education levels were generally similar, with two main exceptions. First, those with a B.A. degree or higher were less optimistic about whether people would adhere to the law (38.8%) as compared to other education groups (which were between 68.7% and 70.0%). Second, respondents in Dohuk were also much less optimistic with 52.9% believing the law would be obeyed compared to 67.8% in Erbil, 91.7% in Halabja, and 70.6% in Sulaymaniyah.

Mothers were asked to identify reasons why they thought people might not follow the law, and 475 mothers offered their thoughts on that issue (just under 8.0% of the sample). Women believed the law would not be followed due to tradition being too strong (34.6%), lack of enforcement (32.9%), and strong religious beliefs (31.8%). Religion and tradition are historically the top reasons given for continuing FGM/C practice in general; weak enforcement of the law was an additional important reason named in this study.

Asked to suggest activities to inform people about the law, the most frequent response was information campaigns from the government using media (61.0%). Other activities frequently suggested were to better enforce the law (58.7%), get support from religious leaders (56.5%), education in schools (50.4%), and education activities by civil society organizations (47.3%). One-third of respondents suggested getting the community leader's support for the law. Most of the differences between rural and urban areas were quite small, except that in rural areas the support of community and religious leaders and more enforcement were perceived as far more important.

Figure 26 shows the differences in what respondents identify as the best way to strengthen the law by governorate.

Figure 26. How to Increase Awareness of Anti-FGM Law by Governorate



CONCLUSIONS

The results of this study demonstrate that the practice of FGM/C has declined significantly in the Kurdistan Region of Iraq. The reported prevalence of FGM/C declined from 44.7% among the mothers surveyed to 10.7% among their daughters aged 4 through 14. The magnitude of this drop suggests a substantial decline in the practice of FGM/C over two generations, even considering that the final prevalence in the younger group may be somewhat higher and assuming an under-reporting of FGM/C cases and the potential for future cases (4.3% of mothers reported they want their daughters to undergo FGM/C in the future).

Across the governorates, Erbil had the highest prevalence of FGM/C among both mothers (67.7%) and daughters (16.7%), followed by Sulaymaniyah (60.3% of mothers and 11.8% of daughters). Respondents in Dohuk report much lower prevalence for both mothers (7.4%) and daughters (4.1%). In Halabja the number of both mothers and daughters in the sample who report undergoing FGM/C is too small to meaningfully analyze.

Attitudes towards FGM/C have grown increasingly negative. The vast majority of women (85.4%) felt that FGM/C has become less common in the KR-I since their own childhood, and a similar number (87.3%) wanted the practice of FGM/C to end. In the 2014 HAI KAP survey, conducted with a smaller population in the area just 18 months earlier, only 66% of respondents reported similar attitudes.

Religion and tradition are the most often cited reasons to justify a daughter's FGM/C, however these are also common reasons given as justification for daughters not undergoing FGM/C. Of the 640 mothers who had their daughters cut, 63.3% said it was a religious requirement and 61.7% said it was a cultural tradition. On the other hand, of the 3,550 mothers who did not have their daughters cut,

40.1% base that decision on the fact that it is not part of their tradition and 23.5% report that it is forbidden by their religion. Since almost 97% of the sample identify as Sunni, there is clearly a difference in interpretation of religious and traditional doctrines. Religion is by far the largest influencer for FGM/C in Dohuk, with 93.8% of mothers citing it, although it is still strong in the other two governorates, with almost 60% of respondents reporting it is a religious requirement. Education also seems to influence the mothers' perception of whether or not religion justifies continuing the practice of FGM. More than half (56.0%) of the mothers with no formal education said that their religion supports FGM/C, while only 31.9% of mothers with post-secondary education said the same.

Female relatives are seen as the main proponents of FGM/C in the community and in the household. When respondents were asked who they felt were the main proponents of FGM/C they named their own mothers (55.4%), their grandmothers (49.3%), and other female relatives (13.1%). Among the 640 mothers who forced their daughters to undergo FGM/C, 42.8% said that no one encouraged them to have their daughter cut, while 41.7% cited pressure from their mother-in-law, 31.1% from their own mother, and 29.4% from their grandmother. Male family members were also named, but much less often, with no male family or community member named by more than 3.0% of the respondents.

There is widespread lack of awareness about the harms and risks associated with FGM/C. Consistent with the KAP study, which systematically assessed knowledge and attitudes toward FGM/C in addition to its practice, this study showed women have limited knowledge of the harmful effects of FGM/C on many aspects of women's health. More than half of mothers (57.4%) were not aware of any health problems related to FGM/C, although awareness of FGM-related health problems varied substantially across governorates. In Sulaymaniyah, 61.6% were aware of FGM/C-related health risks whereas only 19.5% of respondents in Dohuk had any awareness of health complications

FGM/C awareness campaigns have reached about two-thirds of the overall sample, indicating that they have had some success, although there is room for greater saturation of these campaigns. Approximately 75-80% of respondents in Erbil, Halabja, and Sulaymaniyah report having heard messages from an FGM/C eradication campaign, compared to just 34.4% of the population in Dohuk. The largest percentage of respondents report being exposed to stop-FGM/C campaigns through television (88.4%), followed by discussions among social networks such as family (13.4%) and friends/neighbors (14.7%). Almost three-fourths (73.3%) of the sample report that they would welcome the education of their daughters about FGM/C and its risks.

Knowledge of the Law against Domestic Violence in the Kurdistan Region of Iraq is limited, however the respondents believe strengthening the law would further reduce FGM/C prevalence. Just over half (50.4%) of the mothers surveyed had heard of this law. Religion and tradition were the top reasons given for continuing FGM/C practice despite the law, while weak enforcement of the law was an additional important reason named. When asked how they thought that the law might be strengthened, the most frequent response was that the government should run information campaigns using media. Other activities frequently suggested were to better enforce the law, get support from religious leaders, conduct education in schools, and have civil society organizations conduct educational campaigns.

The positive results of this study, especially the drastic decrease of FGM/C prevalence, may be connected to anti-FGM/C awareness activities conducted in the area in recent years and to the law banning FGM/C in the KR-I, passed in 2011. But this remains a speculative interpretation. Indeed, the study results may be unrelated to these anti-FGM/C efforts, as around half of the women reported they had never heard any anti-FGM/C message, and a similar number were not aware of the law. Further analysis is needed to examine a statistical association or causal relationship between these factors. What the survey does show unequivocally, however, is a need for greater awareness of FGM/C and the harms it causes women socially, psychologically and physically, and of the law banning its practice in the KR-I.

RECOMMENDATIONS

Information Sharing: Closing the Knowledge Gap

Equipping women with correct information about the harms of FGM/C is essential to eradicate its practice in Kurdistan Iraq. Both the government and local and international NGOs can contribute significantly to this education effort. Results from this survey indicate that women in the KR-I have a strong desire for more information on FGM/C, suggesting that they are ready and willing to act on knowledge they receive. Their wish for information and guidance is the ideal precondition for spreading information about FGM/C. It is crucial that mothers are educated on the multifaceted harms of FGM/C.

A comprehensive communication strategy should be developed using the findings of this study to guide its content and distribution. The communication strategy should be shaped to leverage the most effective actors in each governorate, including health professionals, schoolteachers, religious and community leaders, and social networks.

Results indicate that core messages should focus on eradicating misconceptions and myths about FGM/C and bridging the gaps in knowledge about how FGM/C harms women's mental and physical health. All planned awareness activities should be evaluated and monitored. This includes pilot testing core messages and materials for effectiveness with members target groups before wide release.

Tailoring Awareness Campaigns

Campaigns should specifically target the various groups and governorates where the prevalence of FGM/C is high, such as Erbil and Sulaymaniyah, and special consideration should be given to targeting the primary supporters of FGM/C identified in this study. Communication and awareness activities should be designed based on the needs, sensitivities, knowledge base, and capabilities of their target audiences, including gender, age group, educational status, and location. The results of this study show that segmenting awareness activities in this way, and carefully choosing the appropriate approach and materials in each situation, is essential in order to meet the varied information needs of a diverse population.

The majority of the mothers surveyed have little or no formal education, and they are often illiterate. Therefore, it is important to launch a visual campaign against FGM/C rather than relying on reading

materials alone. A low level of education requires tailored materials, including information based on pictures, audio recordings, and the use of “easy language.” Approaches suitable to this audience might include comic books portraying risks, as well as social scenarios reinforcing messaging on cultural and religious values. Posters with anti-FGM/C messages should be distributed and posted in public places dominated by women, such as maternity hospitals, women’s wards, gynecology clinics and in female sections of mosques. All materials should be pilot tested to ensure the target audience can understand them.

Because FGM/C practice is more common in rural areas, rural women should also be a special focus of the campaign. Community-based approaches that involve families and community activities may be especially useful in reaching these women. Activities should focus on building capacity in families and at the community level to engage women in learning about FGM/C and empowering them to end it. Possible methods include theatre and role-playing, local meetings for women, and education of anti-FGM/C volunteers. More comprehensive campaigns, such as those pioneered by WADI, involve recruiting local religious and community leaders to formally announce FGM/C-free villages.

Data show that most KR-I residents believe that FGM/C continues to be practiced mostly due to tradition and religious beliefs, and that families, specifically older female family members, are perceived to be its biggest proponents. In other words, societal pressure in various guises plays a major role in perpetuating the practice of FGM/C. To combat this, strategies and messaging targeting mothers and older adult women might be developed to emphasize their role in protecting their daughters. These messages should highlight the most unfavorable findings about FGM/C, including the health risks it poses for mothers and even babies during childbirth, and the need to prevent such harm.

Effective Communication Channels

A comprehensive communications approach should be developed that applies a wide variety of educational and communication tools through a variety of channels. To ensure the broadest possible distribution of FGM/C information, tools should include everything from mass media to face-to-face communication on the community level. Tools should also be included to reach religious leaders, community leaders, and other professional groups whose support and efforts will be important to reach women in their communities, especially in rural areas.

This study shows that mass media, specifically TV, is the most important source for information about FGM. Therefore, TV should be used as the central communication channel in a mass media campaign to disseminate information and messages about FGM. A comprehensive information campaign with a strong focus on TV, complemented by other communication channels such as radio, newspaper, internet, and social media, could be a powerful tool to further increase awareness and fill identified knowledge gaps.

Based on a media analysis, programs should be identified to reach the target groups. As women are the main decision makers for the practice of FGM/C, a concrete media campaign for women should be planned using programs popular among young women; for example, Evin Jin u Jyan, which means

Evin Women and Life. Religious TV channels, such as Speda TV, could be approached to convey anti-FGM/C messages, which may be particularly effective in dispelling the myth that FGM/C is required for religious reasons.

Encouraging debates on the topic of FGM/C on national TV, and providing information on the harms inflicted by FGM/C, could be part of a mass media campaign. Such a campaign would require significant resources from partner groups and the KRG, as well as technical assistance and financing. However, the significant progress toward eradicating FGM/C likely to be achieved would make the effort worthwhile.

Focus group discussions should be used to help define effective messages and develop effective ways of raising awareness. In addition, focus groups can promote community discussions about FGM/C, and focus group participation empowers women to tackle the issue.

Mass media public service announcements should be delivered by spokespersons identifiable as community, family, or religious leaders. Medical messages might be made more effective by combining them with messages expressing cultural or religious values.

Media advocacy is an important tool for communication campaigns and may enhance the coverage of FGM/C related messages. Typical activities for media advocacy focus on journalists, including conducting information workshops for them.

Knowing the Law

In June 2011, the Kurdistan Parliament – Iraq adopted The Act of Combating Domestic Violence in Kurdistan Region-Iraq.²⁷ This law imposes a sentence of up to three years or a fine of up to 10 million Iraqi Dinars as penalties for performing FGM/C. Despite this ban, the practice of FGM/C continues. To this day, there has been no prominent prosecution of an FGM/C case resulting in a criminal conviction of the perpetrator.

This study found that only half of women were aware of the law prohibiting FGM/C. Therefore it is important to increase awareness of the law through a public education campaign explaining its provisions and the penalties for violating it. Since almost five years has passed since this law was imposed, a refresher campaign using mass media, particularly TV, should be launched. The campaign should include messages emphasizing the importance of reporting cases of FGM/C, and that reporting FGM/C is a civic duty. Public service announcements denouncing the illegal practice of FGM/C might also help reinforce that its practice falls outside accepted social norms. These efforts should work in tandem with, and help draw attention to, increased enforcement of the law by the executive and judicial branches of government. Strongly promoting and enforcing the law against violence could help eradicate FGM/C. Concrete measures could include: (1) public prosecution of FGM/C cases to

²⁷ Act No.8 (2011), article six

strengthen Law No.8 and emphasize the credibility of the law, and (2) training lawyers specifically to prosecute FGM/C cases to bring the perpetrators of FGM/C to justice.

Engaging the Community

This study found that the mistaken beliefs that FGM/C is a cultural tradition and/or a religious requirement are among the most significant root causes for the continued practice of FGM/C. Therefore, religious figures could be important partners in any government campaign to eliminate the practice of FGM/C. Working with religious communities and bringing together mullahs, imams, and other religious leaders for discussions on FGM/C is crucial. They should be encouraged to include messages about ending FGM/C in their local communities in Friday prayers and sermons. The Ministry of Religious Affairs also should be considered as a partner to reach religious leaders within the framework of law.

Islamic political parties and their members in parliament could have important influence on eradicating FGM/C in Kurdistan. Efforts to engage religious-based political parties in the anti-FGM/C movement should be considered. Bringing religious leaders together with highly respected Islamic authorities who ban FGM/C and have issued *fatwas*²⁸ against it, such as it was done in Egypt,²⁹ is an important way to positively influence local religious leaders.

In areas of high FGM/C prevalence, religious leaders could discuss the harmful effects of FGM/C with their congregations and support ending the practice. Issuing a *fatwa* condemning the practice of FGM/C is another powerful step religious leaders and religious-based political parties could take toward ending its practice.

Partnerships with key influencers would also be helpful in developing and delivering both general and targeted messages. These influencers include schoolteachers, health professionals, social workers, religious leaders and teachers, community leaders, government officials and workers, and traditional birth attendants. Involving these partners in delivering messages combined with mass media support would be mutually reinforcing, helping ensure individuals are exposed to similar messages enough to create an impression and shift attitudes.

As one of the central groups who perform FGM/C, traditional birth attendants play a crucial role in its practice. However, traditional birth attendants are generally seen as among the top community supporters of FGM/C, and for many, practicing FGM/C generates a substantial part of their income. As a result they may see eradicating FGM/C as a threat not only to their traditional social position but also their income. Providing alternative sources of income to midwives could lessen their dependence on, and therefore their support for, FGM/C, and should be considered as an additional measure to further reduce the practice of FGM/C.

²⁸ A *fatwa* is the legal opinion or learned interpretation that a *mufti* (an Islamic scholar), can give on issues pertaining to the Islamic law.

²⁹ Oral report by WADI

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APPENDIX A – SAMPLE SELECTION

Sample and Sample Frame Selection

The 2015 Baseline and Intervention Strategy Survey for the Eradication of FGM in the Kurdistan Region of Iraq (KR-I) was designed to cover four governorates within the KR-I, namely Erbil (total population 1,905,970), Sulaymaniyah (total population 1,853,445), Dohuk (total population 1,336,944), and Halabja (total population 98,373).

Limited demographic data were available for these target regions and no detailed lists of households exist. Therefore, the sub-districts of Erbil, Dohuk, and Sulaymaniyah, with Halabja included as part of Sulaymaniyah, served as the sample frame for this study. Halabja was grouped with Sulaymaniyah because its population is small in comparison to the other governorates and it was not possible to generate a sample with statistical power similar to the other three governorates. However, the descriptive data analysis for this study yielded meaningful results disaggregating the four governorates. Therefore, results display Halabja as a governorate separate from Sulaymaniyah even though the study sample selection treats it as part of Sulaymaniyah.

The KR-I could not provide detailed household lists for the four target governorates, therefore the household lists could not be used as the sample frame. Therefore, a multi-stage cluster sampling methodology was applied to randomly selected representatives of the target populations in Erbil, Sulaymaniyah, Dohuk, and Halabja governorates. The population numbers used for the sampling were based on the latest census conducted in 2009 and related estimations. The selection process was stratified so that respondent demographics were proportionally representative of the overall population distribution across rural and urban areas, as well as among the districts in the study's target regions.

Sub-districts of the targeted regions served as the Primary Sampling Units (PSUs) for this survey. In the first stage of the sample selection process Probability-Proportional-to-Size sampling (PPS-sampling) was used to select these PSUs. PPS-sampling was determined to be the most appropriate sampling method due to large variation in the size of sub-districts in the target regions. This method ensured that sub-districts with larger populations were assigned proportionally more clusters than sub-districts with smaller populations.

For the PPS-sampling, lists of the urban and the rural sub-districts in each governorate including their population sizes were created. The population sizes were summed and the PPS sampling procedure applied. Sub-districts to be visited in the survey were selected by applying a random starting number and an individually calculated gap interval to each list of sub-districts. The gap interval term was calculated to ensure that the correct number of clusters and households were achieved within the selected sub-districts and to ensure the proportion of households visited in urban and rural areas was equal to the proportion of such areas within the respective governorate.³⁰ This procedure determined how many clusters out of the 66 total per governorate were allocated to which sub-districts. This

³⁰ Data on the proportion of urban and rural sub-districts in each governorate was obtained from latest available statistics (provided by Statistical Office of Government of KR-I, 2009).

selection process guaranteed that a representative cross-section of units was selected. However, some of the clusters or sub-districts identified by this methodology could not be surveyed due to security or logistical problems. In these cases the clusters were replaced by the geographically closest possible substitute with similar demographics, ensuring that the substitute clusters remained representative of the population in the area.

Following the selection of specific sub-districts, the second stage of the sampling process was selection of villages and urban neighborhoods to be visited within each selected PPS-sampling cluster. Each village and urban neighborhood in the cluster was assigned a randomly generated number and a sub-selection was chosen for inclusion in the study.

In the third stage, interviewers identified the households to be visited within each village using a systematic random approach. Interviewers visited houses of a randomly selected interval (e.g. “every fourth house”) starting from a predefined location (e.g., marketplace, village center, or similar population hub given local conditions).³¹

The fourth and final sample selection stage used a systematic random approach to determine the households surveyed. Interviewers visited every house identified by the prior random selection process. In each house they determined if an eligible respondent was present. Eligible respondents were defined as women with daughters of ages 4 through 14 years who also had heard of FGM/C. If a household did not include at least one eligible woman, the interviewers proceeded – as a rule – to the house next door to ensure the saturation of the sample was maintained. In households including more than one eligible woman interviewers attempted to interview *all* eligible women, as opposed to only the female head-of-household or the first woman encountered. Interviewing all of the multiple eligible women in a given house helped ensure that the study did not discriminate against mothers who had moved into a shared or family home.

While the target population of this survey was girls aged 4 through 14 years, data was collected from the girls’ mothers rather than the girls themselves. This is a common approach in surveys of FGM (UNICEF, 2013) because it provides the necessary data while also complying with the strict ethical limitations for research with children (see also “Ethical Issues”).

Trained female interviewers identified the women of each visited household and determined eligibility for inclusion in the study using a systematic and predefined procedure. This approach included the following steps:

1. Approval to interview the woman was sought from the husband if the need for the husband’s permission was indicated by the woman or implied by a man of the house,
2. The women in the selected household were screened for eligibility by asking whether they had one or more daughters in the relevant age group. The eligible women in the household were informed that the survey consisted of questions about FGM.
3. Interviewers invited all eligible women in the household to participate.

³¹ More details on the random sampling procedure in the villages are provided in the field research guide for the interviewers.

4. If all eligible women in the household refused to be interviewed, the interviewer moved on to the house next door until a sufficient saturation for the cluster had been achieved. Once the interviewers had identified the participant(s) in a household, the interviewer identified a private place to carry out the interview. The interviewer explained the study and asked the woman to read an informed consent form. The interviewer explained the study confidentiality and anonymity to each participant. The interviewer then asked the woman to sign the respondent consent form (see “Ethical Issues”). If the woman was illiterate the text was read to her and the interviewer signed on her behalf.

Cluster Design

The survey was conducted in 66.6 clusters in each governorate for 200 clusters in total. The clusters had a size of n=30 households. This is the standard for cluster design (30 clusters x 30 households design) and the largest possible cluster size was used in this study to avoid a loss of statistical precision (Kaiser et al., 2006).

The survey was designed to generate statistically valid and reliable results for the three governorates of Erbil, Dohuk, and Sulaymaniyah as separate units. The total sample consisted of 200 clusters allocated equally to the three governorates, resulting in 66.6 clusters for each governorate (n=2,000). Halabja, which was included in the initial sample size calculation for Sulaymaniyah, became a separate governorate shortly before the data collection started. This was done by allocating to Halabja 2.5 of the 66.6 clusters planned for Sulaymaniyah, which is proportionate to the population of Halabja within the former governorate of Sulaymaniyah. Within each governorate “urban” and “rural” clusters were allocated proportionally to the urban/rural population distribution of that governorate.

Erbil

Area	Female Population	As percent of total female population in governorate	Final number of clusters
Urban*	573,237	60.7%	37
Rural	371,528	39.3 %	29
Total	944,765	100%	66

Table 1: Number of urban and rural clusters in Erbil

*Urban areas are defined as governorate centers

Sulaymaniyah

Area	Female Population	As percent of total female population	Final number of clusters
Urban	626,213	67.0%	42.5
Rural	308,559	33.0%	21
Total	934,772	100%	63.5

Table 2: Number of urban and rural clusters in Sulaymaniyah

* Centers of the governorates are defined as urban

Halabja

Area	Female Population	As percent of total female population	Final number of clusters
Urban	29,826	61.7%	1.5
Rural	18,476	38.3%	1
Total	48,302	100%	2.5

Table 2a: Number of urban and rural clusters in Halabja

*Centers of the governorates are defined as urban

Dohuk

Area	Female Population	As percent of total female population	Final number of clusters
Urban	300,208	56.0%	37
Rural	236,249	44.0%	29
Total	536,457	100%	66

Table 3: Number of urban and rural clusters in Dohuk

*Centers of the governorates are defined as urban

APPENDIX B – QUESTIONNAIRE DEVELOPMENT

Research Questions

The research team designed the questionnaire based on a literature review of FGM/C, with special focus on surveys conducted in the KR-I (HAI/UNICEF, 2014; Yasin et al., 2013; Rozhgar et al., 2013). Questions were adapted to be culturally relevant and sensitive to the KR-I. The questionnaire also aimed to collect data specific to the KR-I, such as participants' knowledge of and attitudes toward the law prohibiting FGM/C and toward awareness activities previously conducted in the region.

Surveyors received two days of intensive training, including practicing with the questionnaire, exploring issues of cultural sensitivity, and reviewing ethical and security guidelines. Several rounds of mock interviews were conducted in which surveyors' performance was critiqued and coached, survey procedures developed and assessed, and the survey instrument examined, resulting in several rounds of survey instrument revision. The survey was pilot tested and again revised before the data collection began. Field-testing also enabled additional training for surveyors and development of consistent interviewing methods.

The following research questions were evaluated:

1. What is the prevalence of FGM/C in girls ages 4 to 14 years in the KR-I governorates of Erbil, Sulaymaniyah, Dohuk, and Halabja?
2. How is FGM/C carried out? By whom? At what age?
3. How is decision-making regarding FGM/C influenced?
4. What is the role of TBAs in the practice of FGM/C?
5. To what extent are women aware of Law No.8?
6. What are the opinions, beliefs, and perceived trends for the practice of FGM/C?
7. What gaps exist in FGM/C-related knowledge (e.g., health, religious, etc.)?
8. What are culturally appropriate means to raise awareness on the prevention and eradication of FGM/C?

A standardized FGM/C questionnaire was developed, including the following core sections:

- Demographics: age, gender, educational status, literacy, socio-economic status, marital status, age of marriage, number of daughters, etc.
- Practices related to FGM/C of girls ages 4 to 14 years: whether FGM/C was conducted on daughters, age at time of FGM/C, FGM/C procedures, FGM/C of mothers, health problems related to FGM/C, etc.
- Decision-making related to FGM/C of daughters: social norms, social pressure by family/friends, role of TBAs, etc.
- Role of Law No. 8 Against Family Violence: awareness about the law in the Kurdistan Region of Iraq (Anti-Domestic Violence Act)
- Beliefs and opinions on FGM/C: traditional, cultural or religious attitudes related to FGM/C and the role of women and men
- Knowledge of FGM/C effects on health

The questionnaire was translated into Badini and Sorani according to the governorate's main language. A consent form was administered before each interview. This form explained the purpose of the study and the respondent's rights before seeking and recording their formal agreement to be interviewed. A Questionnaire Identification Sheet containing basic information about the questionnaire was added to help identify questionnaires and to monitor data collection and processing.

The data from the completed questionnaires were sent to a server. All questionnaires were automatically registered and verified against the sample requirements. For accuracy, data were also crosschecked for logical mistakes based on a logic error checklist and corrected where necessary. Following the qualitative analysis, data were checked again for errors and corrected where necessary as an additional quality assurance step.

APPENDIX C - PILOT TESTING AND TRAINING

Instrument Testing

Under the direction of the trainers, the interviewers and supervisors reviewed the questionnaire and the translation of each question. For each question, the team focused on whether the grammar was correct, the question was worded clearly, and the intended meaning was being conveyed. The wording was changed if a majority of the team felt it necessary. The entire instrument was reviewed, including the instructions, questions, and response categories, by 30 interviewers and six supervisors with experience in studies on FGM/C.

A pre-test of the questionnaire was conducted before it was piloted in the field to test the survey instrument and field research approach. This included ensuring that translation of the survey instrument was accurate (e.g. back-translation), that the questions were culturally appropriate (e.g. by feedback in the pre-test), and that the survey teams and randomized approach worked in the field. The teams pre-tested the questionnaire and executed pilot tests in the field in “real-life” conditions. Following the pre-test of the survey and analysis of results, the survey instrument and research surveyor approach was modified as necessary. The technical functionality of the tablets and the SPSS mask was also tested.

Training

Interviewers and supervisors received training in how to administer the survey instrument, including use of the tablets. The research project used advanced tablet technology in the field, with software developed for the survey.

To ensure the proper utilization of the questionnaire and data-collection procedures by field research teams, an intensive, two-day training was conducted for surveyors (interviewers) and supervisors. The training included an introduction to the study and its aims and objectives; the roles of interviewers and supervisors in carrying out the study; ethical considerations; the use of the tablets; and role-playing exercises to help familiarize the field research teams with the interview procedure and instrument. Finally, the training included a security briefing outlining procedures and processes should any safety or security issues arise during field implementation. Supervisors received an additional day of training to clearly define their roles as supervisors and to discuss logistical, security, and other issues related to implementing the survey in the field.

During the training, the field team participated in a pre-test of the instrument. The surveyors and supervisors broke out into small groups and carried out interviews. After each interview, the small groups discussed the questionnaire and interview approach. After conducting several rounds of mock interviews, the field research teams reconvened in a larger group for an in-depth discussion about the instrument. The questionnaire was further modified, based on the initial pre-testing, and was then tested again by small groups during the training. After the instrument and data collection procedures were adequately tested and a final survey instrument was completed, a pilot test of the instrument was conducted. Each surveyor completed one interview in a real-world situation to test the instrument in the field.

Pilot Testing

The purpose of the pilot study was: a) to detect any problems with the interview procedure and the survey instrument; b) to determine whether the instrument was acceptable and understandable to respondents; c) to give the interviewers practice in interviewing; and d) to detect any problems with the data entry process.

Trainers, the interviewers, and supervisors reviewed the instrument. Under the direction of the trainers, the interviewers and supervisors reviewed the questionnaire and translation. For each question, the team focused on whether the grammar was correct, the question was worded clearly, the translation from English to Kurdish was correct, and that the intended meaning was being conveyed. Adaptions were made, as necessary.

Interviewers and supervisors received training in how to use the draft instrument. This was followed by a pilot testing in the field conducting interviews with a small sample of the target population in the community. The feedback of interviewers and supervisors was used to adapt, where necessary, the interviewing procedures, questions, the order of questions, or other procedures.

APPENDIX D - EXPERIENCES AND REFLECTIONS FROM THE FIELD

Introduction

“It made me so happy to notice that overall FGM has reduced.”

HAI held three workshops with the field researchers, in Dohuk, Erbil, and Sulaymaniyah, including the recently established Halabja governorate, entitled “Lessons Learned and Reflections from the Field.” This chapter uses information collected during these workshops to complement the quantitative study with qualitative information that provides additional context and to provide further insight into the lives of the women interviewed.³² The workshops focused on three main questions: 1) What worked well? 2) What could have been improved? 3) What could be done differently next time? The goal was to encourage the field researchers to reflect on their memories experiences from the data collection process.³³

During the workshops the field researchers raised several themes. One was truthfulness, a factor that has an important influence on the interview results but is difficult to measure. A second recurring theme was accessibility to households and the mothers’ reactions toward the subject of FGM/C. Finally, the challenges and benefits of using tablets for data collection were assessed. In the following sections variations on each of these themes are presented, along with reflections from each of the three governorates (Duhok, Erbil, and Sulaymaniyah (including Halabja) and between urban and rural areas.

Personal Interaction with Mothers

“We had some issues with signing the consent forms, especially with those mothers who were illiterate, because signing forms in this region is associated with signing away your house.”

Overall, researchers reported that built good rapport with participants and put them at ease during the initial stages of the interview. Field researchers needed to be particularly mindful that FGM/C is a sensitive and personal issue when conducting the interviews. The field team adapted to the context and was trained in cultural awareness, especially in rural areas with a more conservative dress code,. In practice, for example, this meant that some field researchers who did not wear a head scarf in the city would wear one in the villages. The interviewers reported that the mothers in villages were more comfortable talking to veiled women.

In the initial interaction with the mothers, field researchers were often mistaken for charity organizations, political parties, or health workers, and on a few occasions as midwives. The interviewers had to explicitly explain who they were and the purpose of their visit. The majority of interviewers said that the mothers often requested advice from the field researchers on the topic of

³² When referring to mothers, the focus is on women who are mothers of daughters 4 to 14 years old, who have been interviewed during the process of data collection.

³³ The workshops were held in Kurdish and English, and researchers expressed themselves in Kurdish. This was then translated by the co-researcher into English.

FGM/C and whether to cut their daughters or not. This was a difficult situation for field researchers, who had to stay neutral during the interview. However, some explained that they felt obligated to give advice after the interview was completed, even though the research had to be objective, and during training, researchers were instructed not to express their personal opinion.

Truthfulness of Interviews

“Elder women in the households were feared more than husbands.”

Since FGM/C is a private and personal issue, it is very difficult know whether mothers were being honest and answering truthfully. When asked: “Did you feel the mothers were giving you honest answers?” the majority of field researchers replied that they felt that mothers gave mostly truthful answers. This assessment was based on the comprehensive nature of the conversations during the interviews, in which mothers often shared detailed accounts of personal stories.

Ideally, interviews should have been conducted with mothers in a private setting with no presence or interruption of any other family member. But due to the collective society culture in the KR-I, this was often not possible. Mothers-in-law and unmarried siblings of the husband or wife often were also present, and their presence clearly influenced the interviews. Such family settings and living practices were much more common in rural areas. Interviewers also reported that when they entered a remote village almost all of the inhabitants would gather around the researcher and sit with the mothers while the interview was conducted. Neighbors would often respond on behalf of the mother and give their opinion on the questions. Even when they did not interfere directly their presence at times influenced the answers given by mothers.

In Sulaymaniyah governorate, particularly in rural areas, interviewers reported profound influence of male family members, especially husbands and sons, on the interviews. Often field researchers were viewed suspiciously in these areas and the mothers were not left alone to answer the questions. In one particular case, the researcher reported the son answered all of the questions, and the mother was not allowed to talk or give her opinion. In these rare cases, surveyors realized the invalidity of the interview and the interview was excluded from the results.

In the rural areas in Erbil governorate, mothers-in-law were present at most of the interviews and influenced the truthfulness of the mothers’ answers. Interviewers observed that mothers-in-law were usually the household heads and, thus, had to be respected. Mothers-in-law also were generally in support of FGM/C and would enforce this belief on their daughters or daughters-in-law who were being interviewed, even when the younger women did not appear to support FGM/C.

One interesting effect noticed by the interviewers was that participants were often inconsistent when answering questions about Law No.8: the Law Against Domestic Violence in the Kurdistan Region of Iraq (Anti-Domestic Violence Act), which prohibits FGM/C in the KR-I. If the participant agreed with FGM/C in previous questions, after hearing about the law they would change their answers in fear of being prosecuted. As the question on Law No. 8 was put strategically at the end of the questionnaire, this did not affect the answers given to previous questions.

Accessibility to Households and Mothers' Reactions towards FGM/C

"Mothers requested education, awareness, and advice in regards to the subject of FGM/C."

Most mothers made the decision to cut their daughters due to cultural traditions and religious pressure. However, some acknowledged that times were changing and the above mentioned Law No. 8 (Anti-Domestic Violence Act) made FGM/C illegal. Being aware of this change in legislation, mothers would thus ask the researchers for their advice but also their opinion on FGM/C. This search for knowledge from the mothers indicates the possibility for change.

Access to households was generally reported to be easier in rural areas, where field researchers were often invited for lunch. However, men in the households were often suspicious that field researchers were influencing their wives with inappropriate ideologies. In comparison, in the urban areas, the majority of the interviewees felt less welcomed by households and often were not welcomed into the homes. In the upper class neighborhoods researchers were often greeted by the maids of the households, who were not Kurdish.

Different attitudes on the issue of FGM/C prevailed in different governorates. For example, a woman in Dohuk³⁴ said she was married to a Sorani man whose family practiced FGM/C. To protect her daughter from undergoing FGM/C, she separated from her husband and returned to her family in Dohuk. Some women made it clear that not practicing FGM/C was non-negotiable, even if it affected marital life and a woman's reputation. However, FGM/C was often a low-priority concern. Especially in low income rural areas, women highlighted issues that need attention more than FGM/C. Such issues included the threat of the Islamic State, the financial crisis, and lack of basic amenities such as water, electricity, and gas.

Use of Tablet Technology

"Mothers feared technology."

Field researchers in all three governorates reported that in general mothers feared the tablets used to conduct the interviews as they were scared that field researchers might take pictures of them or record their voices. While no pictures were taken without consent, the interviewees had to be convinced of the harmless nature of the tablets. To reassure mothers, surveyors let them see how the tablets were used. In some cases, the interviewer asked a younger family member who was more familiar with technology to view the tablet and observe what the interviewer was doing. Some interviewees noticed that while they were looking down at the tablets to fill out the questionnaires, mothers sometimes felt they were being ignored by the interviewers because they were not making eye contact. In these cases, the tablets were seen as interfering with building strong rapport with the mothers.

However, the tablets were favored by the majority of the interviewees because they were easier to use than pen and paper. In addition, carrying the devices was more convenient, and they weighed less than carrying many questionnaires. In terms of security and preserving the privacy of mothers, the

³⁴ Within Iraq, the Kurds are split into culturally distinct Sorani- and Bahdini-speaking tribes. Sorani is largely spoken in Erbil and Sulaymaniyah governorate, while Bahdini is largely spoken in Dohuk governorate.

tablets were perceived as more secure than paper. The submission of questionnaires was more convenient for field researchers because they did not worry about losing any data. Despite working in very remote areas, the tablets generally had good signals to submit questionnaires. However, in some cases interviewers were concerned that signal problems would hinder the electronic submission of questionnaires and that data would be lost. Interviewers felt more professional with the devices versus using pens and papers. A few interviewers suggested that consent forms should also be available on the tablets rather than in paper format only, which might have encouraged more mothers who feared signing a paper form to consent. It was also suggested that those who were illiterate could have signed on the tablet with a finger print.

Specific Experiences from the Governorates

Dohuk

The general consensus among the researchers was that in Dohuk, mothers in rural areas were more welcoming and more likely to participate in the research than elsewhere. Especially in the remote villages the women were curious about the researchers and were very friendly. In comparison, in urban areas mothers were less welcoming and less likely to participate in the research. Despite the generally inviting atmosphere in rural areas, suspicion remained in certain cases. For one researcher this suspicious atmosphere resulted in a short police arrest. A family refused to believe the surveyor was conducting legitimate research and informed the police of her inquiries. The field researcher in Dohuk described this as an uncomfortable setting in which she could not verify whether the police were actually police. After being brought to the police station, the interviewer, equipped with an approval from security forces of the KR-I to conduct the research, successfully convinced the police of the legitimacy of her research.

In areas where the Islamic State of Iraq and Syria (ISIS) militants had taken control, the researchers noticed the rate of FGM/C had increased, suggesting that ISIS may have been promoting and enforcing the practice. In the outskirts of Dohuk, a researcher shared a poignant story of a four-year-old girl who had gone to play in the neighbor's house. After a few hours, she returned home covered in blood. The grandmother next door had circumcised the little girl without the permission of the girl's mother because the neighbors felt that food and water handled by uncircumcised girls was impure. Incidents like these illustrate the social acceptance of FGM/C and the lack of fear of persecution. There seemed to be a lack of knowledge among perpetrators of FGM/C of its negative effects. Thus, the neighbor in this case performed FGM/C assuming that the act would benefit the girl and facilitate her acceptance within the community, by, for example, making it socially acceptable to consume food that she prepared. This example underscores the importance of dispelling myths that FGM/C is desirable for social, health, or religious reasons.

Erbil

In the outskirts of Erbil, it seemed to interviewers that there were higher rates of illiteracy among mothers, more poverty, and the need for health clinics in remote areas. Field researchers also pointed out that in rural areas near Kirkuk, FGM/C was widely practiced; however, due to security reasons this study did not include Kirkuk. In certain areas FGM/C was not prevalent because it was not traditionally

practiced, as in the Barzan area. However, as people move to Barzan from areas where FGM/C is practiced, they have started to perform FGM/C.

Researchers recounted different stories of women who performed FGM/C, women who were confronted with FGM/C at a later age, and ways in which women resisted the practice of FGM/C. A story of resistance was told by a mother of five daughters who never cut her girls. She had undergone FGM/C herself and suffered from severe health and psychological effects that made her oppose FGM/C. Being aware of societal pressure, she kept this secret and did not inform anyone of the non-cutting of her girls. This ensured that her daughters were not exposed to the practice and kept them safe from being mutilated.

In a remote village in Erbil a mother was forced to perform FGM/C on herself while seven months pregnant. Her husband threatened her with divorce if she did not undergo FGM/C. So to please her husband and avoid divorce, the woman cut herself with a razor while in the bathroom. This case exemplifies the way in which FGM/C differs for each woman: While some women were able to avoid FGM/C, this woman found herself confronted with extreme pressure that she could not resist.

During another interview, as the field researcher talked about FGM/C, a 25-year-old woman from the household collapsed and had a seizure. Her mother explained that whenever the word FGM/C was mentioned her daughter suffered seizures because she had a traumatic experience when she was circumcised at an early age and might be suffering from post-traumatic stress disorder (PTSD). Another mother told a researcher that when she was little, her biological mother died and she was raised by a step-mother. The step-mother circumcised her three times because she was not satisfied with the outcome the first two times as not enough flesh had been removed.

In a remote village, researchers learned of a very unusual and disturbing practice. The flesh collected from multiple circumcisions was preserved and then used in a loofah given to infertile women to bathe with to help them conceive a child.

Sulaymaniyah (including Halabja)

In general, it was believed that FGM/C was practiced less in cities. But many people moved to the city from the villages and brought the tradition of FGM/C with them. In remote conservative areas on the outskirts of Sulaymaniyah governorate, the mothers often were not welcoming and not willing to provide information. Researchers found getting information from mothers difficult because they were not willing to share personal stories.

In rural areas, the male members of many families were very dominant and insisted on signing the consent form themselves rather than letting the women sign because the men did not trust the researchers. Also, the male family members often had a very negative view of international organizations and accused the interviewers of 'empowering' women. To avoid encounters with husbands and sons, the field researchers started visiting the homes in the mornings, when the male family members were away at work.

Conversely, in some households male family members felt comfortable with the interviewer and actually encouraged their wives to talk about their experience with FGM/C. In general, the mothers felt shy and embarrassed to talk about their personal FGM/C experiences, especially in relation to issues related to their sex life. Some husbands requested that future research be done about the ways in which men's sex lives are affected when their wives have undergone FGM/C.

In other cases, field researchers were asked if they knew of any midwives to cut their daughters. Some said that because of the law, midwives were not willing to practice FGM/C in fear of getting arrested and prosecuted.

APPENDIX E - ETHICAL STANDARDS, PROCEDURES AND PROCESSES

Given the sensitive nature of the data on reproductive health and FGM/C, it was of paramount importance to comply with ethical research standards. To protect the data as well as the anonymity of those involved, the data were kept confidential and anonymous. Procedures to ensure strict anonymity included the use of codes rather than names for identifying interviews and requiring all persons related to the research to agree to strict confidentiality rules and practices. The data were gathered based on the voluntary participation of the respondents. The data collection process, the survey proposal, and the questionnaire underwent a stringent ethical review, using the UN approach, to ensure that the study complied with academic and UN ethical research standards. Professor Victoria Fontan, Director, Center for Peace and Human Security and Interim Chair of the Department of Politics and Public Policy at American University Dohuk Kurdistan (AUDK), conducted the ethical review process on behalf of the Institutional Review Board of AUDK.

The main target-group for the study was girl aged 4 to 14 years. However, due to ethical, cognitive, and practical concerns related to their young ages, interviewing the study subjects directly was not possible. According to common guidelines for child protection and rights, children can only be approached for social research when a) there is no other way to gather relevant information from adults; b) when the benefits for children justify a potential harm (in this case e.g. emotional stress); and c) when an informed consent is given (Morrow & Richards 1996). For this survey, asking young girls about FGM/C could subject them to emotional stress that could pose a threat to their psychological and physical health. In particular, research shows that the experience of FGM/C can be connected to PTSD. Recalling these experiences could lead to a recurrence or compounding of the previously experienced trauma. These serious ethical concerns prohibited asking young girls about FGM/C. Additionally, girls' developmental stage and limited cognitive and emotional capacities to comprehend questions and formulate accurate answers, or to understand and give informed consent, were additional ethical and cognitive barriers. Since the information relevant to this study could be reliably obtained from the target populations' mothers without risking trauma to the girls, the mothers were interviewed.

The female interviewers worked in pairs when approaching households but conducted interviews separately to ensure the highest degree of anonymity possible and to create an atmosphere of privacy between interviewer and respondent. It was crucial to ensure that, to the utmost possible extent, interviews were conducted alone with the respondents inside the home. It was recommended not to conduct interviews in public places.

Informed Consent

A requirement for participation in the survey was respondents' informed consent. The respondents were informed about the obligation of interviewers to assure confidentiality and anonymity of the data gathered. Participation in the survey was absolutely voluntary. Considering the high illiteracy rate in the country, the interviewers could sign the consent form on behalf of the respondent if the respondent was illiterate. By this signature it was attested that the responding woman was adequately informed about the study and willing to answer questions.

APPENDIX F - DATA COLLECTION AND DATA PROCESSING

The data collection took place from August 2015 to September 2015, for seven weeks simultaneously in the four governorates. The data collection team consisted of two interviewers; for each governorate (except Halabja) 10 interviewer teams and two supervisors were assigned. A team including a study coordinator and project manager coordinated the fieldwork with only female interviewers conducting the interviews. Many of the interviewers had experience as interviewers in field research on the same or similar topics in Iraq.

A standardized structured questionnaire was applied to collect data via face-to-face interviews. The questions from the questionnaire were read to the respondents and the interviewers filled out the questionnaire data mask on the tablet. Informed consent was taken from the respondents before each interview. All participants in the study were provided with a form of consent, which was signed by the respondent or interviewer assuring the voluntary participation in the study, and the confidentiality and anonymity of the received data. For documentation of the data collection process, a data collection documentation sheet was filled out for all visits.

Eligibility criteria for the respondents were the affiliation to the target-group of the survey, namely to be a female in the age group 15 years or older and living in a household in one of the target regions. The fulfillment of eligibility criteria was checked in the process of data collection in the households and only eligible women participated in the study.

For training and data collection, a comprehensive interviewer manual was developed. The manual included background, explanations of the questionnaire, and the procedures of data-collection as well as quality assurance and data processing. Security and safety processes and procedures were also included.

Data were collected by applying a standardized, structured questionnaire on a tablet device. The interviewers and the supervisors were trained on the use of the tablets. The questions from the questionnaire were transferred to a data mask that was filled out on the tablet. The mask included filters for variables to minimize typing errors and other data entry mistakes. The questions were read to the respondents and the interviewers filled out the questionnaire. Informed consent was taken from the respondents before each interview. For documentation of the data-collection process, researchers completed a data collection sheet for all visits.

The completed questionnaire mask on the tablet was submitted to a data server and was automatically registered. The server was accessible only by the staff involved in data processing and analysis. For security and safety purposes, files on the server were encrypted with a confidential password.

Quality Assurance

Additional monitoring quality checklists for the supervisors and interviewers were included in the manual. After data collection, the project team crosschecked logical errors in the data files and corrected them.

Data Analysis

Statistical methods were applied to analyze the data and obtain the results, which were assessed on both the dataset as a whole as well as segregated by governorate and specified by urban/rural region. Data analysis was primarily descriptive; frequencies and/or means of FGM/C were calculated for each of the variables, separated on the level of the governorates as units and by urban/rural women.

The data were analyzed using SPSS software, based on an SPSS mask prepared prior to the data analyses that was transferred to tablets. To ensure the accuracy and quality of the data-entry procedure, data filters were installed in the SPSS mask that controlled equivalent answer formats and automatically detected mistakes and gave error messages. These filters automatically prevented many data entry mistakes. Based on the structure and coding scheme of the questionnaire, the SPSS mask codes questions using primarily numeric variables in nominal, ordinal, and interval scales. A small number of variables were coded as string variables (e.g. for use when survey questions ask respondents to specify 'other' answer options not provided in the questionnaire).

The qualitative analysis, specifically for reasons for FGM/C, was done based on Qualitative Content Analysis (Mayring, 2014; 2000). A systematic procedure of steps was applied to structure and summarize text units to categories; in a later step the qualitative categories were quantitatively analyzed.

APPENDIX G - STUDY INSTRUMENT

<p>CONSENT FORM</p>					
<p>Code:</p> <p>E=Erbil or S=Sulaymaniyah, D= Dohuk (e.g. 'E' for Erbil) H= Halabja</p> <p>Next 2 digits for interviewer number (e.g. 09 for number of interviewer)</p> <p>Next two digits for number of interview (e.g. 05 for the fifth interview conducted by this interviewer)</p> <p>Example:</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 33%;">E (Erbil)</td> <td style="width: 33%;">09</td> <td style="width: 33%;">05</td> </tr> </table>			E (Erbil)	09	05
E (Erbil)	09	05			
<p>Hello. My name is.....and I am working with Heartland Alliance International and UNICEF to improve the understanding of Female Cutting/Mutilation in the Iraq Kurdistan Region. We are therefore conducting a household survey and ask women about it. The results shall be later used to improve the information of the population. I would like to ask you about this subject and would appreciate your participation. We will not share any personal details with the Kurdistan Regional Government and no one will be prosecuted for any information you disclose in this survey.</p>					
<p>Your answers will be recorded anonymously and kept strictly confidential. No name or address will be collected so that you cannot be identified later. Your answers can only be accessed by research team members and will only be used for the purpose of this research. The survey usually takes 30 minutes to complete. Participation in this survey is voluntary and you can choose not to answer any question. You can withdraw your consent at any time.</p>					
<p>At this time, do you have any questions about the survey?</p>					
<p>1) Do you have daughters between 4 and 14 years of age? Yes/No (<i>Eligibility question</i>)</p> <p>Only continue questionnaire if 'YES'. If No, thanks respondent for the time and terminate interview.</p>					
<p>2) Have you ever heard about Female cutting/genital mutilation? Yes/No (<i>Eligibility question</i>)</p> <p>Only continue questionnaire if 'YES'. If No, thanks respondent for the time and terminate interview.</p>					
<p>3) Are you willing to participate in this survey? Yes/No</p> <p>Only continue questionnaire if 'YES'. If No, thanks respondent for the time and terminate interview.</p>					
<p>Please read the following to the responding women:</p> <p>I have understood the information and give my voluntary consent to participate in this research.</p>					
<p>Signature (of respondent)date.....</p>					

If women are illiterate, use the following:
Verification of the interviewer:
I certify that I have explained the above to the participant of the study and that she understood what I said and has agreed to take part in the study.
Signature:_____ Date:_____
Name of interviewer:_____

Questionnaire Identification sheet (S)												
The following section has to be filled out by the interviewer prior to the interview.												
Categories		Response										
S1	Name of governorate:	Erbil <input type="checkbox"/> Sulaymaniyah <input type="checkbox"/> Dohuk <input type="checkbox"/> Halabja <input type="checkbox"/>										
S1a	Code of questionnaire:	<table border="1" style="width: 100px; height: 20px; margin-bottom: 10px;"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> Code: E=Erbil or S=Sulaymaniyah, D=Dohuk, H=Halabja (e.g. 'E' for Erbil) Next 2 digits for interviewer number (e.g. 09 for number of interviewer) Next two digits for number of interview (e.g. 05 for the fifth interview conducted by this interviewer)										

S2	Cluster number:	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>																				
S3	Interviewer name:	_____ (Name)																				
S4	Date of interview:	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td colspan="3">Day</td> <td colspan="3">Month</td> <td colspan="4">Year</td> </tr> </table>											Day			Month			Year			
Day			Month			Year																
S5	Area:	Urban <input type="checkbox"/> Rural <input type="checkbox"/>																				
S6	Name of sub-district:	_____																				
S7	Name of neighbourhood/village:	_____																				
S8	In these rows you can add specific events or specific remarks related to the interview. Remarks: _____																					

FGM Questionnaire

Number	Questions	Answers
1.	What is your age in years?	Under 15 <input type="checkbox"/> 15 - 19 <input type="checkbox"/> 20 - 24 <input type="checkbox"/> 25 - 29 <input type="checkbox"/> 30 - 34 <input type="checkbox"/> 35 - 39 <input type="checkbox"/> 40 - 44 <input type="checkbox"/> 45 - 49 <input type="checkbox"/> 50 - 54 <input type="checkbox"/> 55 - 59 <input type="checkbox"/> 60 - 64 <input type="checkbox"/> 65 and above <input type="checkbox"/>
2.	What is your religion?	Islam - Sunni <input type="checkbox"/> Islam - Shi'i <input type="checkbox"/> Christian <input type="checkbox"/> Yezedi <input type="checkbox"/> Kakai <input type="checkbox"/> Shabak <input type="checkbox"/> Mandaean <input type="checkbox"/> Bahai <input type="checkbox"/> Other <input type="checkbox"/> Please specify: _____
3.	What is your ethnicity?	Kurd <input type="checkbox"/> Arab <input type="checkbox"/> Turkmen <input type="checkbox"/> Assyrian <input type="checkbox"/> Other <input type="checkbox"/> Please specify: _____
3 a.	Which dialect do you speak?	Sorani <input type="checkbox"/> Badini <input type="checkbox"/>
4.	What is your marital status?	Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>

		Single <input type="checkbox"/> (If never have been married, skip the next question about age of marriage and go to question 5.)
4a.	If you have ever been married, how old were you when you first got married?	_____ years
5.	What is your highest level of education?	None <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Institutional degree or certificate <input type="checkbox"/> Bachelors degree or higher <input type="checkbox"/>
6.	Does your household have:	Electricity <input type="checkbox"/> Radio <input type="checkbox"/> TV <input type="checkbox"/> Non-mobile telephone <input type="checkbox"/> Electric refrigerator <input type="checkbox"/> Satellite system (parabolic dish) <input type="checkbox"/> Internet <input type="checkbox"/> Shared grid (external generator) <input type="checkbox"/> Own power generator <input type="checkbox"/> Deep freezer <input type="checkbox"/> Split unit air conditioner <input type="checkbox"/> Air cooler <input type="checkbox"/> Cold Box (wood or asbestos) <input type="checkbox"/> (Multiple answers possible)
7.	Does any member of your household own:	Wrist watch <input type="checkbox"/> Mobile telephone <input type="checkbox"/> Bicycle <input type="checkbox"/> Motorcycle <input type="checkbox"/> Animal drawn cart <input type="checkbox"/> Car or truck <input type="checkbox"/> Computer <input type="checkbox"/>

	(Multiple answers possible)
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Now I will ask you some general questions about Female Cutting/Genital Mutilation.						
8.	What do you think, compared to the time of your childhood, is female cutting/mutilation now more or less common in your region?	Less common <input type="checkbox"/> The same <input type="checkbox"/> More common <input type="checkbox"/> I don't know <input type="checkbox"/>				
9.	What do you think are the general reasons for female cutting/mutilation in your community?	Religious beliefs <input type="checkbox"/> Traditional customs <input type="checkbox"/> Social pressure from family/relatives <input type="checkbox"/> Social pressure from community <input type="checkbox"/> No enforcement of law <input type="checkbox"/> Other <input type="checkbox"/> Please specify: _____ (Multiple answers possible)				
10.	I will read some statements that people have made about this practice for women, please tell me how much you agree or disagree with them.	Strongly agree	Agree	Disagree	Strongly disagree	Neither agree nor disagree
10a.	Female Cutting/Mutilation increases the chance of marriage.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10b.	Female cutting/mutilation is beneficial for the health of the women.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10c.	Female Cutting/Mutilation causes difficulties and complications in labor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10d.	Female Cutting/Mutilation is necessary for better female hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10e.	Female Cutting/Mutilation promotes fertility and increases chances of pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10f.	Female Cutting/Mutilation is against human rights.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10g.	Female Cutting/Mutilation prevents sex before and outside of marriage.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10h.	Female Cutting/Mutilation causes health and psychological problems for women.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10i.	Female Cutting/Mutilation ensures female purity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10j.	The food that an uncircumcised girl prepares is forbidden.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10k.	Uncircumcised women will be excluded from the community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10l.	Female Cutting/Mutilation is a religious requirement.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Who are the main supporters of Female Cutting/Mutilation in your community?	Mothers <input type="checkbox"/> Fathers <input type="checkbox"/> Grandmothers <input type="checkbox"/> Other relatives like aunts <input type="checkbox"/> Midwives <input type="checkbox"/> Doctors and nurses <input type="checkbox"/> Religious men <input type="checkbox"/> Tribe leaders <input type="checkbox"/> Other community leaders <input type="checkbox"/> Others <input type="checkbox"/> Please specify: _____ I don't know <input type="checkbox"/> (Multiple answers possible)				
12.	What do you think: should female cutting/mutilation be continued or NOT continued?	Continued <input type="checkbox"/> Not continued <input type="checkbox"/> No opinion <input type="checkbox"/>				
13.	Have you heard any message to stop female cutting/mutilation?	<input type="checkbox"/> Yes <input type="checkbox"/> No If 'No', skip the next question and go to question 14.				

13a.	<i>If yes: Where did you get this message?</i>	TV <input type="checkbox"/> Radio <input type="checkbox"/> Newspaper <input type="checkbox"/> Brochures/leaflets <input type="checkbox"/> Billboards/Posters <input type="checkbox"/> Family/Relatives <input type="checkbox"/> Friends/Neighbors <input type="checkbox"/> Religious leader <input type="checkbox"/> School teachers <input type="checkbox"/> Mobile units <input type="checkbox"/> Civil society organizations <input type="checkbox"/> Health or social workers <input type="checkbox"/> Midwives <input type="checkbox"/> Other <input type="checkbox"/> Please specify: _____ (Multiple answers possible)
14.	Would you like girls in Kurdistan to be taught about female cutting/mutilation and its harms?	Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> If No, skip the next question and go to question 15.
14a.	<i>If yes, who should do it?</i>	Families <input type="checkbox"/> School teachers <input type="checkbox"/> Social workers <input type="checkbox"/> Religious teachers <input type="checkbox"/> Health staff <input type="checkbox"/> NGOs <input type="checkbox"/> Midwives <input type="checkbox"/> Other <input type="checkbox"/> Please specify: _____ (Multiple answers possible)
15.	How many daughters aged 4-14 years do you have?	_____ (enter number)

16.	Did any of them undergo Female cutting/mutilation?	Yes <input type="checkbox"/> No <input type="checkbox"/> If 'no', go to question 26.
17.	If yes, how many of them have undergone female cutting/mutilation?	_____ (enter number)
18.	How old were your daughters when they were cut?	1) _____ (age in years) 2) _____ (age in years) 3) _____ (age in years) 4) _____ (age in years) 5) _____ (age in years) 6) _____ etc. List ages of all cut daughters.
19.	Why were your daughter/s cut?	Traditional custom <input type="checkbox"/> Religious requirement <input type="checkbox"/> Decision of my family <input type="checkbox"/> To increase chance of marriage <input type="checkbox"/> More cleanliness/ hygiene <input type="checkbox"/> To protect virginity <input type="checkbox"/> More sexual pleasure for the man <input type="checkbox"/> To ensure faithfulness <input type="checkbox"/> It is demanded by the community/ relatives. <input type="checkbox"/> I can't say <input type="checkbox"/> Other <input type="checkbox"/> Please specify _____ (Multiple answers possible)
20.	What kind of tool was used for performing the cutting on her?	Razorblade <input type="checkbox"/> Scalpel <input type="checkbox"/> Knife <input type="checkbox"/> Scissors <input type="checkbox"/> Other <input type="checkbox"/> Please specify _____

2 1 .	Who performed the cutting?	Midwife <input type="checkbox"/> Mother <input type="checkbox"/> Grandmother <input type="checkbox"/> Other female relative <input type="checkbox"/> Other male relative <input type="checkbox"/> Health staff <input type="checkbox"/> Other <input type="checkbox"/> Please specify _____
2 2 .	Where was the cutting on her carried out?	At her home <input type="checkbox"/> In a health facility like a hospital <input type="checkbox"/> At another place (shop, house of relative or circumciser) <input type="checkbox"/> Other <input type="checkbox"/> Please specify: _____
2 3	Did your daughter/s suffer from any complications, health or psychological problems due to the female cutting/mutilation?	Yes <input type="checkbox"/> No <input type="checkbox"/> Can't remember <input type="checkbox"/> If 'No' or 'Can't remember', go to question 28.
2 4 .	Which problems or complications did or does she suffer from? Let respondent list information and record answers on the list	Only tick if mentioned. Yes
24a.	Excessive bleeding	<input type="checkbox"/>
24b.	Failure or problems to heal	<input type="checkbox"/>
24c.	Infections (including e.g. HIV, Tetanus etc.)	<input type="checkbox"/>
24d.	Difficulties in and after delivery for mother	<input type="checkbox"/>
24e.	Danger for the baby in delivery	<input type="checkbox"/>
24f.	Difficulties with urination or incontinence	<input type="checkbox"/>
24g.	Reduced sexual desire	<input type="checkbox"/>
24h.	Less or no sexual pleasure during sexual intercourse	<input type="checkbox"/>

24i.	Reduced sexual satisfaction	<input type="checkbox"/>
24j.	Painful sexual intercourse	<input type="checkbox"/>
24k	Menstrual problems	<input type="checkbox"/>
24l.	Cysts or abscesses	<input type="checkbox"/>
24m.	Fistulae	<input type="checkbox"/>
24n.	Keloids	<input type="checkbox"/>
24o.	Psychological problems Please specify: _____	<input type="checkbox"/>
24p.	Other problems Please specify: _____	<input type="checkbox"/>
25.	If there were health complications, did you seek for medical assistance for her?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't want to say <input type="checkbox"/> If 'yes,' go to question 27 If 'no' or 'don't want to say', go to question 25a.
25a.	If 'NO' or 'don't want to say': Why did you not seek for medical assistance?	Too far/difficult to reach <input type="checkbox"/> Too expensive <input type="checkbox"/> Afraid because of the law <input type="checkbox"/> There are only male doctors available. <input type="checkbox"/> There was no need <input type="checkbox"/> Other <input type="checkbox"/> Please specify: _____ Multiple answers possible. Skip question 26 and go to question 27.
26.	Why were your daughters NOT cut?	Too young <input type="checkbox"/> Decision of family <input type="checkbox"/> Advice by health mobile teams <input type="checkbox"/> Advice by religious leader <input type="checkbox"/> My religion forbids it <input type="checkbox"/> Did not want to harm my daughter <input type="checkbox"/> I think there are harms on health <input type="checkbox"/> It is not part of our tradition <input type="checkbox"/> Other <input type="checkbox"/>

		Please specify: _____ (Multiple answers possible)
27.	Have you ever heard of medical, health or psychological problems that may be caused by Female Cutting/Mutilation?	Yes <input type="checkbox"/> No <input type="checkbox"/> If no, skip to Q29. If yes, ask them to list any problems and mark those mentioned...do not read list.
	Possible health problems	Heard about it
27a.	Excessive bleeding	<input type="checkbox"/>
27b.	Failure to heal	<input type="checkbox"/>
27c.	Infections (including e.g. HIV, Tetanus etc.)	<input type="checkbox"/>
27d.	Difficulties in and after delivery	<input type="checkbox"/>
27e.	Danger for the baby in delivery	<input type="checkbox"/>
27f.	Difficulties with urination or incontinence	<input type="checkbox"/>
27g.	Reduced sexual desire	<input type="checkbox"/>
27h.	Less or no sexual pleasure during sexual intercourse	<input type="checkbox"/>
27i.	Reduced sexual satisfaction	<input type="checkbox"/>
27j.	Painful sexual intercourse	<input type="checkbox"/>
27k.	Menstrual problems	<input type="checkbox"/>
27l.	Cysts or abscesses	<input type="checkbox"/>
27m.	Fistulae	<input type="checkbox"/>
27n.	Keloids	<input type="checkbox"/>
27o.	Other problems:	<input type="checkbox"/>

		Please specify: _____ _____
27p.	Psychological problems	<input type="checkbox"/> Please specify: _____ _____
28.	Were there different opinions whether to cut your daughter in your family?	Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know <input type="checkbox"/>
29.	Do YOU personally want your daughter/s to be cut?	Yes <input type="checkbox"/> If 'yes', go to Q29a. No <input type="checkbox"/> If 'no', go to Q29b. I don't want to answer <input type="checkbox"/>
29a.	If yes, what is your reason?	Please specify: _____ _____
29b.	If no, why not?	Please specify: _____ _____
30.	Whether your daughter is cut or not, who was encouraging you to cut your daughters?	Nobody <input type="checkbox"/> Husband <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Mother-in-law <input type="checkbox"/> Grandmother <input type="checkbox"/> Aunt or other female relative <input type="checkbox"/> Religious men <input type="checkbox"/> Tribe leader <input type="checkbox"/> Community <input type="checkbox"/> Relatives <input type="checkbox"/> Midwives <input type="checkbox"/> Other please specify: _____ I don't know <input type="checkbox"/> (Multiple answers possible)

31.	Did you yourself undergo Female circumcision?	Yes <input type="checkbox"/> No <input type="checkbox"/> If no, go to question 35.
32.	At what age?	_____years
33.	Did you personally experience problems related to the circumcision?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> If 'no', skip to question 35.
34.	Which problems or complications did or do you suffer from? Ask them to list any problems and mark those mentioned...do not read list.	Only tick if 'YES'. Yes
34a.	Excessive bleeding	<input type="checkbox"/>
34b.	Failure or problems to heal	<input type="checkbox"/>
34c.	Infections (including e.g. HIV, Tetanus etc.)	<input type="checkbox"/>
34d.	Difficulties in and after delivery	<input type="checkbox"/>
34e.	Danger for the baby in delivery	<input type="checkbox"/>
34f.	Difficulties with urination or incontinence	<input type="checkbox"/>
34g.	Reduced sexual desire	<input type="checkbox"/>
34h.	Less or no sexual pleasure during sexual intercourse	<input type="checkbox"/>
34i.	Reduced sexual satisfaction	<input type="checkbox"/>
34j.	Painful sexual intercourse	<input type="checkbox"/>
34k.	Menstrual problems	<input type="checkbox"/>
34l.	Cysts or abscesses	<input type="checkbox"/>
34m.	Fistulae	<input type="checkbox"/>
34n.	Keloids	<input type="checkbox"/>
34o.	Psychological problems	<input type="checkbox"/> Please _____ specify: _____ _____
34p.	Other problems	<input type="checkbox"/>

		Please specify: _____ _____
35.	Have other women in your wider family undergone circumcision?	Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know <input type="checkbox"/> If 'yes', go to question 35a./ If 'no' or 'don't know', go to question 36.
35a.	If yes, who?	My mother/aunt <input type="checkbox"/> My sister/my female cousin <input type="checkbox"/> Other <input type="checkbox"/> Please specify: _____
36.	Have your neighbor's daughters undergone circumcision?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>
37.	Do you plan to cut any other of your daughters?	Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure. <input type="checkbox"/> All of them are cut. <input type="checkbox"/>
38.	Have you ever heard about the law against domestic violence that prohibits female genital cutting?	Yes <input type="checkbox"/> No <input type="checkbox"/> If 'no', skip to question 42.
39.	From where did you hear about this law against domestic violence?	TV <input type="checkbox"/> Radio <input type="checkbox"/> Newspaper <input type="checkbox"/> Brochures/leaflets <input type="checkbox"/> Billboards/Posters <input type="checkbox"/> Family/Relatives <input type="checkbox"/> Friends/Neighbors <input type="checkbox"/> Religious leader <input type="checkbox"/> School teachers <input type="checkbox"/> Mobile units <input type="checkbox"/> Civil society organizations <input type="checkbox"/> Health or social workers <input type="checkbox"/> Midwives <input type="checkbox"/> Other <input type="checkbox"/>

		Please specify: _____ (Multiple answers possible)
40.	Do you think that <i>most</i> people in your governorate adhere to this law?	Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know. <input type="checkbox"/> If 'no', or 'don't know' to question 40a. If 'yes', go to question 41.
40a.	If NO or Don't know, why does not everybody adhere to this law?	Very strong religious beliefs <input type="checkbox"/> Don't fear prosecution <input type="checkbox"/> Too strong tradition <input type="checkbox"/> Strong demand by family <input type="checkbox"/> Will of mothers <input type="checkbox"/> There are no consequences - law is not enforced. <input type="checkbox"/> Other <input type="checkbox"/> Please _____ specify: (Multiple answers possible)
41.	What do you think could be done to support the law?	Information campaigns from government <input type="checkbox"/> Education activities by civil society organizations <input type="checkbox"/> Enforcement by government <input type="checkbox"/> Support from religious leaders <input type="checkbox"/> Support from tribe leaders <input type="checkbox"/> Education in schools <input type="checkbox"/> Other <input type="checkbox"/> Please _____ specify: (Multiple answers possible)
42.	Is there anything else you would like us to know or any comment? _____	

Thank you for your help and participation in this survey!	