LONG-TERM EVALUATION OF THE TOSTAN PROGRAMME IN SENEGAL: KOLDA, THIÈS AND FATICK REGIONS

Working Paper

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Contents

Foreword

Programming for protection and development should engage populations as actors in their own development. UNICEF's approach to child protection - building a protective environment for children - recognizes the importance of the capacities of children and their caregivers, as well as the significance of open dialogue to promote change within communities. Evaluating such approaches, including a hard look at quantitative outcomes, has often proved challenging.

Tostan is a non-governmental organization set up in Senegal in 1991 to encourage social change based on capacity building at the community level. In 1998-1999, Tostan started a capacity-building programme in the regions of Thiès, Fatick and Kolda. UNICEF requested an evaluation to assess the long-term impact of this programme, and this was conducted by the Centre for Research in Human Development and the Population Council in Dakar, under the direction of Macro International Inc.

The main objective of the evaluation was to assess the impact of the Tostan programme on the prevalence rate of female genital cutting among girls, their age at first marriage, and improvements to the health status of mothers and children. In its qualitative component, the evaluation aimed to examine Tostan's establishment process in the villages, to understand how villages organized their participation in the public declarations, and to learn women's opinions about the impact of the programme. This report presents the broad outline and most salient conclusions of the evaluation. We hope it will give policy makers and programme managers insights into community dynamics and contribute to the debate on mechanisms to promote social change.

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Acknowledgements

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Our deep appreciation goes to both research teams, which spared no effort to collect this data and complete the coding and analysis. We also wish to thank the staff in the field: drivers, surveyors, team leaders and supervisors, whose professionalism, dedication and resilience were decisive factors in this survey's success, together with the administrative staff of the CRHD and the Population Council for their effectiveness.

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[1] This report was written by Paul Stanley Yoder, Macro International Inc., based on the analyses and texts prepared by Salif Ndiaye (Centre for Research in Human Development, Dakar) and Nafissatou Diop (Population Council, Dakar). UNICEF accepts no responsibility for errors included in the report. The original text has been revised and translated into English. The editing process has been coordinated by Claudia Cappa (Statistics and Monitoring Section, UNICEF, New York) and the final document has been approved by MACRO International Inc. The Statistics and Monitoring Section wishes to thank Marc Chalamet (Division of Communication, UNICEF, New York) for the support provided with the translation of this document.

List of tables and graphs

List of abbreviations and acronyms

ARIs	Acute Respiratory Infections
BCG	Bacille Calmette-Guérin (Anti-tuberculosis vaccine)
CRHD	Centre for Research in Human Development
DHS	Demographic and Health Survey
DTP	Diphtheria-Tetanus-Pertussis
EIT	Evaluation of the Impact of Tostan's programmes in Senegal
NGO	Non-Governmental Organization
OR	Oral Rehydration
ORS	Oral Rehydration Salt
ORT	Oral Rehydration Therapy
PD	Public Declaration
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

Summary

Quantitative component

The quantitative component of the long-term evaluation of the Tostan programme was conducted in 2006 by the Center for Research in Human Development (CRHD) in the rural areas of the Kolda, Thiès and Fatick regions. The qualitative assessment of the Tostan programme was conducted by the Population Council staff in Dakar. In conducting the quantitative component, the CRHD utilized the technical assistance of Macro International Inc. through the international Demographic and Health Survey (DHS) programme.

Appropriate guidelines for evaluating the impact of the Tostan programme were defined in agreement with the various stakeholders. Evaluations focused on the levels and trends of early marriage and the practice of female circumcision; knowledge and behavior patterns in the area of health; knowledge of Tostan and its programme; participation in a public declaration; and participation by community members in a Tostan programme and an assessment of the benefits derived from it.

Following are the main topics covered in the quantitative component of the study.

a) Background and methodology

The survey focused on a sample of women who ranged in age from 15 to 49. They come from 53 rural villages in the regions of Fatick, Kolda and Thiès, where circumcisions have been common practice. Public declarations were made in these communities in 2000 or earlier. The villages were split into three categories:

- **Group A villages** benefited from a Tostan programme before 2000 and publicly declared that they would abandon the practice of circumcision.
- **Group B villages** were associated with a public declaration before 2000 but did not directly benefit from the Tostan programme. The survey team could not find group B villages in the regions of Thiès and Fatick, and subsequently selected villages in the region of Kolda, where circumcisions were being performed.
- **Group C villages** are the “control villages”. This group includes villages which perform circumcision but have not been directly or indirectly exposed to the Tostan programme.

A total of 600 households (200 in each village category) and about 900 women aged 15

to 49 were covered by the study.

In the Fatick and Kolda regions, about 85 per cent of women are rural. By contrast, 47 per cent of women in the Thiès region are urban. Almost half of the women in Thiès (47 per cent) have attended school, while female illiteracy is widespread in the other two regions: 68 per cent of Fatick women and 78 per cent of Kolda women never attended school. The three regions also have a very different ethnic make-up: in Fatick, 61 per cent of the population are Serers and 25 per cent Wolofs; in Kolda (not including the Department of Sédhiou), 61 per cent are Poulars and 18 per cent Mandingues; lastly, in Thiès, 49 per cent are Wolofs, and Serers account for 27 per cent.

b) Knowledge of Tostan and of its programme

Women who are considered to know the Tostan programme are those who declared that they knew it or heard about it. The level of knowledge about the Tostan programme is highest in group B villages (92 per cent). However, group A comes a strong second (82 per cent), while residents of group C villages have the lowest knowledge of the programme (40 per cent).

In group A villages, the most widespread way of transmitting information is learning "through someone living in the same village," representing 39 per cent of all cases. Other main sources of information noted by residents of group A villages are radio (cited by 25 per cent of villagers) and the presence of a Tostan officer (26 per cent). Television and other ways of transmitting information have a very low representation rate in all villages.

c) Maternal and child health

Indicators of Tostan's impact on maternal and child health include the number of prenatal visits, place of delivery, vaccine coverage of the children, and the prevalence and the treatment of diarrhoea and of acute respiratory infections.

With respect to prenatal visits, group A villages do not stand out as a role model. We also observe that the percentage of women who gave birth at home (61 per cent) in group A villages is higher than in control villages (50 per cent). The percentage of immunized children is above 95 per cent in all types of villages for most vaccinations. Overall, the proportion of 12- to 23-months-old children who had all their shots ranged from 70 per cent in group A villages, to 58 per cent in group B, to 76 per cent in group C villages.

Ultimately, the quantitative analysis did not find that the programme had an impact on

the health of women and children, since immunization rates and the use of health and other public services are no better in the villages where the programme was based. The intervention may have once been effective in improving the health situation in this region, but its impact may have faded after a few years, or social conditions and the condition of the services were just not conducive to effecting measurable long-term changes.

d) Nuptiality

Early marriage is most prevalent in group B villages, where 35 per cent of women were married before the age of 15, versus 20 per cent in group A villages. This partly reflects the different ethnic customs of the communities: most group B villages (Kolda region) are inhabited by Poulars, known for their early marriage practice, and among whom nearly all women are married before age 20.

Most marriages (54 per cent in A and B villages, and 58 per cent in C villages) occur in the 15-to-19 age group regardless of the village type. Almost no marriages occur after the age of 20 in group B villages, while in the other two groups the percentage of first-married women over age 20 reaches or exceeds 12 per cent.

Statistics reveal that the proportion of girls married before the age of 15 has decreased over the last 10 to 15 years in all three village types. The most significant declines were observed in the intervention villages (group A) for girls aged 10- to 14- years: 23 per cent of girls were married before the age of 15 in the period 10- to14- years before the survey, 16 per cent in the period 5- to 9- years before the survey and 12 per cent in the period 0- to 4- years before the survey. In the control villages, marriages of girls under age 15 fell from 18 per cent to 13 per cent in the last 10 to 15 years. A comparison of group A and group C villages following intervention reveals that public declarations and Tostan programmes may have combined to slightly lower the prevalence rate of marriages under age 15. However, when one examines the overall marriage rate for girls under 18, the difference between the group A villages and the control villages disappears.

e) Knowledge and practice of female circumcision

The proportion of women who know about circumcision is higher in group C villages (99 per cent) in all age groups. Women in group A and group B villages have roughly the same level of awareness about circumcision, with 90 per cent and 92 per cent of women, respectively,

professing knowledge. The proportion of women who underwent circumcision is lowest in group A villages (64 per cent), followed by group B (81 per cent) and group C villages (87 per cent). The starting point for assessing changes in the rate of circumcision was therefore lower in Tostan intervention villages (group A).

A lower percentage of women in group A (30 per cent) than in group C villages (69 per cent) declared that at least one of their daughters underwent the procedure. Among women whose daughters did not undergo the procedure, three times as many mothers in group A than in group C villages declared that they did not intend to have it done.

Statistical results on circumcision performed on girls reveal that its prevalence has decreased in Tostan intervention villages and in villages that took part in a public declaration (groups A and B). For the 0-to-9 age group, 15 per cent of girls underwent circumcision in group A villages, versus 8 per cent in group B villages and 47 per cent in group C villages. We clearly see a result of participation in a public declaration in the seven Kolda villages (group B) even without the Tostan programme. In conclusion, circumcision still exists in all villages, but its frequency has strongly decreased in intervention villages. By contrast, in control villages, practices and opinions remain favorable to circumcision.

Qualitative component

In 1998-1999, Tostan initiated a capacity-building programme in the villages of Thiès/Fatick and Kolda. During that period, the Tostan programme focused on teaching the following modules: problem resolution; basic hygiene; oral rehydration and vaccination; material and financial management; leadership; feasibility study (economic projects, micro-credit); women's health (including sexuality, child-bearing, and rights); children's development; democracy; and sustainable management of natural resources. The outcome of the programme was to mobilize communities and have them publicly declare that they were giving up harmful practices.

The qualitative evaluation methodology is based on conversations conducted and observations made in two categories of villages: group A villages, which both applied the Tostan programme and participated in a Public Declaration (PD) to abandon circumcision, and group B villages, which only took part in a public declaration without having previously benefited from the programme; group C villages (control villages) were not visited by the qualitative component. Interviews were conducted in 12 villages. It turned out that only two group B villages could

eventually be considered, as all others had been subjected to the programme at a later stage.

In total, 150 individual interviews were conducted with the following groups: women who had participated in the programme, women from either type of village who had not participated, facilitators who ensured programme implementation, and leaders and other focal points of these localities. It should be noted that collecting evidence from leaders, whether men or women, about perceptions and outcomes of the programme can elicit responses that are biased on the positive side.

The establishment of the programme in the villages followed several participatory stages: preliminary discussion, the identification and choice of participants, and the development of the programme. In the process of selecting villages, Tostan would set a certain number of conditions including the village's commitment to take care of the facilitator, establishing lists of beneficiaries, and building a shelter for use by the class. Some informants also emphasized that the abandonment of circumcision should be set as a prerequisite. Overall, these communities significantly contributed to the establishment and the implementation of the programme in the villages.

Subsequent to the education programme, various changes occurred in the villages. Results show that the programme contributed to the improvement of knowledge, both among participating women and women who did not take part in the programme. The women emerged with greater knowledge of their rights and duties, especially regarding the place and role of women in their communities.

The organization of public declarations evolved considerably over time, even between 1996 and 2000. The information collected shows that the strategy was initially suggested by Tostan, then implemented by the women of the Malicounda class. An evolution is evident at the third declaration, which took place at Médina Chérif. The increased involvement of several parties within the community led to the organization of the PD and mobilization for the abandonment of circumcision in this village. Ultimately, the implementation of the measures announced during the PD required contributions from various social groups of the villages. Data analysis points to a collective dedication marked by a determination by communities to meet their commitments, with the involvement of leaders, committees and especially women, which would determine the scope of the declaration. However, the general population of group B villages was not really involved in the PD. A few people from these villages heard about a celebratory event that was going to take place in a neighboring village. Some people from these

villages decided to go and while at this event, they received information on the PD for the abandonment of circumcision.

In villages where the programme was applied in its entirety, there was better awareness of the risks involved in circumcision, but less knowledge about the risks arising from early marriage. This translated into a mobilization of the population around a PD to give up these practices – which was perceived as the culmination of the implementation process of the Tostan programme. The data collected reveal that communities have been abandoning the practice of circumcision since the advent of the PD. However, some accounts show that there is still some resistance in the villages. Interviews revealed that early marriage is declining, but influences on this phenomenon cannot be exclusively attributed to Tostan.

Some important constraints are limiting communities in their will to capitalize on the assets provided by this programme. The formation of social groups in the villages took place before the development of the programme. The PD seems to have contributed to the strengthening of these committees as far as monitoring the measures taken and the decisions made during these declarations. However, with the passage of several years, these groups/committees have all but vanished. The lack of organized follow-up and the absence of basic infrastructures in the villages limit the full use of the new capacities that populations now have.

1 Introduction

1.1 Objectives of the report

This report presents the methodology and results of an evaluation aimed at assessing the long-term impact of the Tostan programme in the Kolda, Thiès and Fatick regions of Senegal. The survey was conducted in 2006 for UNICEF's New York office under the leadership of Macro International Inc. For the implementation of this survey, the Senegal Ministry of Women, the Family and Social Development, which sponsored the research, set up a steering committee in charge of monitoring and supporting the technical team.

This evaluation is the result of a collaborative joint effort between several institutions: UNICEF, Macro International Inc., the Population Council, the Center for Research in Human Development (CRHD) and Tostan. With funding from UNICEF, Macro International Inc. conducted this evaluation with the assistance of the Population Council and CRHD. USAID, the second financial partner, provided the human resources support required for this evaluation through the Frontiers Programme of Reproductive Health implemented by the Population Council.

This study has two components, a quantitative and a qualitative one, conducted respectively by CRHD and the Population Council office in Dakar. In the implementation of the quantitative component, the CRHD received technical assistance from Macro International Inc., through the Demographic and Health Survey (DHS) programme. In the implementation of the qualitative component, the Population Council office in Dakar received technical assistance from Macro International Inc. to train the surveyors and prepare the conversation handbooks used during data collection.

The main objective of the study's quantitative component is to see whether it can be statistically established that the Tostan programme has had an impact on the prevalence rate of circumcision among girls and on their age at their first marriage, and to assess whether the health status of mothers and children has improved. The main objective of the study's qualitative component is to examine Tostan's establishment process in the villages, to understand how villages organized their participation in public declarations, and to learn what women have to say about the impact of the Tostan programme. This report presents the broad outline and most salient conclusions of the study's two components.

1.2 Tostan and its programme

Tostan is a non-governmental organization created in February 1991 to encourage social change based on capacity building, in which the beneficiary of the programme becomes the main agent of change. The Tostan approach is centered around an education programme geared at a group of people in a village, as well as a community mobilization programme. Tostan primarily targets women and, through their strong involvement in the learning process, seeks the adoption of healthy behavioral patterns.

During 1998 and 1999, Tostan had initiated a village capacity-building programme in the Thiès, Fatick and Kolda regions. At the time, the Tostan programme hinged on the teaching of more detailed modules: the problem resolution process, basic hygiene, oral rehydration and immunization, material and financial management, leadership, feasibility study (economic projects, micro-credit), women's health (sexuality, pregnancy, rights, etc.), children's development, democracy, and sustainable management of natural resources.

Tostan's modules have evolved considerably since the beginning of the programme in accordance with the needs and requests of the participants. The organization has conceived a programme of informal basic education which aims to provide populations, especially in rural areas, with skills and knowledge (factual and behavioral) that will enable them to be the actors in their own development. Since 2000, its capacity-building programme has been mainly composed of four basic modules:

- Human rights and responsibilities
- The problem resolution process
- Basic hygiene
- Personal health

Women are the main beneficiaries of this programme, but men also participate now. The skills acquired by the beneficiaries of both sexes at the module level – especially in the "human rights and responsibilities" module – have enabled populations to develop greater awareness of their multiple problems, mostly in the health area. These problems are identified by the populations themselves during training on the theme of personal health. Emphasis is placed on certain traditional practices that are detrimental to health, especially to women's health, such as early marriage, frequent pregnancies, and circumcision. The development of the education programme only accounts for one aspect of the Tostan approach, comprising the knowledge

and awareness-building stage. The culmination of this process is community mobilization during a public declaration (PD), where villagers collectively commit to giving up all forms of harmful practices.

Since 1996, Tostan has made it possible to organize PDs, which it conceives as a means to get populations to publicly announce that they are giving up traditional practices such as circumcision and early marriage. Almost all villages that benefited from the programme have made a declaration expressing their desire to give up these practices. The social mobilization also reaches neighboring villages which have not taken part in the full Tostan programme but are participating in the public declaration.

Before, during and after the training, the beneficiaries generally implement various activities that they perform on their own initiative or with Tostan's support. These activities pertain to their socio-economic development, and they are instrumental to the exploitation, rationalization, consolidation and sustainability of the knowledge provided by their training. These initiatives range from revenue-generating activities, to public declarations for the abandonment of circumcision, basic health and hygiene activities in their communities, and participation in the various health and hygiene campaigns.

1.3 The challenges of evaluating the impact of a social programme

We live in an era when social change projects, whether private or government-run, have to show a certain level of cost-effectiveness. The evaluation of a programme's impact should serve as a justification for the outlay of intervention funds, but also as a set of instructions for future programmes of a similar nature. Those who are leading the evaluation process typically conduct a survey in the target population before and after the intervention to identify the programme's outcomes. The discrepancies between appropriately chosen outcomes in both surveys can therefore be attributed to the intervention.

A second method, although more complex, is also possible: a single cross-cutting survey in intervention and non-intervention villages. This is the approach we adopted in the study, making a distinction between the villages that went through the Tostan programme and those that did not.

To demonstrate in statistical terms that Tostan's activities have had an impact on the

age of marriage and on the rates of girls' circumcision, the following have to be established or described:

1) the prevalence of circumcision and girls' marriage age in intervention villages;

2) the prevalence of circumcision and girls' marriage age in control villages ("control" villages);

3) in both groups of villages: the long-ranging trends of circumcision rates and marriage age, to predict what the situation would have been without Tostan.

However, it is not easy to set up indicators or to measure them in a population, especially for a programme as diversified as Tostan's, whose effect would be felt in the smallest details of daily life. The effect of such a programme varies from one village to the next according to social dynamics, the courses chosen and the commitment of village leaders. Although Tostan's advertising mostly focuses on circumcision and also the marriage age of girls, the themes of the programme are not limited to those two elements.

The quantitative component will therefore present data on the rate of circumcision and the age of girls on their first marriage; data on the use of health services by women and children and on the treatment of children's diseases will also be taken into consideration. However, some of the possible impacts of the programme (more participation in community life, better management of social problems, the establishment of village committees) cannot be identified through a mere questionnaire. It is the qualitative component that will present women's accounts of their participation in programme activities and of the changes that occurred in their daily lives as a result of the Tostan programme. The qualitative component will also tell the story of the setup of Tostan in the villages and the organization of public declarations.

2 Objectives and background of the study

2.1 Objectives of the survey

2.1.1 General objectives

Several evaluations have been made to assess the impact of the intervention (Tostan's actions) on its beneficiaries (participating women) in the various villages. However, there are no evaluations, particularly at the community level, that assess the impact of the long-term programme and participation in public declarations (PDs) on early marriage and the practice of circumcision.

UNICEF, one of the agencies supporting Tostan, wants the approach developed by Tostan to reduce and even get rid of early marriage, frequent pregnancies and the practice of circumcision. To refine this strategy, UNICEF Headquarters envisaged collecting relevant data on the way the programme works and on its impact through PDs and the interventions targeting men and women.

Two main objectives are being pursued:

- To evaluate the impact of the Tostan programme, through specific indicators, on daily life in villages and the impact that it has on the rates of early marriage and circumcision;
- To evaluate the impact of village participation in public declarations on early marriage and circumcision.

2.1.2 Specific objectives: quantitative component

The specific objectives of this survey are to measure some relevant indicators in order to assess the impact of Tostan's interventions in the rural zones concerned. In particular, the following topics are addressed:

- knowledge of Tostan and of its programme;
- participation in a programme and the benefits derived from this participation;
- knowledge and practices relating to reproductive health and hygiene in the village;

- participation in a PD;
- early marriage (level and trends);
- practice of circumcision (level and trends);
- evaluation of the continuation of circumcision at the village level after the PD.

In principle, the quantitative component will provide statistical tables from responses to a questionnaire by a sample of women 15- to 49-years-old in villages where Tostan has conducted its activities, and in control villages where Tostan was never present. For some of the indicators, statistical data from the two types of villages can be compared to find out whether Tostan's action had an impact on the situation.

2.1.3 Specific objectives: qualitative component

Objectives for the qualitative component of the Tostan programme included:

- describing the process of establishing Tostan in the villages;
- assessing whether the intervention led to the establishment of social groups set up for the welfare of the community;
- describing the composition of these groups, the tasks that they are vested with and the recent activities that they organized for the welfare of the community;
- identifying the individuals who play a leading role in the village or who specialize in circumcision or marriage;
- understanding the perspective of village leaders on the effects of the Tostan programme in their respective villages.

Regarding public declarations, the objectives are:

- to identify individuals in the village who participated in the organization of the PD;
- to clarify the manner in which the participation of the villagers was organized for the PD;
- to describe the nature of discussions with and reports to village communities after the PD.

The qualitative component includes memoranda, accounts and descriptions of what happened in the field when Tostan introduced itself in the villages and their leaders got together to make a PD, the experiences and the benefits that women shared in the programme, and the opinions expressed on the practices of early marriage and circumcision.

2.2 Launch of the study

Since at least 1992, Tostan has taken action in many Senegalese villages that practice circumcision. To assess the impact of Tostan's action on circumcision or on the age of marriage, a survey had to be conducted in Tostan villages five or six years after the programme was implemented, a sufficient time for a change to have occurred in the practice of circumcision. We therefore conducted a survey in a series of villages where Tostan had operated between 1996 and 2000. Furthermore, some villages have publicly declared that they have abandoned circumcision without Tostan's input; the survey therefore also had to be conducted in those villages to assess the impact of participation in a PD organized between 1996 and 2000.

At a meeting held in Dakar in August 2005, representatives of all evaluation planning partners (UNICEF New York, UNICEF Dakar, Population Council Dakar, CRHD, Macro International Inc., Tostan) decided to base the evaluation on a comparison between three types of villages: those that took part in the Tostan programme and followed it up with a PD (group A); those that made a PD without taking part in the Tostan programme (group B), and control villages, where Tostan has never operated and which did not make a PD (group C). The intervention villages for this period of Tostan's action are mainly located in the Thiès and Kolda regions. It was believed that some control villages could also be found in Thiès.

As for control villages (group C), they had to be found not too far from the villages of the other categories, and still practice circumcision. We found no such villages in the Thiès region, so we had to look in the neighboring region of Fatick. The quantitative component therefore conducted its survey in the following three regions: Kolda, Thiès and Fatick.

2.3 Background: women's characteristics in the three regions

In this section, we will briefly present the main features of rural women in all three regions in accordance with the results of the latest DHS conducted in 2005 (DHS-IV). These

three regions have very different ethnic make-ups: in Fatick, 61 per cent are Serers and 25 per cent are Wolofs; in Kolda (not counting the Sédhiou Department), 61 per cent are Poulars and 18 per cent Mandingues; lastly, in Thiès, 49 per cent are Wolofs and 27 per cent are Serers.

Fatick and Kolda are essentially rural (83-85 per cent of women are rural), and the two regions are characterized by very high female illiteracy rates (68 per cent of Fatick women and 78 per cent of Kolda women have never attended school). In contrast, in the Thiès region, practically every other woman is urban (47 per cent) and 54 per cent are illiterate.

A common feature of these three regions is that circumcision is restricted to several ethnic groups: while it is practically non-existent among Wolofs (1.6 per cent) and Serers (1.8 per cent), almost three-quarters of all Mandingue women have undergone circumcision (74 per cent), as have 78 per cent of Soninké women. Among Poular women, 62 per cent have undergone circumcision, as have 60 per cent of Diola women. Ethnic differences partly explain regional discrepancies in Senegal. In Kolda, where 79 per cent of the population are Poular and Mandingue, 94 per cent of women have undergone circumcision, whereas circumcision rates in Thiès (7 per cent) and Fatick (6 per cent) are very low.

2.4 Background: marriage in the three regions

In Senegal, marriage is the haven of sexual activity and procreation. In this country where 95 per cent of the population are of the Muslim faith, marriage is universal and being permanently single is a rare phenomenon. For the purposes of this survey, the term “union” applies to all men and women who have declared that they are married or share a marital relationship with a partner.

The entry into union still occurs at an early age: in 2005, 46 per cent of women aged 20-49 were already in union by age 18. In 1997, 50 per cent of women aged 20-49 were already in union by age 18. The median age at the first union has increased over the last 25 years, especially in urban areas. Among women living in rural areas, the median age at first union was 16.6 among women aged 45-49, and 17.6 among women aged 20-24, which corresponds to an increase of one year. In urban areas, the median age at first union was 18.1 among women aged 45-49, and 21.7 among women aged 25-29. This suggests that social change occurred more slowly in rural areas – where there was a one-year increase of the median age in 25 years – than in urban areas, which saw an increase of almost four years (3.6) in twenty years.

There are wide regional variations in marital age in Senegal. At one extreme is Dakar and Thiès, with a median age of 20.8 and 19.1 respectively for women aged 25-49. At the other extreme are the regions where the transition to marital life occurs at the earliest age: Tambacounda (15.9), Kolda (16.4), Louga and Matam (16.5). Similarly, the median age at the first union – which is our starting point for early marriage – varies from one region to the other, from 19.1 in Thiès, to 17.8 in Fatick and 16.4 in Kolda.

2.5 Background: the practice of female circumcision in the three regions

The practice of female circumcision is widespread in Senegal, where 28 per cent of women aged 15 to 49 have undergone the procedure. The likelihood that a woman will be circumcised is largely determined by her ethnic background. Among Wolofs and Serers, two of the main ethnic groups, the percentage of women who are circumcised is under 2 per cent. Among the Soninkés, Mandingues, Poulars and Diolas, the proportion of women who are circumcised varies from 60 to 78 per cent. Circumcision rates in the three regions of the survey can be explained by the ethnic fabric of the population. In Kolda, where 79 per cent of the population are Poulars and Mandingues, the rate is 94 per cent; in Thiès, with 79 per cent Wolofs and Serers, it is 7 per cent; in Fatick, where Wolofs and Serers account for 86 per cent of the population, the rate is 6 per cent.

2.6 The strategy of the evaluation

The quantitative component is based on a comparison of the data collected in the three groups of villages that were defined by their degree of involvement in the Tostan programme or in public declarations. When assessing the impact of Tostan alone, group A villages are compared with group B and group C villages. When the impact of public declarations is being measured, group A and B villages are compared with group C villages. Actions addressing women's and children's health, together with the treatment of childhood diseases, only occured in group A villages, while group A and group B villages are supposed to have brought down their circumcision rates and enabled girls to remain unmarried longer thanks to Tostan's intervention, or a public declaration, or both.

3 Methodology

3.1 Quantitative component

3.1.1 The scope of the study

The survey focused on a sample of women between the ages of 15- and 49-years-old. They reside in 53 rural villages where Tostan intervened and in which public declarations took place in 2000 or earlier:

- Thiès region: Departments of Thiès and Mbour;
- Fatick region: Departments of Fatick and Foundiougne;
- Kolda region: Departments of Kolda and Vélingara.

For the purposes of this study, the villages were split into three categories (Table 3.1):

- **Group A villages**: These are villages that benefited from a Tostan programme before 2000 and publicly declared that they were abandoning circumcision.
- **Group B villages**: These are villages that were brought into the public declaration process before 2000 without direct involvement from the Tostan programme. The team in charge of the survey was not able to find group B villages in the regions of Thiès and Fatick. They were only found in the Kolda region.
- **Group C villages:** These are the "control villages." These villages practice circumcision and have not been directly or indirectly exposed to the Tostan influence, and did not hold public declarations. The team in charge of the survey was not able to find group C villages in the districts of Thiès and Mbour, so these villages were found in the neighboring department of Fatick.

As Table 3.1 shows, the survey was conducted in:

- 21 **group A** villages;
- 7 **group B** villages;
- 25 **group C** villages.

Table 3.1: Distribution of the villages surveyed by type and by region, EIT Senegal 2006.

	Village type			
Region	A	B	C	Total
Thiès	6	0	0	6
Fatick	5	0	8	13
Kolda	10	7	17	34
Overall	21	7	25	53

We note that group B villages have very little representation in the sample (7 out of a total of 53 villages surveyed) and are only located in the Kolda region.

3.1.2 Household sampling and count

The survey focused on a sample of women aged 15 to 49 in the rural zones that practiced circumcision. In the Thiès region, with a regional circumcision rate of only 7 per cent, very few villages that practice circumcision can be found; in the Kolda region, with a 94 per cent rate, almost all villages practice circumcision. In total, 600 households (200 in each village category) and about 900 women aged 15 to 49 were surveyed.

The size of the villages and of the clusters defined therein is based on population estimates drawn from a variety of sources and times. Consequently, the decision was made to number households in sample clusters:

- 21 **group A** villages, or 15 clusters;
- 7 **group B** villages;
- 25 **group C** villages, comprised of 8 villages (or 5 clusters) in Fatick, and 17 villages (or 5 clusters) in Kolda.

3.1.3 Questionnaires

The questionnaires prepared for Senegal's DHS-IV were the basic data sources for this evaluation survey. Some changes deemed necessary were made to the basic questionnaires in order to address the specific objectives of this research, while nevertheless preserving their comparability with the results of DHS-IV.

Two questionnaires were used over the course of the survey: a household questionnaire and an individual questionnaire for women aged 15 to 49.

The **household questionnaire** helped create a list of all household members and gathered data on their basic sociodemographic features and the characteristics of their accommodation. The main information collected focuses on age, sex, the registration of children under 5 at the civil registry, the education level of individuals aged 5 or over, the school attendance of individuals from ages 5 to 24, access to clean water, the type of toilets, waste disposal, the number of sleeping rooms in the household, hand-washing, and the availability of mosquito nets. The household questionnaire also enabled us to identify women who qualified for the individual survey.

The **individual woman's questionnaire** is made up of seven sections addressing the following topics about the person surveyed: sociodemographic characteristics; her reproductive, contraceptive and pregnancy history; the immunization and health of her children; marriage and sexual activity; circumcision; and knowledge about the Tostan programme and of public declarations.

3.1.4 Data collection and entry

The data collection work in the field was done by former officers who took part in DHS-IV in 2005. The collection lasted one month, from February 20 to March 16, 2006. Four data entry operators were chosen for a one-month period. They followed a three-day training to upgrade their level and familiarize themselves with the questionnaires of the survey. Data entry and processing was conducted with the CSPro software (Census and Survey Processing System) developed by the DHS+ programme and the U.S. Bureau of Census. These operations include, among other things, checking, entering and editing the data.

3.2 Qualitative component

The qualitative approach is based on an analysis of the responses to research questions geared at understanding the outcomes related to the village's participation in the Tostan programme, the organization of public declarations and their follow-up, and the practices of early marriage and circumcision in the various villages as reported by the various focal points.

3.2.1 Sampling

The villages of the study

The choice of villages for the qualitative survey was based on the choice of the sample villages targeted by the quantitative survey. At the outset, 16 villages had been targeted for the survey and were split into two sub-groups of villages (group A and group B) in the regions concerned.

- **Group A villages,** which benefited from the Tostan programme and made a PD during the indicated reference period;
- **Group B villages,** which were not subject to a Tostan programme, but took part in a PD for the abandonment of circumcision during the same period.

In the Thiès/Fatick zone, a major constraint came up in the choice of these villages due to the absence of group B villages. All villages in Thiès and Fatick received the Tostan programme and took part in a PD for the abandonment of circumcision. For this reason, only four group A villages in this area were surveyed for this evaluation.

In the Kolda region, information found in the field revealed that some of the villages that were picked as group B villages also received the Tostan programme after the reference period defined in this study. A total of 12 villages were surveyed for this study. Eight villages were surveyed in Kolda: six group A villages and two group B villages. Four group A villages were surveyed in Thiès/Fatick.

3.2.2 Target populations

The choice of the target population in the various villages of the study was first based on the identification of focal points who were likely to answer questions aimed at creating a portrait of the villages. These focal points were also expected to help identify other members of the community who fit the classification criteria adopted for the research: women who benefited from the programme, women who did not benefit from the programme, leaders (men, women or young people), and other individuals who witnessed the process such as health or education officials.

In each village, lists were drafted to facilitate the selection of individuals to interview. The choice of which leaders to interview was drawn from a pre-established list of village leaders, which generally included the village chief or his/her assistant, the imam, the school principal, and the committee or group chair, among others. On average, three individuals from this category were queried in each village.

The other target group was made up of women, who accounted for the majority of the sample. The evaluators relied upon leaders of women's groups, who were usually very involved in the organization and the life of the village, to help the research committee identify female subjects. In each village, at least six women were surveyed: three who took part in the programme, and three who did not.

Table 3.2 : Distribution of the target population by village type, EIT Senegal 2006.

	Targets				
Village type	Participating women	Non-participating women	Leaders	Facilitators	Other informants
A	28	33	36	7	24
B	–	12	8	–	2
Overall	28	45	44	7	26

We recognize that data collection among male and female leaders generates a bias. Leaders are usually the main target of the Tostan programme, and consequently are more inclined to have a positive perception of the programme. We therefore acknowledge that our discussions about the programme's perception, the knowledge acquired, and the image presented may be biased on the positive side.

3.2.3 Instruments of collection and analysis

Four guides were developed to train and support those doing data collection and analysis:

- A guide for drafting a portrait of the villages;
- A guide for the interviews with the women, both those participating and not participating in the Tostan programme;
- A guide for the interviews with the “leaders” of these villages;
- A guide for the interviews with the facilitators who were in charge of the development of the Tostan programme.

Training of the interviewers

Training sessions were set up during the month of February 2006, with the assistance of the main researcher of Macro International Inc. On this occasion, an upgrade on evaluation logic made it possible to present quickly the contents of the Tostan programme and the objectives of the evaluation.

3.2.4 Data collection and processing

Data collection occurred in several phases from February to March 2006, during which time interviews were conducted in the 12 villages of the study. The members of the research team who took part in the transcription and the processing of the data also advocated the use of the NUDIST software for codification purposes. A gradual, cross-cutting analysis of data was undertaken aimed at following up on the various developments that occurred in the villages, from acceptance of the programme’s establishment to its impacts, from mobilization to a public declaration calling for an end to female circumcision.

4 The establishment process of the Tostan programme

4.1 Programme establishment

The idea to implement the Tostan programme in selected villages originated at a meeting between officials of the NGO Tostan and UNICEF. The activities initially undertaken by Tostan in the Thiès region triggered great interest among UNICEF officials, who were interested in building on this experience and replicating it in Kolda.

The establishment of the programme in the villages went through various stages, starting with preliminary discussions, then identifying and selecting the participants. It was through this process that a number of villages joined the programme, except for a few that apparently sent a request directly to Tostan after they found out about the effect that the programme was having where it was in operation.

Matrimonial alliances also played a part in the dynamics of setting up the programme in some communities. This was the case for the village of Soudiane. The president of the women's promotion group had a sister who got married in the nearby village of Fadiaale that initially benefited from the Tostan programme and where she played specific role: *"Her role is to attend all of Tostan's events and report back to us on all that was said."* (President Dahira, individual interview, 45-year-old, married). The impressions of the president's sister were apparently instrumental in triggering the request. *"When she saw the way the men and women of the village were mobilizing for those events, she managed to get the village of Soudiane to join the programme, because she had realized that Tostan's activities and its objectives matched the activities of the village. This is why Tostan came with a letter, which gave us much satisfaction."*

However, in selecting the villages, Tostan imposes a certain number of conditions, particularly in relation to the village's commitment to take care of the facilitator, draft a list of beneficiaries, and build a shelter for the classroom. A few informants also emphasized that abandonment of circumcision was a prerequisite. As one of the facilitators put it, *"That's right, they're being asked if they will abandon circumcision. If they do not accept, the programme will be offered to another village. As soon as they accept, the awareness-building programme that precedes literacy training can start."* However, this information was not reported by everyone. There was usually unanimous support for Tostan's requirement to have the village take care of the food and accommodation of the facilitator. This established Tostan's participatory approach

in the implementation of its programme. Another facilitator noted, *"Indeed there were criteria. They asked the village: 'Can you supply an audience? Secondly: when you do have an audience, will you take care of the food and the lodging of the facilitator who will come, including his hut?'... Those were the conditions!"* (Facilitator, farmer, married).

In conclusion, we observe that establishing the programme followed two patterns. In the first case, Tostan approached the villages, after which a long negotiation process took place. In the second case, local people themselves requested the programme after they received good feedback about it, or following the migration of a person who knew the programme. These migrations were often caused by matrimonial alliances.

The village's participation in creating the classroom and supplying room and board to facilitators were conditions that were often not easy to accept for villages that are very poor; this explains the long discussions that were often part of the programme establishment. For a few villages that were reached in the second stage, such as Diabougou, it was mainly the issue of circumcision, which the populations knew to be a crucial element of the programme, on which leaders dwelt before they accepted the programme. Ultimately, the benefits brought by the programme were probably what clinched the decision in each village. The persistence of Tostan's officers and their numerous negotiation strategies also ended up convincing village leaders.

4.2 Programme implementation

Interviewee accounts show how communities contributed significantly to the establishment and effective implementation of the programme in the villages. Among the most visible indications of community support was the creation of the work space, or "classroom," whether it was a *tourdou*[2] that was sometimes laid out under the *tabaki* tree, or a relatively well-built straw hut that could shelter participants from unreliable weather.

It is through a participatory dynamic involving the various parties that the classroom was created. Tostan provided the teaching materials and the populations took care of the outfitting. As the president of a local youth group (a farmer who is married) observed of the participatory dynamics, *"We villagers are those who built the classroom, but it is Tostan that brought all the*

[2] Outfitted space, open and unfenced.

materials, including even exercise books, pens, pencils, etc. But the choice of the workplace has to be left to the village. This is like funding: Tostan brings its share and the village participates."

At the community level, decision-making responsibilities were largely shared, but followed a certain chain of command. This is why the village chief had the entire responsibility for authorizing setting up the classroom and selecting its location. As one chief expressed: *"Absolutely not Tostan! It has to be the village chief. Tostan cannot pick a spot just like that. It is the prerogative of the village chief."* On one hand, these words express a certain quest for authority, but on the other, they illustrate the role that is conferred on leaders in collective decision-making, a fact which a school principal expressed in these terms: *"We are in a territory where nothing is done without the opinions of dignitaries, who are traditionally vested with power of decision.*"

A collective mobilization therefore took place around the development of the programme, where *"everybody worked as one and went to great lengths to help Tostan so that classes could be conducted without a hitch and participants had no problems relating with each other.*" (Village chief, 56-years-old, farmer, married)

Of course there was no shortage of challenges, but "*overall we still found that the whole community provided efficient support for a smooth operation of the programme,"* a school principal told us. *"Even dignitaries were giving support, to the same extent as village officials. In particular, the village chief was outstanding in the constant support he provided to protect the programme from any problems.*"

By contrast, the community's effort to establish the programme was not reflected in course attendance. The programme was perceived as useful, but this was offset by everyday survival constraints that led to lack of attendance. For many women, domestic chores prevented them from attending classes regularly. As one woman in Médina Chérif attested: *"Yes, all the people registered had participated in the training. But not everyone had completed the programme because there were some dropouts during the training and sometimes some people did not attend. This could be explained by the fact that some of them did not take the training very seriously, and the reason they gave was that they could not grasp the importance of this literacy training on the social level – that is, the concrete fulfillment of their needs in terms of daily experiences. Others justified their absence through the heavy domestic workload which was taking up all their time, and sometimes they were compelled to stay away from classes to*

be able to rest or perform certain tasks." (Participating woman, member of the women's promotion group)

Some beneficiaries were nevertheless determined to follow the whole programme. They were intent on acquiring knowledge in spite of the challenges it posed. These women conveyed a sense of personal satisfaction. *"I had my daily activities well planned so I could fit the training in my programme of the day. For me, it was a challenge I had to take up, and I felt like following this training even if I could not use it afterwards to get a job. My objective was to acquire some knowledge so I could take better care of my family, my children and my household as a whole."* (Participating woman)

In conclusion, we observed that in most villages there was substantial community involvement in establishing the programme, as mobilization was built around this "new thing." Each party brought its own contributions to the process. However, once classes started, enthusiasm subsided and absences and dropouts increased. The burden of household duties, the lack of financial pay-back and the obligation to ensure economic survival on a daily basis discouraged some volunteers from going to class. Naturally, the women who were very motivated kept attending regularly. In two Kolda villages, the establishment of the programme met with serious difficulties. In one of the villages, this was caused by very old antagonisms between two village chiefs, and in the other case, it was due to the acts of one of the leaders. However, in the first case the programme was eventually allowed to develop completely, despite the reluctance of the village chief.

5 Knowledge of Tostan and of its programme

The topics addressed in this chapter help provide responses to important questions about the NGOs' level of popularity, and also look at what populations have retained or gained from the presence of Tostan in their village. The following questions are addressed:

- How well-known are Tostan and its activities within the villages that were surveyed?
- What are the efforts undertaken by the village after the public declaration to abandon the practice of circumcision and early marriage?
- What are the effects of the village's participation in a PD, and what is sustainable over a 4-to-5-year period?
- What efforts were undertaken by the village after the public declaration to monitor the practice of circumcision and early marriage?
- In what Tostan-initiated activities did women participate, and what benefit did they get from them?

5.1 Knowledge of Tostan and of its programme

Table 5.1 provides data on the level of knowledge that people have of Tostan. The women who are considered as knowing Tostan are those who spontaneously declared that they did, or who heard about it in some way. The surprising result is that the proportion of women who knew Tostan was higher in group B villages (92 per cent), where Tostan never intervened, than in group A villages (82 per cent). Among inhabitants of group C villages, the proportion of women who knew Tostan was 40 per cent.

In group C villages, which are normally outside Tostan's sphere of influence, knowledge of Tostan should be minimal. The high percentage of women who declared that they knew Tostan in group C is due to the women of the rural community of Némataba (district of Kounkané, Department of Vélingara, Kolda region). In reality, these Némataba villages were very likely to know Tostan[3] because of the radio programmes to which they had access. This media exposure helped strengthen the programme by fostering debate on the topics presented

[3] Nevertheless, the choice of these as control villages was motivated by the fact that, according to the information supplied by Tostan at the time, they were not under the influence of its programme.

during training sessions.

This result is consistent with data about the effectiveness of different information channels in disseminating information about Tostan (see Table 5.1): in groups B and C, radio was the main information source on Tostan; 50 per cent of women of group B and 70 per cent of group A who knew Tostan cited the radio as an information source. In group A villages, the most widespread information channel is “inhabitants of the same village” (39 per cent), followed by the radio (25 per cent) and the Tostan officer (26 per cent). As an information channel, television had low representation in all village types. Percentages on other information channels were very low in all villages.

Table 5.1 : Knowledge of Tostan

Percentage of women who declared that they knew Tostan by village type and by channel that got them acquainted to Tostan, EIT Senegal 2006.

	Village type			
	A	B	C	Total
Know Tostan				
Percentage	82.2	92.4	39.9	68.8
Number of women surveyed	629	118	386	1133
Information channels				
Inhabitant of the same village	38.9	20.2	104	30.6
Inhabitant of another village	8.3	25.7	12.3	11.5
Radio	24.6	49.5	69.5	36.9
Television	0.8	---–	5.2	1.5
Tostan officers	26.3	4.6	1.3	18.3
Health staff	0.6	---–	0.6	0.5
Relay officers	0.2	---–	0.6	0.3
Posters/signs/papers	0.4	---–	---–	0.3
Other	38.9	20.2	10.4	3.,6
Total	100.0	100.0	100.0	100.0
Number of women who declared that they knew Tostan	517	109	154	780

5.2 Type of activities conducted by Tostan in the village

Table 5.2 shows the percentage of women who declared that Tostan intervened in their village by conducting activities. Group A villages had the highest proportion of women (75 per cent) who declared that Tostan conducted activities; these women were also among the only ones identified at the outset as having benefited from a Tostan programme. However, 14 per cent of women in group B villages and 4 per cent of women in group C also claimed that Tostan intervened in their village. According to our information, Tostan never intervened in group B or C villages.

Table 5.2: Tostan's intervention in the village

Percentage of women who declared that Tostan intervened in the village, EIT Senegal 2006.

	Village type			
Tostan has conducted some activities in the village	A	B	C	Overall
Yes	74.5	13.8	3.9	52.1
No	11.4	72.5	79.9	33.5
Do not know, are not sure	14.1	13.8	16.2	14.5
Total	100.0	100.0	100.0	100.0
Number of women surveyed	517	109	154	780

Respondents (primarily from group A villages) reported that the activities conducted by Tostan mainly focused on literacy training (50 per cent), education geared at giving up the practice of circumcision (46 per cent), hygiene (22 per cent), revenue-generating activities (19 per cent) and women's and children's health (13 per cent). Activities conducted in the area of human rights had a representation level of only 6 per cent, in spite of the importance of this theme in Tostan's advertising.

5.3 Women who participated in Tostan's activities in the village

Results on the percentage of women who personally took part in a Tostan activity were only significant in group A villages, due to the very low number of such women in the B and C

villages. The proportion of women who took part in Tostan's activities in group A villages was 46 per cent.

The main activities in which women declared that they personally participated included: education to abandon circumcision (22 per cent), literacy training (22 per cent), behavior patterns in the hygiene sector (11 per cent) and human rights (5 per cent). It is not obvious where discussions on early marriage can fit within these categories; perhaps this could be a discussion item in women's health and human rights.

During the survey, women were asked to say in which subject area they felt that Tostan's presence benefited them most. As expected, the topics and their importance matched Tostan's main activities in the village. Women declared that the main activities from which they benefited most were: education to abandon circumcision (22 per cent), literacy training (16 per cent), behavior patterns in the hygiene sector (13 per cent), maternal and child health (8 per cent) and income-generating activities (8 per cent).

5.4 Lessons learned according to women

In the qualitative component, women from group A villages were invited to talk about what they had learned through Tostan's classes. There was a close correlation between responses to the questionnaire and the women's answers.

The lessons learned mostly pertained to aspects of everyday life, including *set setal* (hygiene), the virtues of *jarum xetalli* (OR), and arithmetic, among other things, whose use contributed significantly to the dynamics of behavioral change. As one 40-year-old female participant explained: "*What we can say today is that Tostan has taught us a lot of things, and if someone tells you that it's not true, it's because they live in a fantasy world! Tostan taught us how we can maintain our children, our household and ourselves in hygiene and cleanliness, but also informed us on the hygiene and cleanliness of our food. We also learned how to live in harmony with our husbands, the behavior we must adopt towards others, and the relationships that must prevail among neighbors of the same locality and of various villages. We now know how to behave when our children are sick, what we must do to treat them, etc. On top of everything, we now know how to read and write, but also how to count in our national language, Peulh …"*

Another aspect of lessons learned relates to health in general, and to reproductive health in particular, an area of knowledge that has become accessible to women in these zones. The data confirmed the interest they have for the programme and the advantages they derived from it. As this non-participating village woman attested: *"As far as maternity is concerned, for instance, the knowledge acquired through the Tostan programme is very important to me. In the past, we would not pay any importance to prenatal consultations. This behavioral change has considerably improved the health of the women in our village*." (Non-participating woman, farmer, married, 45-years-old)

There are now women who are able to follow their pregnancy cycle thanks to the lessons learned in the Tostan programme, as this participating woman from the village noted: *"I have better knowledge of everything that concerns my health. I found out about the duration of a pregnancy, while previously I was arguing a lot. When the number of 280 days was coming up frequently, I was often wondering if it was true or not. But with module 7, I found out that it was true."*

In addition, the changes that stemmed from the programme were also evident in the knowledge that women gained about the roles they should play in the community. The Tostan programme to some extent promoted a review of the status of these women. Some women are now convinced that they can substitute for men in positions that were previously limited exclusively to men. A participating woman from Goundaga expressed: *"Yes, we now know that women must decide, help with orientation, and take part in the great decisions on the socio-economic development of the country to the same extent as men. Nowadays, we are convinced that everything a man does, a woman can do it just as well if not better, because we have abilities and skills. Why not a female village chief?"*

The programme also seems to have promoted a "culture of hygiene" in the villages. Cleaning now seems to be a precursor to any action, as one participating woman indicated: *"It is thanks to these people that we have acquired a lot of knowledge in several areas: truck farming [market gardening], literacy training, set setal [hygiene], and child health… This has brought a change in ourselves, because we did not used to take care of our homes or our children before. We did not even have time to wash because we were in the bush all the time. But since Tostan has come to our village, we have noticed great changes. All the things we did not know before, Tostan introduced them to us."*

The knowledge of basic arithmetic that was acquired has turned out to be a significant

asset for women who engage in a revenue-generating activity. As a participating woman in Malicounda shared: *"For that, I am not very gifted [laughs]. But if someone today owes me money, even if I cannot write the name entirely, I can write the beginning, I can also write in the amount. And when I go and buy goods, all they give me I can write down."*

Many participating women – there were between 15 and 25 in each village – shared similar comments about their newly acquired skills and knowledge. However, the accumulation of all this knowledge is apparently not limited to participating women; there were a number of female beneficiaries who did not follow the programme. For example, this woman from Saré Waly observed: *"Today, even prenatal visits and the immunization of children are a real thing in this village, as opposed to what could be seen before Tostan's arrival, when women did not attach great importance to these issues. We also know how to fight the spread of malaria."*

This reflects the greater impact of the Tostan initiative's social communication component. It validates the objective of the *Ndeye Dikké* (adoption of a friend) strategy, which contributed to the community-wide dissemination of the lessons learned in the class.

However, in another village where the programme met with some difficulties, feelings of regret were expressed about the programme, which was not completed. According to a participating woman from Saré Demba Modou: *"Within the village, the training did not last. We learned a few things for a while, and then the training stopped and we don't know why. To tell the truth, I swear to God because I am a believer, we have not learned anything during this training. I could not tell you that we grasped a single point or module of this training. In reality, we acquired no knowledge during the training. Now, nobody can tell you that they know how to read and write or even count with this training which, in fact, did not last long enough to have the expected effect."* However, another woman from this village highlighted some benefits: *"What they taught us was to cultivate peace, solidarity and unity forever."*

5.5 Knowledge implementation: collective initiatives

A variety of actions were conducted at the village level both during and after the implementation of the Tostan programme. Tostan contributed to the creation of coordination groups, or committees, whose missions have evolved.

These committees were created in many villages as part of the programme

implementation. They do not appear to be a source of profitable collective actions for populations that seek resources for their subsistence. However, their existence within the villages "is extremely useful, because *addani kaaliss, addi ganndal* [even if it has not brought us money, it has given us knowledge]." (Non-participating woman, married, 45 years-old, farmer)

The knowledge gained, and the general subject of the programme, improved the villages in a variety of ways. For example, cleaning activities were conducted periodically in some villages, occasionally leading to a collective investment, as this participating woman from Goundaga described: *"Each time there is a need for it, we engage in set-setal activities to make the village and its surroundings a cleaner place. [We conduct] awareness-building activities on themes that relate to reproductive health, cleanliness and hygiene to create public awareness on these aspects that are important for the improvement of people's daily life experiences."* (Participating woman, married, 30 years-old, treasurer of the women's promotion group)

These activities already were already ongoing in some villages, but the programme was instrumental in reinforcing them. A participating Malicounda woman noted: *"We have things here that existed before Tostan, like the clinic.… I can say that it gave us some boldness, because before Tostan's arrival all the things I have just told you about existed here, in the village. We were holding meetings and exchanging ideas. We were holding awareness-building talks on health. Tostan only gave us the determination to amplify what we were doing*." (Participating woman, married, 44 years-old, instructor)

Initiatives were also focused on the development of small revenue-generating activities which would contribute to the improvement of the living environment within the villages. A non-participating woman in Keur Simbara talked about the management abilities that the programme taught: *"Before, women had nothing, they only had the things that their husbands would give them. Now, when they are given some money, they buy goods to resell them. When they do well, they buy their chairs, their cabinets, sheets and curtains. They buy everything. So you see that these activities are important."* (Non-participating woman, widow, 70 years-old, midwife)

A number of initiatives within the villages focused on the schooling of girls: "*For parents, girls' schooling was not important. But since this public declaration, it has become a crucial matter. As a matter of fact, as each new year gets closer, there is a car that goes around all villages to let parents know that registration time is coming and they have to let their children go to school, and also to tell those girls who would like to attend school to go and register personally with education authorities."* (Non-participating woman, 30 years-old, treasurer of the

women's promotion group)

People frequently requested that Tostan help improve their environment, since one result of the programme is that villages see a need and value for basic services; the NGO could not always satisfy these requests. These requests varied from one village to the next, and ranged from hulling machines to mills, drilling equipment and toilets. A villager in Soudiane observed: *"We were holding 'Gamou' religious wakes on Sundays, and on Saturday the guests were already there. When people wanted to go to the bathroom they had to go into the bush, and sometimes we would see some people who would shamelessly squat in front of everybody. We thought that this is not good. When Tostan came and they asked us what we wanted, our first complaint was that we had no toilets and we wanted some built. Since we have had toilets, we have not had any problems; when people come, you get everything really clean and you leave a kettle full of hot water."* (Participating woman)

There was an obvious desire by some participants to use the knowledge offered by the Tostan programme. However, the lack of infrastructures or human resources in certain villages was a hindrance to the implementation of the lessons learned. A stakeholder from Médina Chérif told us: *"The health hut is not functional because of the lack of qualified staff. I was the only one who worked there and I could not fulfill all the health care needs of the people. These days, only headaches, injections and wounds are addressed by this structure."* (Participating woman, member of the women's promotion group, married, 40 years-old, midwife)

One of the objectives of the qualitative component of this study was to "check whether the intervention was conducive in the different villages to the establishment of social groups organized for the welfare of the community" and to "describe the composition of these groups." During the evaluation, we could not find functional committees besides those that worked on hygiene. An informant explained: *"This is not caused by a lack of organization or will to set them up, because we are convinced of everyone's will to abandon these practices that were deemed detrimental to the health and welfare of our populations. Nowadays, all of the community's components, whether ethnic, social or other, agree on the principle that these harmful practices should be abandoned at any cost."*

In conclusion, we can say that the programme reinforced the knowledge of most of the women surveyed, and gave them a better grasp of health and hygiene information. We do not know to what extent the programme has affected the knowledge and the practices of all women, but we now have a nucleus of women who possess new knowledge in many of these villages.

The programme also helped increase women's confidence in their own capacities and their leadership aspirations. Hygiene and health are the areas where the lessons learned had a very quick effect. The knowledge in literacy and arithmetic enabled women to acquire better management abilities. These behavior patterns even reached some women who did not attend class, but who still live in the village. They follow the leaders, striving for better hygiene and health.

However, the programme was not well implemented in all villages, nor did it consistently reach its objectives. Two of the villages visited met with problems which limited the learning of the residents there. In these latter communities, the programme's effect was primarily to improve communication within families and in the village.

The will to implement new skills and knowledge has come up against the problem of inadequate basic infrastructure. The lack of clean water, latrines, health huts or health staff limits the ability of communities to implement what they have learned in the programme. The result is that local people have made strong demands for basic infrastructure improvements, targeted at an NGO whose mission at the start was to induce healthy behavioral patterns. The NGO was able to respond to this demand in just a few villages by providing additional funding, but this was not typical. There was also a lack of follow-up, which limited the programme's long-term impact. Most of the committees that were established during the development of the programme do not exist anymore. Only the actions of the hygiene committee are still noticeable.

6 Public Declarations

The organization of public declarations (PD) in the zones covered by the study was done in the villages of Médina Chérif, Malicounda and Diabougou. In the implementation of the Tostan programme, PDs were part of the capacity building process. These PDs take on a solemn form, engaging communities to publicly renounce all forms of practices that are deemed harmful, including circumcision and early marriage.

6.1 Initiation of the Public Declaration and adherence to the process

Public declarations are the logical result of a public awareness process about the harmful effects of circumcision. Women who took part in literacy classes were taught about their own rights and about reproductive health – a strategy that was initially suggested by Tostan, and then implemented by the women of the Malicounda class. A participating woman explained: *"Tostan came here one day and told us: 'You should set up a programme.' We answered them, 'What programme?' Tostan replied, 'You should let the whole village know what you are learning. We could invite dignitaries and reporters to discussions."* Following this preliminary discussion, negotiations were initiated by these women. *"Everybody was in agreement. We had told local dignitaries and they agreed. We had told the imam and he agreed, and so did the village chief. We went to the village chief, and he himself came to see us at the class. When we did the play, he saw it, so it is obvious that we did not make this decision alone."* (President of the women's group)

Another informant also stressed the importance of this broad dialogue with leaders, including the religious head. *"So when we talked with the village chief, he suggested to us that we were natives of this village, and that he could not oppose a health-promoting initiative. Then we went to see the imam to ask him if it [the abandonment of circumcision] did not compromise our religious practice, and he told us that there was no way it could compromise our religious practice. The problem is that we could not meet all the people of the village."* (Participating woman, 44 years-old)

The PD of Malicounda Bambara originated from discussions in class, not from dialogue in the village. As a result, the women later met, from their accounts, with huge challenges, including criticism, opposition, threats and insults. The women did not intend for their PD to be

so controversial. The problem, according to the vice-president of the women's promotion group, *"is that reporters misinterpreted our statements and added things we had never said. Everybody withdrew, nobody supported us anymore. People would say anything: 'Bambara women sold themselves. If they opted for abandonment [of circumcision], it is because they received money.' Well, none of it was true, we did not receive any money. [Painfully] It is only because we had learned about our rights and women's health that [the trouble] all started, and we decided to abandon circumcision."* (Vice-President of the women's group)

Some informants, including participating women who were at the heart of the event, got the feeling that they had been "deceived" by the NGO, which was criticized for disappearing as soon as it got what it wanted. The women felt that considering what they dared to do for the first time in Senegal, they were not rewarded enough. It is for this reason that some informants claimed that they could not continue being activists on public watch committees against circumcision. These women argued that this took time, and therefore they lost opportunities to make money for the family, and they had not received any compensation from Tostan.

6.2 Organization of the Public Declarations

Tostan played an important role in the villages of Malicounda, Diabougou, and Keur Simbara, where the first PDs were held. Diabougou's PD had an impact in Malicounda, because of the position that Diabougou took on circumcision and in how the PD was conducted. The Malicounda village leader did not want to promote the abandonment of circumcision, but Tostan asked him to go back home to discuss with his parents the consequences of circumcision. The leader returned two weeks later with another point of view, and was ready to encourage the abandonment of the circumcision. In the village of Keur Simbara, a remarkable movement was created that influenced many other villages, drawing upon a whole series of historical, emotional, human, cultural and social links. A leader in Keur Simbara explained the importance of convincing other villages to accept the principle of abandoning circumcision in order to avoid marginalization: *"Our village is composed of 10 other villages. And this is where our girls get married, our boys take their wives. So if we abandon [circumcision], how will people find wives? We will be rejected and marginalized!"*

Discussions about taking part in the PD took place in numerous villages affiliated with Keur Simbara, including in the village of Diabougou were the PD was organized. The women of Malicounda went to see the women of Keur Simbara at a leader's request. The president of the

women's promotion group recounted: *"D.D. came here to ask us to go to his village… He told us to go there because they have received the education programme but [they] do not dare to mention the abandonment of circumcision. He told us to go and build awareness in his village."* These negotiations occasionally created feuds in the village. This was the case in Diabougou, where people reportedly came to blows. The president of the women's group confided about this situation: *"Initially, when D. came for this purpose, we had refused because he told us that we were going to give up our tradition… and people were negotiating to get us to accept it… We were born, we grew up with this custom, our elder daughters underwent it without a hitch. All of a sudden, Tostan comes to tell us: 'Drop it.' At this point, there was no shortage of stories, and incidentally I am among those who were fiercely opposed to abandonment [of circumcision]."* (President of the women's group, 44 years-old, married)

The lessons learned in the class, the persistence of some people, visits by Malicounda women and conversations with them all helped to reverse the process. A group president said: *"It [circumcision] does create problems. We inherited it from our forebears, true, but through what we learned, we did see that it created problems."* The same informant emphasized the importance of parental involvement in abandoning circumcision: *"We who learned so much in the Tostan class had discussions with our parents, we showed them the problems involved. They did not learn, but we told them about the problems, so we were able to take part in the Diabougou Declaration."*

The third PD – in Médina Chérif – showed an evolution in the PD process. There was greater involvement by several parties within the villages, and combined with mobilization around the abandonment of circumcision, this made the PD possible: *"It is caused by the will of the various parties but also by the results that we got from the training, and lastly by the importance we attached to this Tostan programme. The initiative came from the people themselves, who had found it necessary to call a meeting where all actors in this issue could take stock of the situation and exchange their views. This is how we ended up telling Tostan about the situation. Tostan responded favorably and asked us to get the other villages involved if we could, so they could take part in this meeting by sending emissaries to Médina Chérif, a suggestion we welcomed. So eventually Tostan took care of all the financial expenses of this meeting." (*Participating woman, member of the women's group, married, 40 years-old)

Mobilization for PDs even took place in villages where some criticism was expressed about the programme, but there was no outright opposition within the villages during the time that those PDs were conducted. One of the facilitators confirmed: *"There was no opposition on*

the part of the villagers. Even the imam whom we had contacted was favorable to this declaration."

Adherence by the villages to the PDs of Diabougou and Médina Chérif followed a number of stages. Ultimately, adherence was the result of a consensus between the leaders, backed by the population. *"It is a spontaneous decision. It is not only a decision by the village chief. The decision was a consensus between village leaders who, after they discussed these matters at the village level, made the decision to take part in the PD."* (Participating woman, president and treasurer of the women's group) However, this consensus was arrived at after lengthy negotiations, as recounted by a facilitator: *"To be honest, the debate was stormy. It took hours before a consensus was reached, because some people had trouble coming to terms with the situation."*

The Tostan programme also contributed to other villages joining in the declaration process.

6.3 Steps taken in conjunction with the Public Declaration

After a PD, a series of measures were taken in conjunction with the collective decisions arising from the event. These decisions hinged on the follow-up that was to take place after the abandonment of circumcision and the establishment of strategies to respond to other ills affecting the villages. This was the case in the fight against malaria, where *"commitments were made to create pharmaceutical displays where people can buy medication against malaria in the rainy season, because access to health stations is very difficult at that time."* (Facilitator, married, 38 years-old)

A set of measures were adopted with a view to follow up on this commitment. These measures varied from one village to another, but they all stressed abandonment of this practice and follow-up within the communities. In this respect, as the Goungada facilitator pointed out: *"The first thing they were asked is whether they were sure about giving up the practice and sticking with this decision, because it is something they affirmed in public. Mostly, they were asked to keep an eye on the woman doing circumcisions, because some people might be tempted to go to see her in secret. Well before that, I had told them that they had to create a [public watch] committee for this purpose."* (Facilitator, married, 44 years-old)

However, since the initiative to abandon circumcision is a collective one, monitoring the implementation of the decision is the people's responsibility. Accordingly, the treasurer of Goungada's women's group determined the tasks that were subsequently entrusted to the village chief: *"During the village meeting, after the people made the decision to abandon these practices, the village chief let them know that he has the moral responsibility to see to it that these decisions are implemented and that he would not hesitate to bring to trial any person who would practice circumcision or indulge in early marriage within the village."*

In addition, Soudiane's facilitator described the measures taken in the village: *"People thought that 'since you gave it up yourselves and nobody forced you, whoever breaches this decision will be taken to court.' And they all agreed to this warning."* (Facilitator, married, 46 years-old)

6.4 Implementation of the Public Declaration and collective follow-up

Intense negotiations precede the organization of a PD. The sharing of experiences between the new groups and people who have already gone through a PD is a decisive factor. The lessons learned in class strengthen the arguments for holding a PD. Since some people are more convinced than others that it has to be done, a PD does not immediately follow the implementation of the programme. A reflection and discussion period is necessary to consolidate the process. The involvement of the other villages follows patterns of kinship and alliances, but it does not necessarily arise from a well thought-out strategy; sometimes, other villages become involved out of a feeling of curiosity, or even by a fluke. Only a few leaders travel to the organizing village. The rest of the population of the villages are generally not aware of the implications of the event and view the whole thing as a celebration. This is why there is a lack of social mobilization activities around these issues. Even leaders go mostly as observers; it is when they return that negotiations take place with their communities.

The implementation of the measures announced during the PD required contributions from various social groups. Among the most important components of success, according to our data, is collective dedication, characterized by a determination by the communities to honor the commitments made. However, we observed that there were sometimes conflicting opinions within the communities.

Overall, the implementation of these measures rests primarily on a dialogue within the

villages, where a promise – one's "word" – is considered sacred and commits communities to respect the decisions made. The people's honor is at stake regarding the commitments that arose from the PD, and there is a sort of public pledge that a relapse will not occur. The president of Diabougou's women's group reviewed the value of the commitments made by her community though the PD: *"I simply tell myself that when an 'ass gorr' [an honorable person] comes out in the open to tell everybody that she has abandoned circumcision, she must stick to her word…'Kaddu gogou gnou wax, mo gnou ci rey' [it is our word that got us together]. We would really be ashamed if people said, 'Diabougou declared that it was abandoning circumcision, yet people keep on doing it.'"*

A village chief also reflected on what it meant for his community to have abandoned circumcision: *"For circumcision, a broad discussion took place, largely conducted by the women themselves. All of us accepted to abandon this custom, which has nothing Islamic about it. This commitment we made in front of the whole world. It is something beyond us but we would not have committed ourselves this way if we were not convinced of the fairness of the cause and if we were not determined."* (Village chief, married) Men were also be engaged: *"Men never refused the abandonment of circumcision, because if they did not approve, the PD would not have occurred, and if abandoning circumcision is still in force, it is because they are still approving,"* the imam told us.

For the organizing villages, the PD enhances their reputation; they are now well-known and it is an honor for them to have hosted an event of such importance. A school principal spoke about this issue: *"First of all, it's the honor of the thing. Médina Chérif held the PD, and it is really a good thing for the village. This is the feeling people have. We were honored because Tostan came and we are now doing something that has an impact in the area. …In fact, not only in the area, but in the whole world, everywhere, because when we talk about Médina Chérif in Kolda, we see that people have a good reaction."* The decision to abandon circumcision should last, and it is no longer necessary to monitor the process. As the imam attested: *"You know, before, nobody would hide when they were practicing [circumcision]. I don't think there is a need for control now, because they decided to abandon it on their own accord.*"

The engagement of the population in the PD and the promises made by these communities are the guarantors of the decisions that were undertaken. Structured public watch committees are not all frequent, but some awareness-building and follow-up activities help strengthen the commitment. So, even without any public watch committees, people in the villages claim that they are honoring their word. Informants also indicate that voting a law

provided a decisive argument in favor of honoring the decision.

A few monitoring strategies were nevertheless adopted in connection with the decisions. They ranged from communication, to coercion and the use of deterrent methods, including the actions of informal committees in the villages. A facilitator explained the case of his village, where *"there was an informal committee, composed of the village chief, the imam and a few representatives of the women's group that would see to it that the measures were applied. If a family was caught indulging in these practices again, it could be penalized by this committee."*

However, the information collected for the survey does not indicate a single penalty was given. Awareness-building and monitoring at the village level contributed to the follow-up, as attested by the president of Keur Simbara's women's group: *"Being vigilant cannot be more than what we, the people in charge, have done, including myself as president; we only talk to our membership to create awareness. And I know that if one of the leaders had caught somebody in the act, he would not have failed to say point-blank to that person: 'You must not do it again, or I will blow the whistle or do this or that.' But I still have not seen a case where leaders issued a summons. Really, since we sat together to discuss these things and we came to an agreement, we have stuck to our commitment."* (President of the women's group)

The PD has generated positive change. According to a school principal, this change hinged on *"the way mentalities have evolved since the organization of the PD*, *[including an opportunity for] women to enjoy more consideration in the community as compared to what was happening in the past. If the word 'liberated' is too strong, let's say that women have found a certain dignity again, and that they are playing a dominant role in the economic life of their society.'"* Addressing the sustainability of these actions, he predicted, "*I have no doubt that these activities will last, because they are being pursued on a normal, regular basis."*

In summary, the information collected shows that the PD has contributed to the end of circumcision, among other practices deemed to be harmful. Its importance within the villages is attested to by the imam: *"It [the PD] has great significance in this village, because I have not seen or heard of a single case of circumcision in the village since then. So it appears that there is a decline of the practice in the village, if not its total abandonment by the population."*

In conclusion, we must remember that the first public declaration was suggested by Tostan as a mechanism for the women of the class to share their knowledge with the rest of the village. Even though this was a declaration from the class, it nevertheless included a discussion

process with the village leaders. This first PD was a catalyst for all those that followed. The PD has evolved in its meaning and its organizational strategy. From a declaration by a group of women who had followed the programme – and the consequent marginalization of this group –, the PD went on to include deeper involvement by other members of the village, with its leaders at the helm. The role played by a leader of the Thiès region, where the first PDs were held, was probably a key factor in this transformation.

6.5 Participation in a Public Declaration according to the questionnaire

Oddly, the proportion of women who had heard of a PD was lower in group A villages (66 per cent) than in group B (80 per cent); the proportion was sharply lower in group C villages (47 per cent – see table 6.1). The proportion of women who attended a public declaration was 40 per cent in group A, 28 per cent in group B and 6 per cent in group C.

Table 6.1: Knowledge of and participation in a public declaration

Percentage of women who declared that they had heard of a public declaration, and percentage who personally attended a public declaration, EIT Senegal 2006.

	Village type			
	A	B	C	Overall
Have heard of a PD	66.3	79.8	47.4	64.5
Have attended a PD	40.2	28.1	5.6	36.4
Number of women	517	109	154	780

6.6 Follow-up on the Public Declaration according to the questionnaire

The questionnaire examined PD follow-up and the impact of Tostan's action by asking whether people had discussions with friends, what their opinions were regarding the decrease in the prevalence of circumcision and early marriage, whether there was a committee that monitored the implementation of the commitments of the PD and, lastly, whether legal sanctions had been taken against offenders.

Of the women who claimed that a PD had taken place in their village, 72 per cent reported that that their friends or families were holding discussions about the public declaration. However, the questions about the discussion of the PD, along with questions about the impact of the PD on circumcision and early marriage rates, were expressed in a form that suggests or promotes a positive answer (Do your friends or relatives often talk about…?). This makes the responses less meaningful. According to more than 70 per cent of women in group A villages, there was a follow-up on PD implementation; however, fewer than three women in ten have said that action was taken against those that did not abide by decisions taken at the PD. Due to the low number of respondents in group B and C villages on these questions, we should refrain from making too many comparisons on these issues between the three types of villages.

Table 6.2: Follow-up and impact of the public declaration

Percentage of women who declared that their relatives or friends had discussions on the PD and its follow-up, EIT Senegal 2006.

	Village type			
	A	B	C	Overall
Discussion of the PD with friends				
Percentage	70.8	73.4	77.8	71.6
Number of women	281	64	18	363
There is a follow-up committee for the implementation of the PD				
Yes	70.8	51.6	83.3	68.0
No	9.6	32.8	5.6	13.5
Do not know / not sure	19.6	15.6	11.1	18.5
Total	100.0	100.0	100.0	100.0
Number of women	281	64	18	363
This committee has contemplated legal proceedings against violators				
Yes	29.1	21.2	13.3	27.1
No	20.1	24.2	20.0	20.6
No circumcision since then	40.7	51.5	66.7	43.7
Do not know / not sure	10.1	3.0	0.0	8.5
Total	100.0	100.0	100.0	100.0
Number of women	199	33	15	247

The establishment of social groups within the villages preceded the development of the programme, but the programme encouraged their training or activities. The PD seems to have contributed to strengthening some of these committees by following up on the measures and decisions adopted during the declarations. However, after all these years, these groups or committees could not be found again during the qualitative component of the survey. Some of the people surveyed also said that sanctions were possible, but no case has been documented.

In all types of villages, over 90 per cent of women declared that the PD had contributed to reducing the practice of circumcision (unpublished table). However, the phrasing of the question and its position in the questionnaire must once again trigger a degree of scepticism about these responses. After many questions about circumcision and a long series of questions on the Tostan programme, women were asked whether they saw a connection between the two phenomena.

7 Maternal and Child Health

The questionnaire addressed Tostan's intervention on maternal and child health. Indicators were selected that measured to what extent Tostan's education and social mobilization programme contributed to the transformation of people's daily lives in the area of health. The questionnaire compared the population in the three types of villages according to a variety of indicators, including: number of pre-natal visits, number of months of pregnancy before the first prenatal visit, places of childbirth, post-natal care given, vaccination coverage of the children, and treatment of diarrhoea and acute respiratory infections. The following indicators deserve special attention: the number of visits for pre-natal care, whether childbirth took place at home or in a health center, total vaccination coverage, whether fever treatment was sought, whether diarrhoea treatment was sought, and whether more liquids were administered during diarrhoea.

One must exercise caution in interpreting the data and indicators above, since Tostan's approach is not always the same in all villages, and baseline conditions vary widely in the three types of villages. If we do not find any empirical evidence that the health and hygiene situation is better in group A than in group C villages, it does not necessarily mean that the programme has had no effect. Instead, it shows the paramount importance of the social context and the condition of the infrastructure at the start.

7.1 Prenatal consultations

Table 7.1 presents a distribution of the number of prenatal visits among women who had a live birth in the five years that preceded the survey, looking at the most recent birth. Group C villages had the highest proportion of women who had no prenatal visits (42 per cent), followed closely by group A villages (38 per cent). Among women who had at least four prenatal visits, the table shows an equal percentage (27 per cent) in both group A and C villages. We conclude that, with respect to prenatal visits, group A villages do not appear to be role models.

Table 7.1: Number of prenatal visits

Percent distribution of women who have had a live birth in the five years preceding the survey, as per number of prenatal visits for the most recent birth by village type, EIT Senegal 2006.

	Village type			
Prenatal visits	A	B	C	Overall
None	38.3	30.5	41.5	38.6
1	1.3	6.8	2.6	2.3
2-3	32.8	29.7	26.9	30.5
4+	26.6	31.4	26.9	27.2
Don't know/Missing	1.1	1.7	2.1	1.5
Total	100.0	100.0	100.0	100.0
Number of women	629	118	386	1 133

7.2 Place of delivery

The location chosen for delivering a child is also a determining factor for maternal and child health; it is likely to show Tostan's impact, as this NGO encourages women to give birth in health centers rather than at home.

As table 7.2 indicates, group C villages have the lowest proportion of children delivered at home (50 per cent), versus 61 per cent in group A and 85 per cent in group B villages. The situation in group C is thus quite a bit more favorable in terms of maternal and child health. The same conclusion applies for the proportion of children delivered in health stations: half of childbirths in group C villages take place in health facilities, versus only 15 per cent in group B and 39 per cent in group A villages. Group A villages therefore do not appear to be better off in this criterion of maternal and infant protection.

These data lead us to emphasize two points: 1) The only way to fully and accurately assess Tostan's impact in this area would be to compare the rates of child delivery in the three types of villages over time, in 1996, 2001 and 2006; 2) We must point out that 10 of the 21 group A villages are in Kolda, that all seven group B villages are also in Kolda, as are 17 of the 25 group C villages. One would therefore expect to find an improvement in group A villages because of Tostan, but that is not the case.

Table 7.2: Place of delivery

Percent distribution of births[1] during the five years preceding the survey by place of delivery and village type, EIT Senegal 2006.

		Health structure				
Village type	Home	Public	Private	Other	Total	Number of births
A	60.7	38.8	0.5	–	100.0	415
B	85.1	14.9	–	–	100.0	87
C	49.8	49.8	–	0.4	100.0	231
Overall	60.2	39.4	0.3	0.1	100.0	733

[1] Only includes the latest live birth during the five years that preceded the survey.

7.3 Child vaccination coverage

Table 7.3 presents the vaccination coverage of children for all live births in the last five years based on data collected from children's personal health records and mothers' statements. The proportions of children whose personal health records could be examined are fairly comparable: 79 per cent in group A villages, 74 per cent in group B and 80 per cent in group C (not presented in this table). The results presented in this table reflect data from groups A and B villages.

More than 95 per cent of children are immunized for BCG, DTP1 and polio 1 in all village types, and for DTP2 and polio 2 in group A villages.

The proportion of children who did not receive any vaccines is close to zero in all village types. Polio 0 had the lowest immunization rates in all villages with 43 per cent in group A, 42 per cent in group B and 39 per cent in group C. This, to a great extent, is the result of the high rate of child deliveries at home.

Overall, 70 per cent of children 12- to 23-months-old were completely immunized in

group A villages, versus 58 per cent in group B, while the highest overall immunization rate (76 per cent) occurred in group C villages.

Table 7.3: Child immunization

Percentage of children 12- to 23-months-old who have received specific vaccines, according to the child's personal health records or his/her mother's statements, per village type, EIT Senegal 2006.

	Village type			
Vaccines	A	B	C	Overall
BCG	97.3	100.0	95.7	97.0
DTP 1	99.1	100.0	97.1	98.5
DTP 2	96.4	89.5	94.3	95.0
DTP 3	85.7	73.7	87.1	85.1
Polio 0	42.9	42.1	38.6	41.3
Polio 1	99.1	100.0	97.1	98.5
Polio 2	99.2	89.5	94.3	96.0
Polio 3	88.4	68.4	82.9	84.6
Measles	80.4	73.7	80.0	79.6
Yellow fever	83.0	78.9	77.1	80.6
All vaccines	69.6	57.9	75.7	70.6
No immunization	0.9	0.0	1.4	1.0
Number of children	112	19	70	201

7.4 Prevalence and treatment of acute respiratory infections (ARIs)

The proportion of children who had a fever in the two weeks before the survey was slightly lower in group A villages (31 per cent) than in group B (36 per cent) or group C (39 per cent). In addition, treatment was sought in 48 per cent of cases in group A villages, 26 per cent in group B and 54 per cent in group C. There was no visible effect of Tostan's intervention in this area.

Table 7.4: Fever prevalence and treatment

Among children under 5, percentage of those who had a fever in the last two weeks before the survey, and percentage of those who had a fever for which treatment was sought at a health institution or health care provider, by village type, EIT Senegal 2006.

Village type	Percentage of children with a fever	Number of children	Percentage for which treatment was sought	Number of children
Type A	30.7	563	48.0	173
Type B	36.1	119	25.6	43
Type C	38.7	310	54.2	120
Overall	33.9	992	47.3	336

7.5 Prevalence and treatment of diarrhoea

The prevalence of diarrhoea is roughly the same in all villages surveyed: 26 per cent in group A, 24 per cent in group B and 27 per cent in group C. The percentage of women who know about oral rehydration salt (ORS) bags is quite low, with fewer than 5 per cent in any village type (unpublished table).

Table 7.5 shows that proportions of children for whom treatment for diarrhoea was sought are also quite comparable, with 26 per cent in group A, 21 per cent in group B and 27 per cent in group C. Group C villages have the highest proportion (32 per cent) of children receiving oral rehydration therapy. Consequently, there is no significant difference in the use of ORS between intervention villages (group A) and control villages (group C).

Table 7.5: Treatment of diarrhoea

Percentage of children under 5 who had diarrhoea in the two weeks before the survey, for which treatment was sought at a health institution of a health care provider, percentage of those who had oral rehydration therapy (ORT), by village type, EIT Senegal 2006.

		Oral rehydration therapy (ORT)					
Village type	Percentage for whom treatment was sought	ORS bags	Home remedy	ORS or home remedy	Increased liquid intake	ORS, home remedy or increased liquid intake	Number of children
A	25.5	27.6	33.1	53.8	39.3	71.0	145
B	21.4	21.4	17.9	39.3	39.3	67.9	28
C	27.1	31.8	30.6	52.9	44.7	69.4	85
Overall	25.6	28.3	30.6	51.9	41.1	70.2	258

7.6 Nutrition during diarrhoea

Table 7.6 shows that the overall proportion of children who received a “more than usual” amount of liquid during diarrhoea was the highest regardless of the village type, with 45 per cent in the control villages (group C), followed by group A and B villages (both 39 per cent). The proportion of children who received “much less” liquid was significant, especially in group A villages (12 per cent); it varied between 7 and 8 per cent in other villages.

We were surprised that we did not see more of an indication of Tostan’s impact on women’s and children’s health, as we expected greater differences between the three groups of villages. If Tostan’s intervention did improve health conditions, its effect has either vanished after a few years, or poor social conditions and the state of health services have prevented any changes from being statistically measurable.

Table 7.6: Amount of liquid given during diarrhoea

Percent distribution of children under 5 who had diarrhoea in the two weeks before the survey according to the amount of liquid given versus usual rations, EIT Senegal 2006.

	Village type			
Child nutrition during diarrhoea	A	B	C	Overall
Amount of liquid given				
As usual	33.1	28.6	18.8	27.9
More than usual	39.3	39.3	44.7	41.1
A little less	12.4	25.0	23.5	17.4
Much less	12.4	7.1	8.2	10.5
Nothing	1.4	0.0	4.7	2.3
Don't know/Missing	1.4	0.0	0.0	0.8
Total	100.0	100.0	100.0	100.0

8 The age of marriage or early marriage

8.1 Conversations at the village

It seems that the notion of early marriage is not well understood in most of the villages of the study. Many people interviewed felt that the ideal age for a girl to get married was very early: *"It's between 10 and 12 that a girl must have a husband. At this moment, she is mature enough,"* a non-participating woman from Néma Counda told us. Another woman added: *"The age of marriage, 15? It is as early as 12 or 13. As for myself, they married me off at the age of 15"* (Non participating woman, married, 30 years-old, farmer). One of the women surveyed continued: *"If she is not 15-years-old and she gets pregnant, this can cause her death. At the age of 15, she will be able to bear a child."*

In a few other villages, 15 was considered to be early, posing increased risk of complications during pregnancy and childbirth. The Tostan programme has contributed to the evolution of thinking on this subject, as this non-participating woman from Médina Chérif indicated: *"Yes, we stopped giving our girls off for marriage early. At the beginning, we gave them off at 15 and the girls had complications during pregnancy and childbirth. It is the Tostan programme that made us aware of all these problems that young girls encountered during pregnancy."* (Non-participating woman)

The fear of seeing a daughter pregnant is often cited to justify an early marriage, as a school principal attested: *"Early marriages also have to do with parents thinking one thing: the fact of seeing a girl get pregnant is a problem. So for instance when they see that their daughter is going out too much they get worried."* (School principal)

This fear of a daughter's pregnancy was also reported by a woman: *"Whether they are married off early or not, if you decide not to marry off your daughter very early she brings you back a child. Now there are a lot of them around here… So if you see someone who brings you cola and wants to marry your daughter, you will marry her off or she will give you another problem… It is because of the girls that there are early marriages. It's because they are not to be trusted"* (Non-participating woman, member of the women's group, married, gardener). In some villages, this danger is feared all the more because the abandonment of circumcision goes with the abandonment of the practice of *taf* (the healing that causes the closing of the vagina), which is perceived as evidence that the girl is a virgin.

The Tostan programme had an effect in the awareness and the follow-up of early marriage in some villages, as the Saré Waly village chief attested: *"When you marry off your daughter to a man, if she does not want him, then she is going to give you real problems. Better to wait until she's old enough, or, better still, let her choose a husband herself."*

Generally speaking, girls still marry young in the localities covered by the study. However, perceptions seem to have evolved toward a common understanding of the advantages and the necessity to not marrying one's daughter off very early and without her consent. This was cited to justify the absence of monitoring committees that ensure that the practices of circumcision and early marriage are effectively abandoned. The president of the CORAS association based in Médina Chérif observed: *"Before, we had that committee but we don't any more, since we have noticed that there is not a single guy who gives his daughter away before she is 17 or 18. Now, the girls themselves choose their husbands. Now, with the schools and everything, there are principals who did a good job making people aware of this issue."* (President of the CORAS association)

In conclusion, we note that several informants shared the feeling that early marriage is a declining phenomenon. Both in the Kolda and the Thiès areas, most informants claimed that this practice has many disadvantages and consequently, people would be better off abandoning it. Tostan's contributions are evident, because the programme stresses the consequences of young girls' pregnancies. But other influences also have to be noted, such as the schooling of girls, their greater freedom to contact other cultures, media sensitization and the fear of legal sanctions.

The problem that always arises is the differing perception of what constitutes an "early age" for marriage. In the Kolda zone, early age is defined as below 15; from the age of 15 on, a girl is considered old enough to be given away in marriage. The fear of a pregnancy – i.e., dishonor for the family – often pushes families to marry off their daughters. This has now become a topic of occasional conversation in the villages.

8.2 Quantitative data

One of the main objectives of the investigation was to assess the impact of Tostan's intervention on the prevalence of early marriage. This chapter therefore presents some elements that are likely to shed new light on a girl's age at her first marriage.

8.2.1 Age at first marriage

Table 8.1 presents the average age at first marriage per region in the EIT (Tostan Evaluation Survey) and in DHS-IV (Demographic and Health Survey). We can see here that results are consistent in both surveys, especially if you compare the zones covered with the rural environments surveyed in the relevant regions during the DHS.

Table 8.1: Average age at first marriage

Average age at first marriage by region according to DHS-IV Senegal 2005 and EIT Senegal 2006.

	EIT Senegal 2006		DHS-IV Senegal 2005			
			Rural		Total	
Regions	Average age	Number	Average age	Number	Average age	Number
Fatick	17.8	274	17.2	470	17.4	541
Kolda	15.2	599	16.2	813	16.4	939
Thiès	18.2	114	18.3	600	18.6	1351

The average age at first marriage among women 20- to 24-years-old – those who were 10- to 14-years-old during the intervention period – is the same (16-years-old) in group A and C villages. An older average age was expected in the villages where Tostan intervened (group A).

Table 8.2 confirms the widespread precociousness of marriage mentioned above and associated to an ethnic-based structure. The proportion of women married under 15 is noticeably higher in group B villages, with 35 per cent of all cases, than in the other villages (20 per cent in group A and 16 per cent in group C). It is in the 15-to-17 age group that most marriages occur in all villages, with 54 per cent in group A and B villages, and 58 per cent in group C. By the age of 20, there are practically no longer any more marriages in group B villages; however, the proportion of women aged 20 and above who get married for the first time is 12 per cent or more in the other villages. The average first-marriage ages per region presented in chart 8.3 confirm the results above. We note that the high percentage of women under age 15 who get married in group B villages is consistent with the population structure of this village (highest number of Poulars – 91 per cent – and highest population of girls not attending school – 86 per cent).

Table 8.2: Age at first marriage

Percent distribution of ever-married women by age at first marriage, EIT Senegal 2006.

Village type	< 15 years	15-17 years	18-19 years	20 years or more	Total	Number
A villages	19.6	54.1	14.8	11.5	100.0	547
B villages	34.8	53.6	8.9	2.7	100.0	112
C villages	16.2	58.2	11.9	13.7	100.0	328
Overall	20.2	55.4	13.2	11.2	100.0	987

8.2.2 Age at first marriage by period before the survey

Table 8.3 shows at what age the 987 women who are not single got married for the first time per 5-year period before the survey. The objective is to see if the percentage of early first marriages has changed from one period to another in comparison with all first marriages. We will focus on the last 15 years before the survey to assess Tostan's possible impact on the decline of early marriage. The 0-to-4, 5-to-9 and 10-to-14 year range before the survey roughly match the 2001-2005, 1996-2000 and 1991-1995 periods, respectively.

Overall, the percentage of very early first marriages (under 15-years-old) is likely to have dropped, going from 22 per cent of all unions in the years 1991-1995, to 18 per cent in 1996-2000 and 15 per cent in 2001-2005. The same trend is observed for marriages between 15- and 19-years-old, where rates go from 71 per cent to 67 per cent, then to 64 per cent. A trend can thus be seen in the three village types towards an older age of first-marriage. We can also observe this trend in control villages (group C), where the percentage of first marriages under age 15 drops steadily from 18 per cent to 14 per cent, then to 13 per cent. While the percentage of marriages under 15 seems to be on the rise in group B villages, the number of women in each category is too low to confirm a definite trend.

The most important decreases were observed in intervention villages (group A): 23 per cent, 16 per cent, and 12 per cent respectively. The decline in very early marriages in group A villages, however, is offset by the overwhelming prevalence (70 per cent) of marriages that still occur between the ages of 15 and 19. By contrast, in control villages, even if the frequency of marriages before 15 has only marginally decreased, marriages between 15 and 19 are less and less frequent: 74 per cent in 1991-1995, 72 per cent in 1996-2000 and 56 per cent in 2001-

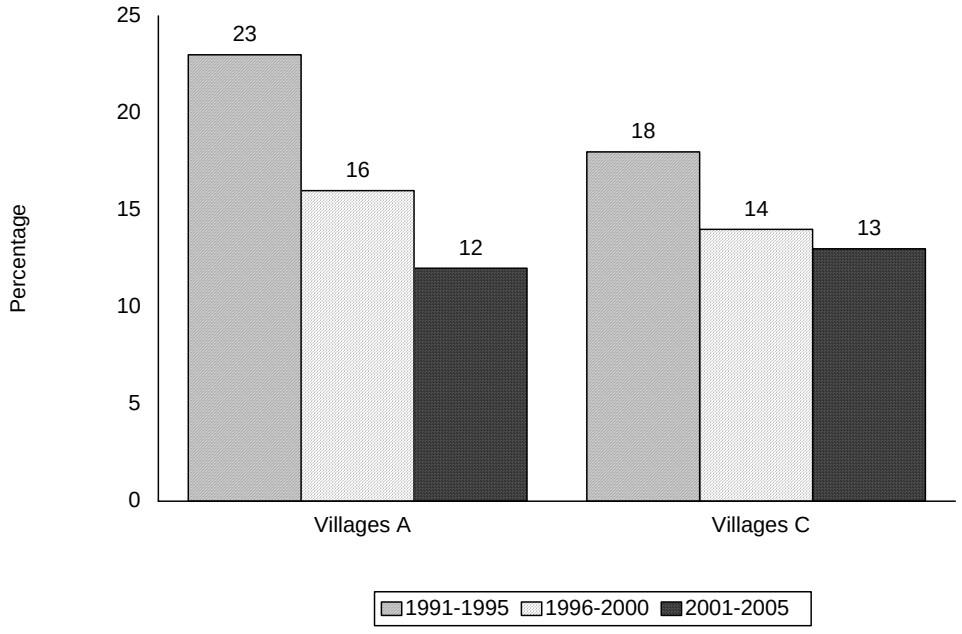
2005. A comparison between group A and group C villages (Graph 8.1) shows that if PDs and Tostan programmes have contributed to a slight decrease in the prevalence of early marriages, it is only for marriages before 15.

Table 8.3: Age at first marriage by period before the survey

Percent distribution of ever-married women by age at first marriage before the survey, EIT Senegal 2006.

Period before the survey	Age at first marriage					Total	Number
	10-14	15-19	20-24	25-29	30-34		
A villages							
0-4 years	11.7	69.9	15.5	2.9	--	100.0	103
5-9 years	15.5	66.0	14.4	3.1	1.0	100.0	97
10-14 years	23.1	69.5	7.2	0.0	0.4	100.0	347
Total	19.6	68.9	10.1	1.1	0.4	100.0	547
B Villages							
0-4 years	40.0	55.0	--	5.0	--	100.0	20
5-9 years	37.5	58.3	--	4.2	--	100.0	24
10-14 years	32.4	66.2	1.5	0.0	0.0	100.0	68
Total	34.8	62.5	0.9	1.8	--	100.0	112
C Villages							
0-4 years	13.1	55.7	26.2	4.9	--	100.0	61
5-9 years	14.0	72.0	12.0	--	2.0	100.0	50
10-14 years	17.5	73.7	7.9	0.9	0.0	100.0	217
Total	16.2	70.1	11.9	1.5	0.3	100.0	328
Overall							
0-4 years	15,2	63,6	17,4	3,8	--	100.0	184
5-9 years	18,1	66,7	11,7	2,3	1,2	100.0	171
10-14 years	22,2	70,6	6,8	0,3	0,2	100.0	632
Total	20,2	68,6	9,6	1,3	0,3	100.0	987

Graph 8.1 Proportion of women married before 15 by village type and time period before the survey



CRDH, Senegal 2006.

The most reliable indicator of an impact on early marriage would be the age of marriage of women in the five years that followed Tostan's intervention. Control villages had an early marriage (under age 15) rate of 13 per cent during this period – down from 18 per cent – whereas early marriages in group A villages declined from 24 per cent to 12 per cent during this time. Put differently, group A villages experienced a 49 per cent decrease in the proportion of women married before the age of 15, versus a 33 per cent drop for control villages. However, if we consider the number of women who got married before they reached age 20 five years after Tostan's intervention, we see that their proportion is higher in group A villages (82 per cent) than in control villages (69 per cent).

The limited impacts of Tostan on early marriage can be better assessed if we refer to marriages before the age of 18. Table 8.4 presents the same data as table 8.3 but the age categories are grouped differently: 10-17 years (early marriage), 18-19 years, and 20 years and above. During the period 10 to 14 years before the survey, in group A villages 81 per cent of girls were married before 18; almost the same proportion of girls (80%) were married before 18

in group C village. However, in the most recent period (0-4 years before the survey), 63 per cent of women were married before 18 in the Tostan villages, while 57 per cent of women were married before 18 in the control villages. In sum, statistics show that Tostan has had an effect on the age of marriage for women under 15, but not for women under 18 as a whole.

Table 8.4: Age at first marriage by period before the survey

Percent distribution of ever-married women by age at first marriage before the survey, EIT Senegal 2006.

	Age at first marriage				
Period before the survey	10-17	18-19	20 +	Total	Number
A villages					
0-4 years	63,1	18,4	18,4	100,0	103
5-9 years	58,8	22,7	18,6	100,0	97
10-14 years	81,0	11,5	7,5	100,0	347
Total	73,7	14,8	11,5	100,0	547
B villages					
0-4 years	75,0	20,0	5,0	100,0	20
5-9 years	87,5	8,3	4,2	100,0	24
10-14 years	92,6	5,9	1,5	100,0	68
Total	88,4	8,9	2,7	100,0	112
C villages					
0-4 years	57,4	11,5	31,1	100,0	61
5-9 years	70,0	16,0	14,0	100,0	50
10-14 years	80,2	11,1	8,8	100,0	217
Total	74,4	11,9	13,7	100,0	328
Overall					
0-4 years	62,5	16,3	21,2	100,0	184
5-9 years	66,1	18,7	15,2	100,0	171
10-14 years	82,0	10,8	7,3	100,0	632
Total	75,6	13,2	11,2	100,0	987

9 Knowledge and practice of female circumcision

9.1 Discussions on the current status of circumcision

The issue of circumcision was the topic of a very detailed exploration conducted by researchers external to the programme. From the accounts of most men and women surveyed, the abandonment process is real in the villages; since the advent of the PD, new cases of circumcision have become rare, and even disappeared. As one of the facilitators indicated: *"Since the declaration, no case of circumcision has been reported, even if new girls were born."* Women from different villages confirm this trend. *"Before the PD, some girls were circumcised. But since we did the PD, we gave it up because we are Bambaras, and when we decide something we do not go back on our word*." (Non-participating woman, 50 years-old) *"We spoke about circumcision and its abandonment and then we put some people in charge of verifying the actual abandon of the practice in the village ; nobody practices circumcision anymore* " (Non-participating women, 37 years-old).

This decision seemed to be supported as firmly by the women who did not participate in the programme as by those who attended the classes: *"Now we cannot tell the difference between participating and non-participating women – they all behave the same way… Our mature girls are following in our footsteps. Up to now we have kept on this course because it is a general decision made by the whole village. We gave up the practice. It is no longer done in the village. After the PD I have not seen or heard of someone doing it in the village or outside."* (Non-participating woman, 39 years-old)

The leaders seem to fulfill their role and remind the communities of their commitment. *"In every village there is a leader. From time to time, this leader calls for a meeting to remind people about the consequences of the practice. I can really see that we abandoned the practice."* (Non-participating woman, widow, 55 years-old)

A few doubts remain, however, as this imam indicated: *"Ah, in any case we were doing it but we are not any more. Because at the beginning it was a great ceremony, we would make it a big party and sing. It was done at the Kassac, but now someone can do it at home and nobody will know. I don't know if they really gave it up, but it is not organized as it was before."* (Imam, 78 years-old)

Another elderly person expressed the idea that *"people will abandon circumcision but it will be very slow"* (President of the women's group, widow, 67 years-old). Another elderly woman reported that she no longer had a girl of circumcision age but she was not convinced. *"About circumcision, the point is that I no longer have a daughter of the right age. But if I did, I would put up a fight. It would be difficult to have me give it up, I'm not trying to hide it."* (Non-participating woman)

Some people claimed that compensation was given to persuade some women to abandon circumcision. Some of Tostan's actions were perceived as privileges granted by the NGO – and this triggered jealousies, as one of the presidents of the sports and culture association suggested: *"They said that they gave it up, and since then I have not personally witnessed a woman excising her daughter… because I heard that Tostan gave the women's group a sewing machine to teach them to make clothes… And by the way, we heard that that Tostan is proposing abandonment for cash… They went all the way to the National Assembly to tell them that we gave it up, and got some money for it. But to this day, even as we speak, I have not seen a cent of this money!"*

Other informants from group B villages doubted that circumcision was abandoned by the whole population. On the contrary, these informants emphasized that the practice has evolved: *"It is difficult to see a person who has been circumcised or hear that circumcision has been performed."* He continued, "*There are people who get their daughters circumcised secretly."* (Village chief)

These doubts and the conviction that people are resisting are not typical. The vast majority of people insisted that the practice was abandoned and that the commitment not to start again is still strong. This was true for all the villages that took part in the process. An imam observed, *"The only effect of the PD that we have noticed is that it effectively put an end to circumcision in our village, where it no longer exists today."* Consequently, a girl's circumcision status does not appear to be a hindrance to their marriage. According to one of the facilitators, mistrust is a thing of the past: *"At the beginning, there was a kind of mistrust for these girls from some of the men, but lately they have realized that girls who had not been circumcised were cleaner and healthier than those who had. From then on, they had great respect for the former. So today these girls have no more problems to find suitors*."

This was confirmed by the women: *"There are lots of uncircumcised girls within the village. They are well considered. They are not submitted to social exclusion in relation to this*

situation. I do not think that people are aware enough of the danger of these practices on people's health and their children's future." (Non-participating woman, 42 years-old, farmer)

There are still a few hard-liners who say that they will never give it up. It is difficult to generalize about these people: in one village, it was an elderly woman who displayed her opposition, while in another it was the youth leader who claimed he was against circumcision. However, some resentment was expressed by pioneering women who felt that they were not sufficiently rewarded for their courage in abandoning this age-old practice.

In conclusion, whether the initiative to abandon circumcision was taken by participating women alone, or in agreement with village leaders and the community, or with Tostan's encouragement, most people claimed that abandonment is a reality in the villages surveyed.

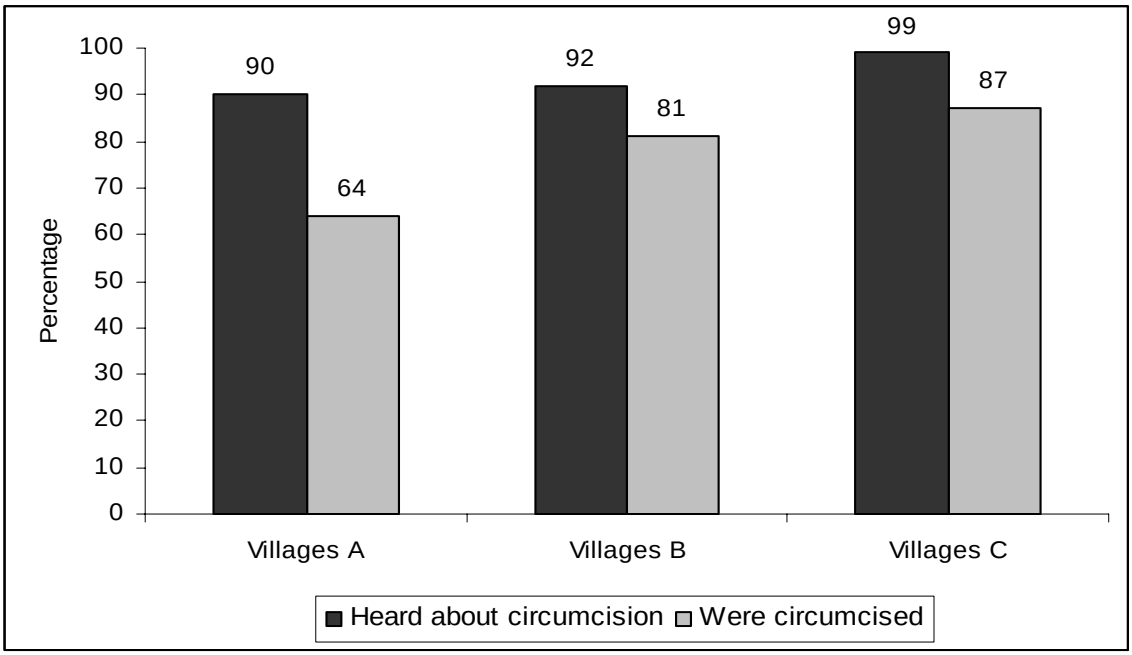
However, there is a slight difference between the zones of Kolda and Thiès/Fatick. Accounts from Thiès and Fatick point to an abandonment rate of 90 per cent. For the Kolda zone, it is not possible to determine the abandonment rate. Nevertheless, if circumcision is still performed, it is no longer done in a public fashion.

9.2. Knowledge and practice of circumcision

In this chapter, we present the levels of knowledge among women about the practice of circumcision, and the prevalence of this practice. We also address the effect that circumcision has had on people who performed the operation, and we present the opinions expressed by women on the advantages of abandoning this practice. Since one of the key objectives of this survey is to understand the tendencies that affect the practice of circumcision, results will be presented on the prevalence of circumcision and the age at circumcision of the daughters of the women surveyed.

Graph 9.1 gives results on the knowledge and the practice of circumcision among the women surveyed. The level of knowledge of circumcision (99 per cent) is higher in group C villages at all ages. Group A and group B villages are at a similar level, with 90 per cent and 92 per cent of women having knowledge of the practice, respectively.

Graph 9.1 Knowledge and practice of circumcision among the women surveyed



CRHD, Senegal 2006

9.3 Age at circumcision

In Senegal, 60 per cent of circumcised women underwent this operation “in early childhood” – i.e. at a very young age – and more than 90 per cent of those girls were circumcised before the age of 10 (DHS-IV 2005). Among the women of this survey, more than half said they were circumcised “in early childhood”. This answer was given by 48 per cent of women in group A villages, 65 per cent in group B villages, and 52 per cent of women in group C villages. If we add these percentages to the percentages of women who were circumcised when they were between 0 and 5 years old, we can see that the percentage of women circumcised before the age of 5 is 61% in A villages, 75% in B villages and 61% in C villages.

Table 9.1 shows that in all villages, women are circumcised before the age of 15 and around 90 per cent underwent the operation before the age of 10, as elsewhere in Senegal.

Table 9.1: Age at circumcision

Percent distribution of circumcised women by age at circumcision, EIT Senegal 2006

	Age at circumcision (in full years)								Number of
Village type	Early Childhood	0-1	2-4	5-9	10-14	15 +	Don't know/ Missing	Total	women circumcised
A Villages	48.1	3.5	9.5	20.0	10.0	0.5	8.5	100.0	401
B Villages	65.3	-	9.5	14.7	3.2	-	7.4	100.0	95
C Villages	51.8	2.7	6.6	20.1	12.6	1.8	4.5	100.0	334

Circumcision now occurs at earlier ages throughout Senegal, as we can see from a comparison between mothers and daughters. Table 9.2 shows that 95 per cent of circumcised girls underwent this operation before the age of ten.

Table 9.2 : Age at circumcision

Percent distribution of circumcised mothers and daughters by age at circumcision, EIT Senegal 2006

	Age at circumcision (in full years)							Number of
	Early Childhood	0-4	5-9	10-14	15+	Don't know Missing	Total	women circumcised
Mothers								
A Villages	48.1	13.0	20.0	10.0	0.5	8.5	100.0	401
B Villages	65.3	9.5	14.7	3.2	--	7.4	100.0	95
C Villages	51.8	9.3	20.1	12.6	1.8	4.5	100.0	334
Overall	51.6	11.1	19.4	10.2	1.0	6.7	100.0	830
Daughters								
A Villages	--	70.4	23.1	4.2	0.9	1.4	100.0	216
B Villages	--	85.2	13.0	--	--	1.9	100.0	54
C Villages	--	66.3	27.8	5.9	--	--	100.0	338
Overall	--	69.4	24.8	4.8	0.3	0.7	100.0	608

Knowing the age of girls at the time of circumcision is useful for our study. If we know that almost all girls who are cut are circumcised before the age of 10, then we can use the

prevalence rate for the circumcision of girls under 10 as a benchmark by which we can assess the impact of Tostan and of public declarations on circumcision.

9.4 Prevalence of circumcision

Knowing the age at the time of circumcision for the vast majority of women in Senegal, we have two data sources to identify the impact of Tostan on the rate of circumcision: women 15- to 19-years-old and girls 0- to 10-years-old. All other women and their daughters were over 10 in 1996, when Tostan's interventions started in the area. About 5 per cent of girls over the age of 10 are likely to be circumcised.

Before assessing Tostan's impact on the circumcision rates of girls, we must know the circumcision rate before there was any intervention. Table 9.3 shows circumcision rates by age group and village type. The proportion of circumcised women is noticeably smaller in group A villages (64 per cent) than in group B (81 per cent) or group C (87 per cent) villages (cf. last column to the right).

Table 9.3: Prevalence of circumcision among the women surveyed

Percentage of circumcised women by age group and village type, EIT Senegal 2006

	Current age							
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Total
A Villages								
Percentage	54.9	60.4	69.8	59.8	69.5	70.9	71.1	63.8
Number	133	111	116	87	82	55	45	629
B Villages								
Percentage	65.2	75.0	72.2	87.5	88.9	100.0	100.0	80.5
Number	23	24	18	16	18	10	9	118
C Villages								
Percentage	77.8	86.7	86.2	88.7	96.2	92.6	84.4	86.5
Number	85	60	58	71	53	27	32	386

We note a steady decrease of the circumcision rate in all villages among women aged 15- to 19-years-old: those who were aged 5- to 9-years-old in 1996-2000, and aged 10- to 14-years-old in 2001-2005. Control villages (C) experienced a decrease in circumcision rates from 92 per cent in women aged 35- to 49-years-old, to 78 per cent among women aged 15- to 19-years-old. This is similar to intervention villages (A), where circumcision rates dropped from a high of about 70 per cent among women aged 35- to 49-years-old, to 55 per cent among women aged 15- to 19-years-old. For group B villages, the number of cases (118) is too limited to draw a valid conclusion. We therefore cannot conclude from these data that this decrease comes solely from Tostan's activities in these villages.

9.5 Attitudes towards circumcision

It is only in group C villages that a majority of women (53 per cent) wish to continue practicing circumcision (Table 9.4). Most women in group A villages (71 per cent) and group B villages (83 per cent) favor ending this practice.

The main factor that brought women to oppose circumcision was Tostan's intervention and a village's participation in a PD, even without Tostan. The data show clearly that in Tostan villages, and in villages that held a public declaration, the effect on opinions expressed during the survey was the same: very few women want circumcision to continue.

Table 9.4: Women's attitudes towards circumcision

Percent distribution of women according to whether they are in favor of or against keeping the practice of circumcision, by village type, EIT Senegal 2006.

	Circumcision should be:					
Village type	Continued	Discontinued	It depends	Don't know	Total	Number of women who head of circumcision
A	18.4	70.8	4.4	6.2	100.0	565
B	7.4	83.4	0.9	8.3	100.0	108
C	52.9	37.4	5.2	4.2	100.0	382

9.6 Intent and practice of girls' circumcision

Table 9.5 and Graph 9.2 represent, for each village type, the percentage of women who had at least one circumcised daughter and those who had no circumcised daughter, but intend to have circumcision performed on their daughters in the future.

The percentage of women who had at least one circumcised daughter is lower in group A villages (30 per cent) than in group B villages (34 per cent); it reaches 69 per cent in control villages.

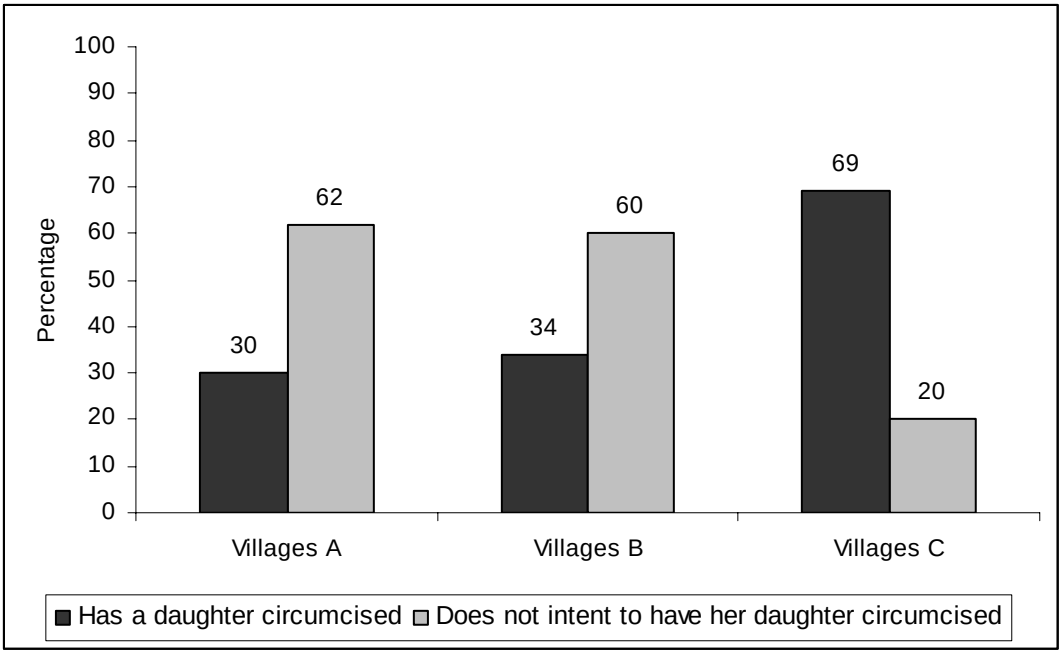
Table 9.5: Intent to have daughters circumcised

Percent distribution of women who had at least one living daughter according to whether the daughter is circumcised and, if not, their intention to have the daughter circumcised in the future, EIT Senegal, 2006.

Village type	Has at least one daughter circumcised	No daughter circumcised and the mother: Intends to have daughter circumcised	No daughter circumcised and the mother: Does not Intend to have daughter circumcised	No daughter circumcised and the mother: Don't know/ Missing	Total	Number of women with at least one living daughter
A	30.0	5.2	61.9	3.0	100.0	367
B	33.8	2.6	59.7	3.9	100.0	77
C	69.1	10.0	20.0	0.9	100.0	230

Similar trends are observed regarding the desire to have a daughter circumcised: only 5 per cent of mothers in group A villages, 3 per cent of mothers in group B, and 10 per cent of mothers in group C villages intended to have a daughter circumcised. In control villages that, in principle, were not exposed to Tostan's influence, there were more women who claimed that they wanted to have their daughters circumcised in the future. It is likely that there are fewer young and educated women who had their daughters circumcised, and more who did not wish to have their daughters circumcised (unpublished table).

Graph 9.2 Practice of circumcision and intent to have daughters circumcised



CRHD, Senegal 2006

9.7 Prevalence of circumcision among the daughters of the women surveyed

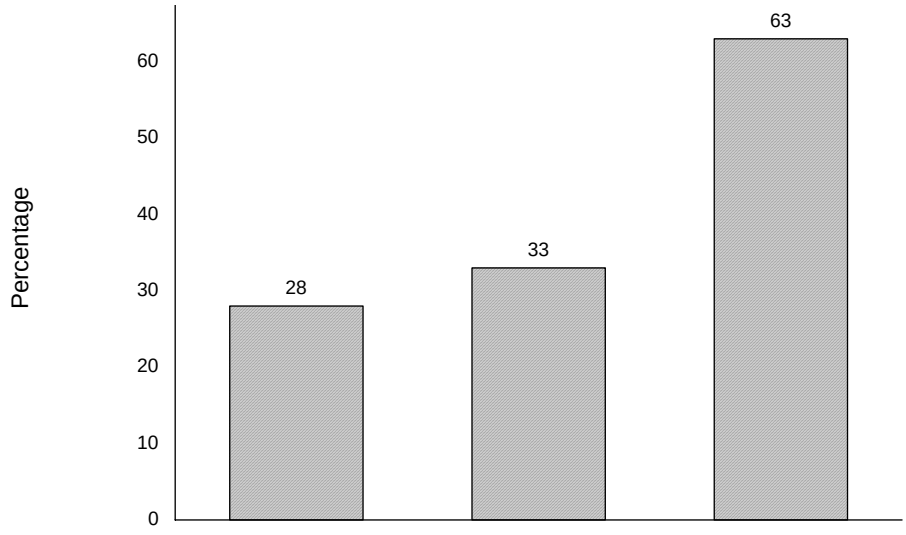
Table 9.6 and Graph 9.3 present the percentage of girls circumcised among all living daughters of the women surveyed, by age group. The proportion of circumcised daughters is noticeably lower in group A villages (28 per cent), than in group B (33 per cent) and group C (63 per cent). We conclude that there probably is a significant impact of Tostan's intervention with respect to this practice. However, if we accept that Tostan's effect on older generations (20-years-old or more) is not important, then the impact of the interventions becomes less obvious since the proportions of circumcised girls are lower in group A.

Table 9.6: Prevalence of circumcision among the daughters of the women surveyed

Percentage of circumcised girls among all living daughters of the women surveyed, EIT Senegal 2006.

Village type	Percentage	Number of girls
A Villages - Age of girls		
0-4 years	7.3	245
5-9 years	22.7	225
10-14 years	33.1	142
15-19 years	58.0	88
20 years +	68.1	72
0-10 years	15.6	533
Total	28.0	772
B Villages - Age of girls		
0-4 years	2.0	51
5-9 years	15.9	44
10-14 years	48.4	31
15-19 years	68.8	16
20 years +	87.0	23
0-10 years	10.7	112
Total	32.7	165
C Villages - Age of girls		
0-4 years	29.5	149
5-9 years	65.0	140
10-14 years	82.0	133
15-19 years	79.4	68
20 years +	85.1	47
0-10 years	53.0	345
Total	62.9	537

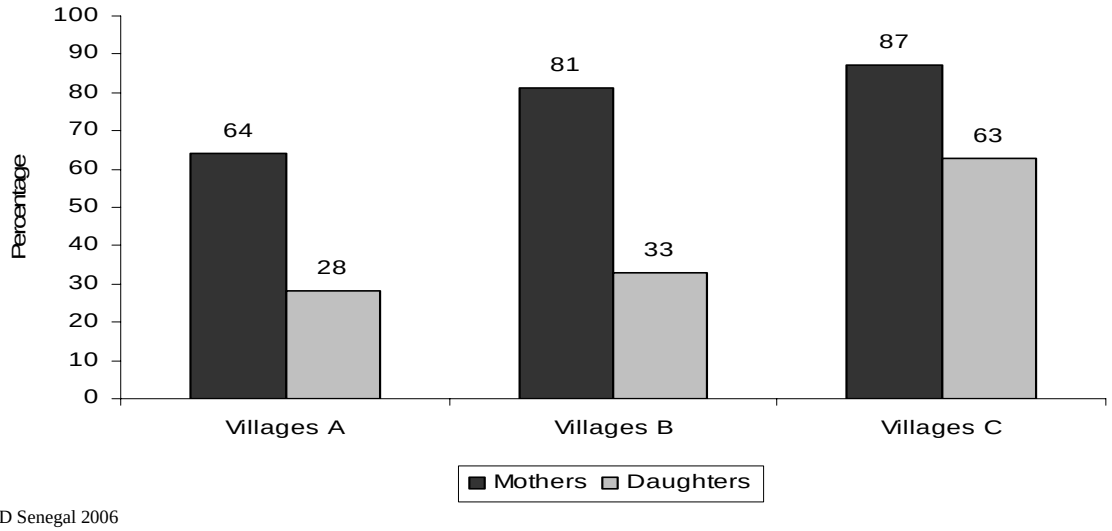
Graph 9.3 Percentage of girls circumcised among the living daughters of women surveyed



CRHD Senegal 2006

Graph 9.4 allows us to compare the percentages of women and girls circumcised for each village type to see whether there is a change between mothers and daughters. The graph shows a lower prevalence in the practice of circumcision among daughters than mothers, with a much stronger decrease in group A and B villages, where Tostan was active[4].

Graph 9.4 Prevalence of circumcision among the women surveyed and their daughters



CRHD Senegal 2006

[4] In spite of a certain difference in girls' ages at circumcision between villages.

Table 9.3 presents circumcision rates among women by age group for the three village types, and table 9.6 presents the findings from their daughters. Table 9.7 adds one age group of mothers to data from daughters to reveal longer term trends.

For a view of the overall situation of these changes in the intervention (A) and control villages (C), we consider the prevalence of circumcision in mothers aged 20-29 compared to daughters aged 0-9. The prevalence of circumcision is decreasing in all three village types. In control villages (C), it dropped from 86 per cent for women aged 20 to 29, to 47 per cent for girls 0- to 9-years-old – a 46 per cent drop in 20 years. In Tostan villages (A), the prevalence of circumcision has fallen from 65 per cent for women aged 20 to 29, to 15 per cent for girls 0- to 9 years-old – a drop of 77 per cent in 20 years. The prevalence of circumcision in B villages follows the same pattern but the numbers are too low to be used in drawing conclusions.

Table 9.7 : Prevalence of circumcision among women surveyed and their daughters

Percentage of mothers and daughters circumcised by age group and village type, EIT Senegal 2006.

	Daughters		Mothers	
	Age		Age	
Village type	0-9	10-14	15-19	20-29
A Villages				
Percentage	15	33	55	65
Number	470	142	133	227
B Villages				
Percentage	8	48	65	74
Number	95	31	23	42
C Villages				
Percentage	47	82	78	86
Number	289	133	85	118

Overall, we see a clear difference in the pace of reduction of circumcision rates in the A villages (Tostan) and the C villages (control): from 86 per cent to 47 per cent for control villages and from 65 per cent to 15 per cent for Tostan villages. That difference can be attributed to the public declarations and to Tostan interventions. These interventions have hastened the abandonment of circumcision.

We recognize that a small proportion of girls 0- to -9 years old will still get circumcised after the age of ten in the next few years in all three types of villages (Table 9.2). Therefore, if we assume for a moment that girls 0-4 would not be cut at age 5-9, the final prevalence for girls 0-9 years of age will be slightly higher than what is shown for all village types. In the case of type A villages, for example, the prevalence would be 15.4 per cent rather than 14.7 per cent for girls 0-9 years of age. One could make the same sort of calculations for the 0-4 year old girls to show that when they reach the age of 15, the prevalence rates will all be slightly higher. More information about the age of circumcision is found below.

Table 9.8 Age of the daughters of the women surveyed at circumcision

Percent distribution of circumcised girls by age at circumcision, EIT Senegal 2006.

	Age group of girls at circumcision					Number of girls
Current age of girls	0-4	5-9	10-14	15 +	Total	circumcised
Villages A						
0-4	100.0	--	--	--	100.0	18
5-9	84.3	15.7	--	--	100.0	51
10-14	77.1	22.9	--	--	100.0	48
15 +	55.6	31.3	9.1	4.0	100.0	99
Total	70.4	23.1	4.2	2.3	100.0	216
B Villages						
0-4	100.0	--	--	--	100.0	1
5-9	85.7	--	--	14.3	100.0	7
10-14	93.3	6.7	--	--	100.0	15
15 +	80.6	19.4	--	--	100.0	31
Total	85.2	13.0	--	1.9	100.0	54

Age group of girls at circumcision						
Current age of girls	0-4	5-9	10-14	15 +	Total	Number of girls circumcised
C Villages						
0-4	100.0	--	--	--	100.0	45
5-9	76.7	23.3	--	--	100.0	90
10-14	56.0	33.9	10.1	--	100.0	109
15 +	52.1	38.3	9.6	--	100.0	94
Total	66.3	27.8	5.9	--	100.0	338

Like their mothers, nearly all daughters (95 per cent) were circumcised before the age of 10; the circumcision of girls probably took place earlier in group B villages – which are primarily Poular, where more than 85 per cent of girls are circumcised before the age of 5 (Table 9.2). Also, although most girls aged 0- to 9-years-old have not entirely escaped the risk of circumcision, the circumcision rate among daughters at that age is already higher than the rate among mothers when they were at the same age. This confirms that daughters are circumcised at an earlier age. If we disregard girls currently aged 0- to 4-years-old who have not entirely escaped the risk of circumcision, we observe that the proportion of girls circumcised between the ages of 0 and 4 rises from one generation to the next, except in group B villages. However, the percentage of girls circumcised after the age of 9 is substantially higher in the group C.

Table 9.9 presents the percent distribution of girls according to current age by period of circumcision before the survey. Years have been grouped into five-year periods. Since the survey took place in February-March 2006, the most recent period (0- to 4-years) corresponds to the 2001-2005 period, and 5- to 9-years period corresponds to the 1996-2000 period. Since the survey was conducted in villages that practiced circumcision and benefited from at least one public declaration in 2000 or earlier, this typology should make it possible to grasp possible changes in the prevalence of circumcision by comparing the 0-to-4 period with earlier ones. Globally, for girls of all villages, the frequency of circumcision has not changed over the last 10 years: 11.4 per cent of girls in the 5-to-9 period before the survey were circumcised before the survey, as were 10.7 per cent of girls in the 0-to-4 period. However, in spite of the low numbers concerned, it appears that the frequency of circumcision has dropped in Tostan intervention villages (group A): the proportion of circumcised girls has gone from 8.5 per cent in the 5-to-9 period before the survey, to 4.7 per cent in the 0-to-4 period. In group B villages that have just

gone through a public declaration, figures are too low to draw a conclusion. By contrast, in villages that are not directly influenced by Tostan, the frequency of circumcision has increased over the last 10 to 15 years, with 22 per cent of girls having been circumcised in the four years prior to the survey, compared to 17 per cent in the 5-to-9 period, and to 16 per cent in the 10-to-14 period.

Table 9.9: Practice of circumcision by period before the survey

Percent distribution of girls by age and by period before the survey, EIT Senegal 2006.

	Current age (in full years)					
Period before the survey	0-4	5-9	10-14	15+	Overall	Number of girls
A Villages						
0-4 years	6.9	7.1	1.4	0.6	4.7	36
5-9 years	--	15.1	14.7	6.9	8.5	66
10-14 years	--	--	17.5	18.2	7.0	54
15 years +	--	--	--	35.2	7.3	56
Not circumcised*	93.1	77.8	66.4	39.0	72.5	560
Total	100.0	100.0	100.0	100.0	100.0	772
B Villages						
0-4 years	2.0	4.5	--	--	1.8	3
5-9 years	--	9.1	19.4	--	6.1	10
10-14 years	--	--	29.0	12.8	8.5	14
15 years +	--	--	--	66.7	15.8	26
Not circumcised*	98.0	86.4	51.6	20.5	67.9	112
Total	100.0	100.0	100.0	100.0	100.0	165
C Villages						
0-4 years	29.8	31.9	20.3	1.7	22.0	118
5-9 years	--	32.6	27.8	8.7	17.1	92
10-14 years	--	--	32.3	34.8	15.5	83
15 years +	--	--	--	36.5	7.8	42
Not circumcised*	70.2	35.5	19.5	18.3	37.6	202
Total	100.0	100.0	100.0	100.0	100.0	537

Period before the survey	Current age (in full years) 0-4	5-9	10-14	15+	Overall	Number of girls
Overall						
0-4 years	14.1	15.2	9.4	1.0	10.7	157
5-9 years	--	20.4	20.8	6.7	11.4	168
10-14 years	--	--	25.1	23.6	10.2	151
15 years +	--	--	--	39.6	8.4	124
Not circumcised*	85.9	64.4	44.6	29.1	59.3	874
Total	100.0	100.0	100.0	100.0	100.0	1474

*Includes cases for which age at circumcision is either missing or erroneous.

10 Discussion

The Tostan programme has had a real impact on individuals and in the life of the villages. The evaluation team is nevertheless aware that informants might have confused certain facts, even though they were constantly reminded that the team was not affiliated with Tostan but worked for an independent research institution. The evaluation raised several questions.

First, we can question the choice of villages. All the information gathered by Tostan as well as by the villagers shows that some pre-conditions are necessary for a village to be included in the survey. Some villages have strong leaders who polarize other villages; a village's obligation to support facilitators is another factor that can influence its selection. After the first public declaration, the name of the NGO was strongly associated with the abandonment of circumcision in the media coverage that this programme enjoyed. We also saw that a transition occurred as villages started asking for the programme due to its popularity and because of the effect of inter-village migrations. We therefore wonder about choice biases. Since abandoning circumcision is a theme that appears to be a prerequisite for establishing a programme, the more intractable villages can exclude themselves from the process. The more deprived villages can also exclude themselves from the process because they cannot afford the facilitator.

We recognize that the NGO's strategy of demanding financial participation from the village provides evidence of ownership. Populations play a great part in the establishment and implementation of the programme. They fully participate in its development, and the programme's acceptance level following the negotiations is very high. The effort made by villages to host facilitators and classes, despite the challenges of poverty, are evidence of full participation.

One can also wonder about participants in the programme. The low attendance level of some participants and drop-outs over time suggest a possible bias. Even if the reasons for dropping out appear justified, the fact is that only the most motivated women thoroughly participate in the programme. Are those who show the most determination and who probably have leading-edge ideas, the ones who benefit most from the programme? Are the most committed, who are already open to change, the main ones who strengthen their knowledge? A previous evaluation showed that at the outset, the level of knowledge of these women is

higher[5]. So the least independent women, the most intractable, and maybe those who are the most occupied by household chores and children (i.e. the youngest women) end up being the least involved. However, one interesting result of the evaluation is that over time, these differences gradually disappear, and other women in the village jump on the bandwagon.

We can also argue about the usefulness of education programmes in the context of dire poverty: even with an important investment by the NGO to increase knowledge and encourage healthy behavior, this investment will not easily bring dividends amid a shortage of water, health and social structures, and qualified health staff. Daily survival challenges limit the impact of the programme. Some informants emphasized the fact that knowledge is fine, but it does not bring benefits for daily survival. In this phase of the programme, we must also note that classes were entirely reserved for women.

The programme did not have as great an effect on reducing early marriage as it did on stopping circumcision. Reasons for this include: 1) a whole series of interventions and outside influences – schooling, law, media coverage, outside cultural models – contributed to this result; 2) sessions on marriage and women's rights were not well structured during this phase of the programme; 3) fear of pregnancies out of wedlock.

A paradigm change has occurred that has spawned new problems: out-of-wedlock pregnancy, rather than circumcision, is perceived to be a cause of shame and marginalization. However, an association is made between non-circumcision and girls' lewdness, because of the lack of education about circumcision. So the main problem with not excising girls, in the view of parents, is the increased risk of out-of-wedlock pregnancy, not the reduced ability to get married. This poses a real problem to parents, and solutions should be found.

The effect of the programme on abandoning circumcision, clearly expressed by everybody and supported by all categories of informants, is impressive. Only a minority of people are not convinced of the necessity of this renunciation. The process of discussion, awareness-building, and negotiation before the organization of the PD promoted adherence to the programme, and was crucial to abandoning this practice and making this action sustainable. However, some frustrations arose from the fact that pioneering women were insufficiently rewarded. The reasoning of some informants, mostly women, can be summarized as follows:

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[5] Diop, N.J., M.M. Faye, A. Moreau, J. Cabral, H. Benga, F. Cissé, B. Mané, I. Baumgarten and M. Melching. *The Tostan program: Evaluation of a community-based education program in Senegal.* Frontiers Final Report. Washington, DC: Population Council.

we were asked to abandon an age-old practice, and we accepted although we were never exposed to all the disadvantages everybody is talking about; so we should get something in return that offsets this great loss (loss of a milestone, loss of a recognition sign, loss of ethnic/cultural identity). Several years later, this resentment remains strong in the pioneering villages that were expecting more of a payback in their daily lives.

This sense of injustice is exacerbated by resentment about the material and financial investments made by Tostan in other villages. Some people felt that even if everyone gave up circumcision, it looked as though Tostan favored some villages at the expense of others. This probably arises from the funding granted to the NGO that it used in support of economic activities in the villages. Ignorance of these matters has caused frustration, and has even led to something like blackmail attempts related to the abandonment of circumcision. This blackmail is spoken about, but it is difficult to assess whether there is truth to it.

Some villages did not directly benefit from the programme but participated as observers in the public declaration. Following their return from these public declarations, open discussions were conducted which ended up in requests to have Tostan implement the programme in their community. Therefore, participation in the public declaration by allied villages is the beginning, not the end of the process for these villages. Ultimately, all villages in the zones covered by the study eventually received the programme. If allied villages felt the process of discussion and association was important, it was crucial to reinforce their decision by establishing an education programme in their communities.

As time went by, populations may have realized that the Tostan programme was synonymous with “funding” and “projects” for village women as a whole. At the time of the PD, there were many people attended (including VIPs, according to informants), and the village received financial aid to offset this cost; even if the amount was nominal, it was not insignificant in places where living conditions were very hard. Following the programme, Tostan generally gave grants or loans to groups that went through the programme. This can trigger envy and jealousy for villages that received the programme, which is why other villages may have wanted to benefit from the Tostan programme.

An important issue is whether structural interventions must come with or follow capacity-building programmes. The problem is that it is not necessarily the domain or the role of an NGO such as Tostan. But the search for partnerships with other programmes endowed with these skills appears to be a necessity.

11 Conclusion

The objective of this evaluation was to assess the impact of the Tostan programme on the daily lives of the villages and on early marriages and circumcision. The information collected shows that the programme helped the villages to develop a set of skills around how to bring about change: in knowledge, in the human and social order, and in the practical perceptions related to circumcision.

In the quantitative analysis, the focus was on the effect of the programme on a social scale, the evolution that took place in health, and the changes that occurred at individual levels. On the social scale, the programme fostered an improvement in social relations within the villages. Informants indicated that the status of women was given higher value within the villages. There was also a kind of synergy the developed, where actions that were being conducted for the programme promoted mutual assistance in the villages.

In the human and social order, significant positive change occurred in perceptions and interpersonal relations, a result of the Tostan programme promoting communication within the villages. According to leaders and participating women, the programme helped reduce conflicts between spouses and thus contributed to the improvement of marital relations.

On the health front, the Tostan programme was instrumental in encouraging people to make better use of health care services; this is one by-product of improving women's knowledge of immunization and prenatal consultations. It is essentially in the implementation of lessons learned that the real impacts in the health sector can be assessed. However, while accounts of women's experiences emphasized greater access to health care, the quantitative analysis did not find an effect of the programme on the health of women and children; immunization rates for children, the use of services and access to health services were no better in the villages that benefited from the programme.

In our conversations about public declarations, we heard that there were wide variations in the organization of PDs and in the quality of participation. However, the people surveyed all indicated that they took very seriously the commitment that their village made to abandon circumcision after the PD.

The establishment of social groups in the villages took place before the programme's implementation, but the programme contributed to their enhancement. The PD seems to have

been instrumental in strengthening some of these committees, especially in promoting follow-up to the decisions that were made at the declarations. The majority (71 per cent) of the women surveyed claimed that there was a committee in charge of following up on public declarations, but these groups/committees were no longer found in the villages that were visited by the qualitative team.

People still encounter difficulties when accessing social services. This and other factors limit the extent to which communities can build upon assets gained through the Tostan programme. Beyond this, there is a lack of follow-up in the field, as well as a lack of supporting structure. Tostan attempted to address these problems by creating committees, but in reality, the committees did not work as expected: people find it hard to identify the committees and define their missions, focus, actions and their achievements within the localities covered by the study.

The status of early marriage remains rather ambiguous in intervention villages because the population does not agree on its relevance. Statistics indicate that the rate of very early marriages (under 15-years-old) decreased in the last 10 to 15 years in all three village types. The biggest drops were observed in intervention villages (group A) for girls aged 10- to 14-years-old: 23 per cent, 16 per cent and 12 per cent during the periods 10- to 14-, 5- to 9- and 0- to 4- years before the survey. In control villages, a less dramatic drop can also be observed for marriages under 15-years-old (from 18 per cent to 13 per cent). The comparison between group A and C villages therefore shows that the combination of PDs and Tostan programmes were instrumental in bringing about a small decrease in the prevalence of under-15 marriages.

There appears to be a very clear change in perceptions relating to circumcision in the villages covered by the study. On this issue, the Tostan programme contributed to the mobilization of communities that were subsequently united around the abandonment of the practice. The majority of the people surveyed declared that circumcision was no longer performed in their village.

Statistical results on the circumcision of girls show that the prevalence of circumcision decreased in Tostan intervention villages and in those that took part in a public declaration (groups A and B). The percentage of circumcised girls between the ages of 0 and 9 is 15 per cent in group A villages, 8 per cent in B villages and 47 per cent in C villages. It is notable that we see effects in the seven Kolda villages (group B villages) of participation in a public declaration that was outside the Tostan programme. It is important to note, however, that about

5 per cent of girls 0- to -9 years old will still get circumcised in the next few years. This fact means that in all three types of villages, the reduction in prevalence is slightly lower. In the case of type A villages, for example, the prevalence would be 15.4 per cent rather than 14.7 per cent. Circumcision still remains in all villages, but its frequency has gone down drastically in intervention villages. By contrast, in control villages, practices and opinions remain favorable to circumcision.

It is generally accepted that Tostan's intervention was globally beneficial to all populations in the zones where the NGO was active. For the general population, these benefits are mostly seen in the drop in circumcision rates. For participating women and some others, they continue to reap the benefits of the knowledge and capacities acquired in class. Commitments made by the population during and after public declarations also help bring down the frequency of circumcisions.

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Photo content: Fatoumatou Diallo, participant in the Tougnifily Public Declaration for the abandonment of FGM/C and child/forced marriage, reads the declaration to the crowd in Tougnifily, Lower Guinea on June 10, 2007.

Photo credit: picture kindly provided by Tostan.