

# **Female Genital Mutilation In The Gambia**

## **A Desk Review**

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*Although the collaborating institutions endorse the main message of the document, it does not necessarily reflect the official views of these institutions or of their boards of directors or affiliated institutions.*

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# Preface

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This document is the product of a collaborative effort that began in June 2002 when representatives of fourteen institutions – including the United Nations Children’s Fund, World Health Organisation, United Nations Development Programme, Medical Research Council/United Kingdom, Department of State for Education/Girls Education Unit, African Centre for Democracy and Human Rights Studies, Forum for African Women Educators, Mainstreaming Poverty and Gender Project, Central Statistics Department, Maternal Child Health Unit, Gambian Committee on Harmful Traditional Practices, Foundation for Research on Women’s Health, Productivity and the Environment; University of The Gambia, and the National Women’s Bureau – met to discuss a Research and Documentation Study project proposal on the elimination of female genital mutilation in The Gambia.

The project proposal was initiated by the Women’s Bureau in the Office of the Vice President and Secretary of State for Women’s Affairs. It emerged from discussions with WHO and UNICEF, to both of which the proposal was initially submitted for funding, that a multi-sectoral approach would be the most viable and effective way forward in the campaign to accelerate the elimination of female genital mutilation in The Gambia.

The proposal was reviewed on 5 June 2002 at a meeting of representatives of the fourteen institutions. The meeting decided to hire the services of a consultant to carry out a desk review and produce a document containing an analysis of existing literature on the subject of female genital mutilation as well as future strategies and recommendations for action.

A seven-member Sub-Committee set up to review the outputs from the consultancy comprised representatives of the Gambian Committee on Traditional Practices, Medical Research Council, Foundation for Research on Women’s Health, Productivity and the Environment; African Centre for Democracy and Human Rights Studies; Maternal Child Health Unit, UNICEF and the Women’s Bureau.

The question of how to eliminate an entrenched practice such as female genital mutilation is a complex one. This document does not pretend to address all the issues surrounding the practice or propose definitive strategies or recommendations for action aimed at addressing all the future challenges in that area. Our central message is: Yes, official attitude towards the campaign to eliminate female genital mutilation in the country is ambiguous and ambivalent; that those involved in campaigns against the practice need to rethink the strategies hitherto employed based on proper and credible information and data in order to effectively address the unmet advocacy needs of policy-makers, and the knowledge and awareness needs of the general public as well as special target groups (practitioners, women, men, religious and traditional leaders, journalists etc.) in the country.

Looked at from this prism, the document proposes strategies that must satisfy three basic needs – the need to persuade government to clearly define an official position on harmful traditional practices, including female genital mutilation; the need to bring about a better and deeper understanding of the immediate, medium and long-term health, psychological, and obstetric sequelae of female genital mutilation in The Gambia; and, based on credible research findings, documentation and “Best Practices”, satisfy the need to create greater public

knowledge and awareness about female genital mutilation.

The strategies should be conceived, owned, and implemented by government and in-country organisations and supported by The Gambia's traditional and potential development partners. A rethink of existing strategies is a necessary condition for mounting effective and successful campaigns to accelerate the elimination of female genital mutilation in The Gambia.

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**Fadinding Manneh**, Maternal Child Health Unit;

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# Acknowledgements

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reflect the official views of these institutions or of their boards or affiliated institutions.

A Technical Sub-Committee representing fourteen institutions and coordinated by Fatou Kinteh (Women's Bureau) collaborated in producing this document. Other members of the Committee were Fatou Waggeh (Bafrow), Dr. Gloria Ekpo (Medical Research Council/UK), Frances Foord (Gamcotrap), Hanna Forster (African Centre for Democracy and Human Rights Studies), Fadinding Manneh (Maternal Child Health/Family Planning), and Salifu Jarsey (UNICEF).

In preparing the document, the Committee was fortunate to have help from different people. Our first thanks go to the Women's Bureau for taking the initiative to coordinate this effort and to the other participating institutions for their assiduity and contribution. Finally, we proffer our special thanks to those institutions, which made useful documents available as requested by the Committee at its initial meeting.

The First Draft of this document was tabled for discussion in July 2002 at a meeting of the Technical Sub-Committee hosted by UNICEF. The comments and observations of members were incorporated before the document was presented to a meeting of the Committee of the whole.

The Technical Sub-Committee would like to express its profound gratitude and thanks to the United Nations Children's Fund and the World Health Organisation for their generous financial and logistic support. However, responsibility for this document remains wholly and solely with the Technical Sub-Committee. Likewise, although the fourteen collaborating institutions endorse its main message, this document does not necessarily

# Summary

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The international legal context for the elimination of harmful traditional practices, including female genital mutilation, is provided by a number of Human Rights Conventions and Declarations to which The Gambia is Party. Consequently, continuation of the practice of FGM can no longer be justified and defended on the grounds that it is a custom within Gambian culture.

Presently, FGM is seen both officially and by the public as a cultural issue, and thus a problem, which is difficult to deal with, as it is deep-rooted and therefore politically sensitive. Its solution therefore lies in attitudinal changes within society, which is obviously a long-term prospect. But arguments that place FGM within the context of culture often mask a lack of commitment by political and cultural (including religious) leaders to deal with the problem.

Three interconnected and mutually reinforcing factors account for the relatively insignificant impact of years of anti-female genital mutilation campaigns in the country. The first is inadequate understanding, within The Gambian context, of the phenomenon itself and its causes. The second is the way in which approaches to the campaign to eliminate the practice are fragmented. Thirdly, most strategies focus on symptoms and consequences, rather than on the problem and its causes.

Recognising the weaknesses inherent in past approaches does not imply a need to discard those approaches. It rather points to the complexity of the problem of female genital mutilation and to the need to work together, and to combine and coordinate the efforts of different institutions involved in the campaign

to eliminate FGM. Networking and exchange of information among key players, thus becomes an important tool for strategy development. It calls for an acknowledgement of the fact that female genital mutilation will not be eliminated unless all the important contributions are institutionalised and coordinated to build on each other, thus creating a momentum of sustained action. It calls for efforts to increasingly involve civil society such as religious leaders which have so far played a limited role in the fight against the practice but whose input is crucial.

The significant fact is that there have been very little or no collaboration or linkage between the approaches so far adopted mainly by non-governmental organisations and the people implementing them. Individual approaches, applied in isolation, have significant weaknesses. Institutions involved in the campaign have tended to deal with female genital mutilation but from different perspectives with little or no coordination. Some are unaware of each other's efforts or the knowledge that there are interventions by other institutions. Scattered efforts arise from, among other things, the complex nature of the phenomenon itself, which results in its being defined and handled differently by different sectoral players.

It is therefore a strategic imperative that a more integrated and multidisciplinary approach should be developed and adopted if female genital mutilation is to be effectively combated. The new coordinatory role of the Women's Bureau defined in the 1999-2009 National Women's Policy could bridge this gap.

An integrated approach to the elimination of female genital mutilation would also require an overall policy, which targets the victim, the practitioner and the systems that make the practice possible and sustainable. Such an

approach should have at least four characteristics: Firstly, it should call for Government and its various departments and agencies to acknowledge the existence of harmful traditional practices as a social problem. This signifies the removal of the different forms of harmful traditional practices, such as FGM, from the private realm of individual women into the public domain. This would qualify the problem to be one in respect of which government has an obligation to develop policies, design strategies and commit resources.

Secondly, Government and its various agencies must perceive harmful traditional practices as a multifaceted problem. As long as official circles continue to perceive the problem as one of culture and tradition, it will be difficult to design an overall policy for the elimination of the problem. Thirdly, and arising from this, an integrated framework calls for the design and adoption of an overall policy framework within which guiding principles are identified, targets are set and the roles of various stakeholders are provided for. The fourth characteristic is that an integrated approach requires the coordination of the efforts of the different actors.

A critical part of the efforts to eliminate female genital mutilation also requires a deepening understanding of the problem. This should be done partly through the identification and analysis of causal factors in order to establish linkages and relationships. It is only then that effective strategies can be developed which target the root causes of the problem and involve all sectors and people who can impact on the causes. Without a clear understanding of the full range of the consequences, it is likely that female genital mutilation will continue to be treated as a private matter rather than a societal problem. It is also likely that interventions will not adequately address the issues raised by the

consequences. With regard to those stakeholders whose interest is the elimination of the practice, identifying and understanding the problem facilitates the development of strategies, which will enable government to involve them and collaborate with them in its efforts to eliminate the practice.

# Abbreviations

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ACDHRS	African Centre for Democracy and Human Rights Studies	MRC	Medical Research Council
ACRWC	African Charter on the Rights and Welfare of the Child	NBD	North Bank Division
ADB	African Development Bank	NGO	Non-Governmental Organisation
APGWA	Association for Promoting Girls and Women's Advancement	NPAGW	National Policy for the Advancement of Gambian Women
BAFROW	The Foundation for Research on Women's Health, Productivity and the Environment	NWB	National Women's Bureau
BV	Bacterial Vaginosis	NWC	National Women's Council
CATCID	Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment	PHPNP	Participatory Health Population and Nutrition Project
CBO	Community Based Organisation	POP/FLE	Population/Family Life Education
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women	PRA	Participatory Rural Appraisal
CRC	Convention on the Rights of the Child	RHR	Reproductive Health Research
CRD	Central River Division	RTI	Reproductive Tract Infection
DfID	Department for International Development	STI	Sexually Transmitted Infection
DoSE	Department of State for Education		
DoSH	Department of State for Health		
FGM	Female Genital Mutilation		
GAMCOTRAP	Gambian Committee on Traditional Practices		
GOTG	Government of The Gambia		
GTU	Gambia Teachers' Union		
HSV2	Herpes Simplex Virus 2		
IAC	Inter-African Committee on Traditional Practices		
KAP	Knowledge, Attitude and Practice		
LRD	Lower River Division		
MCH	Maternal Child Health		
MOU	Memorandum of Understanding		
MPGP	Mainstreaming Population and Gender Project		

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# International Context

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Female genital mutilation (FGM) is a term used to describe traditional practices that involve the mutilation of female genitalia. Other commonly used terms for these procedures are female genital cutting, female circumcision or female genital surgeries. It is estimated that 130 million women worldwide have undergone FGM while 2 million girls and women a year are subjected to these operations (Toubia 1996).

The World Health Organisation (WHO) has classified these operations into four types (WHO 1995). Type I involves the partial or total removal of the clitoris. Type II involves the partial or total removal of the clitoris together with partial or total excision of the labia minora. Type III is partial or total removal of the external genitalia and stitching or narrowing of the vaginal opening. Type IV is relatively rare and refers to other traditional genital mutilation such as pricking or stretching the clitoris and/or surrounding tissues. An estimated 85% of cutting operations are Type I or II with around 15% being the more severe Type III (Toubia 1993). Female genital mutilation tends to be practised in North-East Africa and in Sub-Saharan Africa north of the equator.

FGM has become a major concern of the international community. The United Nations Convention on the Elimination of All forms of Discrimination Against Women (CEDAW), which came into effect in 1981 contains provisions which, although recognising the role of culture and tradition, nevertheless urges State Parties to take appropriate measures “to modify the social and cultural patterns of conduct of men and women, with a view to achieving the

elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or superiority of either of the sexes or on stereotyped roles for men and women”. The Committee on CEDAW, the body vested with power to monitor implementation of the Convention makes several recommendations calling on State Parties to take effective measures with a view to eradicating harmful traditional practices, including information about measures taken to eliminate FGM in the periodic reports they send to the Committee. The Gambia is in the process of finalising its ‘Initial Report’ to that Committee. In addition to the CEDAW, the United Nations Declaration on the Elimination of Violence Against Women adopted by the General Assembly in 1993 calls on State Parties to abolish harmful traditional practices including FGM.

Moreover, Article 24 (3) of the United Nations Convention on the Rights of the Child (CRC) requires that State Parties “shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of the child”. The 1994 Fourth United Nations World Conference on Women held in Beijing, classified FGM as a form of violence against women, equated with battering, rape, sexual abuse, and forced prostitution.

FGM is also defined as a form of torture under the 1984 UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CATCID). CATCID defines torture as any “act by which severe pain or suffering whether physical or mental, is intentionally inflicted on a person for...purposes... including any reason based on discrimination of any kind”.

Within the regional context, the African Charter on the Rights and Welfare of the

Child (ACRWC) to which The Gambia acceded in 2002 stresses that positive traditional values and cultures be preserved and strengthened, while article 21 requests Parties to take appropriate measures “to eradicate traditional practices and customs, which are prejudicial to the child”. Similarly, the African Commission on Human Rights in The Gambia, on its part, organised a seminar in 1991 on harmful traditional practices in Africa and recommended legislation, education, and other measures for the abolition of harmful traditional practices, including FGM.

The support that children, young people, women and men need, in order to behave in health promoting ways, has thus been defined as a basic human right. Governments and civil societies therefore have an obligation to see that words of these internationally adopted conventions and resolutions are turned into action and upheld by law. These conventions and conferences make key contributions to creating a supportive environment at global advocacy levels.

However, at the national level it is important to recognise that there is a gap between what is legislated and what is actually enforced. Nearly all countries, including The Gambia, are signatories to the CRC but nevertheless children around the world continue to have their basic rights ignored and undermined. Similarly, despite many signatories to the CEDAW, discrimination and inequities based on gender continue to abound.

The reality is that such broad based Conventions have only been adopted at the theoretical level in many countries. Many governments have ratified them through international advocacy and pressure, not through a belief that they can or must enact

their provisions immediately (Unicef 2000). There has been much criticism of such “jumping on the bandwagon” in order not to be seen as a bad guy on the international scene. However, there is another side to this issue. If a country ratifies an international convention through international pressure, it can, thereafter, be held accountable, and the power of advocacy for the enactment of the convention’s provisions may increase. In other words, if international and national lobbyists can succeed in getting governments to pass important social laws and social policies, they can then use such legislation for leverage, even if it actually takes years for all the provisions to be implemented.

#### **Box 1: Government’s Obligation**

- Highly placed government officials have defended the maintenance of the practice of FGM on the grounds that it is a custom within Gambian culture. As The Gambia is Party to many of the human rights conventions, particularly the CEDAW and CRC, there is need to convince policy-makers that Government can no longer invoke any custom, tradition, or religious consideration to avoid its obligation to eliminate violence against women (CEDAW, Article 4 of the Declaration).
- FGM also falls into the category of harmful traditional practices. It is necessary to persuade government officials and civil society organisations that it is no longer possible either to defend FGM practised on children on the grounds that it is a custom within

# National Context

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Situated in West Africa, The Gambia is surrounded on three sides by the Republic of Senegal with the fourth side being the Atlantic coastline. The borders of the country loosely follow the course of The River Gambia, which bisects the country into two roughly equal northern and southern halves. The country has a total surface area of 10,689 square kilometres and a narrow physical configuration.

## Background

The population of the country, which grew at 4.2% per annum, was estimated at 1,038,145 in 1993 (Census 1993). During the same period, the urban and rural populations were estimated to have grown at 6.2% and 3.2% per annum, respectively.

There are five distinct ethnic groups in the country. The Mandinka ethnic group is concentrated mostly in the Lower River and North Bank Divisions (LRD/NBD) and constitutes 40% of the population. The Fulas, found mainly in the Central River Division (CRD), constitutes 18.5% of the population. The Wollofs, which make up 14.6% of the population, constitute the third largest ethnic group. They are concentrated in the Central River Division where they form an almost homogenous bloc that corresponds to a larger group across the border in Senegal. They are found in greater numbers in the capital city, Banjul, and its environs (UNICEF Sitan 2000).

The Bundu and Bambo Wollofs are originally from Senegal Oriental while the Saloum and

Fana Wollofs originated from Sine Saloum also in Senegal. All are predominantly Muslim.

The Jolas and Karonikas together constitute 10.6% of the population. They are found mostly in the Western Division (WD) and the Kanifing Municipal Area. Sarahules, who are predominantly Muslim, constitute 8.9% of the population and are found mainly in the Upper River Division. The rest of the population belong to minor ethnic groups including the Serer (2.8%), Creole/Aku Marabout (1.8%), Manjago (0.8%), Bambara (0.7%) and other (1.5%).

The ethnic and geographic origin of these groups is highly relevant to the prevalence and type of FGM practised in their respective communities.

Gambian ethnic groups are bonded by factors such as religion (Islam and Christianity), and extended family linkages through cross-marriage. The family itself is a network of households and mutually supportive extended family, particularly in the rural areas. Most households are male-dominant, partly because men are considered 'bread-winners' although there are a growing number of female-headed households due to divorce, rural/urban migration or widowhood.

Thus, while the Gambian family acts as the key agent of early socialisation in cultural norms, etiquette, desirable social behaviour and ultimate social control (World Summit for Social Development 1995), the individual in society is an integral part of the community with his/her identity depending on his/her role, status and relations within society. Traditional or historical determinants of status are age, gender, kinship and, in some cases, caste.

## Official Policies

Female Genital Mutilation has been a matter of considerable concern to the international community since the 1980s such that the WHO and the United Nations Human Rights Commission have recommended that governments take specific measures aimed at its elimination wherever it is practised (Hedley R *et al.* 1996).

The WHO *Regional Plan of Action to accelerate the Elimination of Female Genital Mutilation in Africa* was launched in The Gambia in 1997. In addition, The Gambia is Party to a number of international human rights instruments, on the issue of harmful traditional practices. These instruments include the CEDAW, CRC, and ACRWC.

### **Box 2: Absence of Official Policy on FGM**

- Despite being party to international human rights instruments calling on State Parties to eliminate harmful traditional practices, including FGM, The Gambian Government has not yet defined and declared a national policy on the practice.
- Official attitudes continue to be ambiguous and ambivalent.
- There is need to present key policy-makers with the results of in-country research and documentation studies in order to convince and persuade them about the necessity of adopting and declaring an official policy on harmful traditional practices, including FGM.

## Public Opinion

There are no nation-wide statistics on public attitude towards FGM. Limited sample size surveys carried out by some NGOs indicate that the majority (69% of respondents in one such survey) want FGM maintained for “purposes of tradition” (Bafrow 1997). However, only 15.4% of males and 11.2% of female respondents aged 14-24 years in a nation-wide Adolescent Reproductive Health Survey by the Department of State for Health (DoSH 2000) were in favour of FGM.

The Gambia is 95% Muslim and anecdotic accounts indicate that the majority are in favour of maintaining the practice on “traditional and religious” grounds although Islamic scholars in the country are divided on the subject. For adherents of the Muslim religion, FGM is an “Islamic obligation.” According to the Umm Attiah Hadith “circumcision is a Sunna (obligation) for men and a sign of respect for women.” Traditionalists on the other hand claim they inherited the practice from their ancestors who had been doing it for centuries. Their ancestors, they argue, would not have handed it down if it were bad.

These two positions could account for the unfavourable public attitude towards the elimination of female genital mutilation to the extent that an Islamic pro-FGM lobby is very active in the country. The lobby comprises religious and traditional leaders who urge Muslims to maintain the practice on both religious and traditional grounds.

**Box 3: Low Knowledge and Awareness**

- There are limited data and information on the level of knowledge and awareness among the population about the need to eliminate harmful traditional practices including FGM is low.
- There is need to conduct Knowledge Attitude and Practice (KAP) studies as input to information education and communication strategies and programme development.

## FGM in The Gambia

### Prevalence

Genital mutilation is widely practised in The Gambia. It is estimated that 60% of Gambian girls and women undergo the practice of FGM (Hedley R. et al 1992). There are no nationally representative estimates but in a community-based survey on the long-term reproductive consequences of FGM in rural Gambia, of the 1,156 respondents from the three main ethnic groups surveyed, 98% of Mandinkas, 32% of Fulas and 4% of Wollofs had signs of genital cutting (MRC 2001).

Other less representative surveys (Bafrow, Gamcotrap) estimate practice among the Sarahules and Mandinkas at 100%, relatively diminishing among the Jola (96%), Fulas (84%), Serer (64%) and Wollofs (20%). Practice among the minor ethnic groups (Aku Marabout, Tilibonka and Karonika) is also estimated at 100%.

Strong adherence to traditional values and the reluctance of many Gambians to change their culture are given as explanations for the high incidence of FGM despite efforts to eliminate the practice.

### Types

Like the rate of prevalence, no nationally representative studies have yet been carried out on the types of mutilation practised. However, the Medical Research Council's (MRC) community-based survey of the *Long-term reproductive health consequences of female genital cutting in rural Gambia* revealed that the frequency of the different types of operation performed fell mostly into the WHO type II classification. Of the 1,156 women who reported their circumcision status and were assessed by a gynaecologist, 10 reported 'normal' (Type II) circumcision but had evidence of closure (Type III).

The MRC study is consistent with other studies (Bafrow 1997, Gamcotrap 1999, Daffeh et al. 1999, Singhateh 1985) on the type of female genital mutilations practised in The Gambia.

### Practitioners

A number of studies have assessed the role of traditional practitioners in maintaining and reinforcing the practice. The Circumcisers or *Ngamanor* ('the cutter') are elderly women with various backgrounds including the *Numu* smith caste, Mandinka *karanke* caste, *Jabanke nyamalo* caste, and the Mandinka slave caste (Gamcotrap Annual Report 1999). A *Ngasingha* or Assistant Circumciser assists the *Ngamanor*. Their role is to take care of the girls from circumcision to healing.

However, the studies have reached different conclusions as to the motivations of the Circumcisers for engaging in the practice. In one study (Bafrow 1997), the operation is a main source of income. Income-generation activities for the circumcisers have therefore been developed as 'alternative' to lure them away from the practice. Gamcotrap on the other hand has found that the motivation differs from one circumciser to another. For most circumcisers interviewed in its programme, the operation is not the primary source of livelihood although there are some circumcisers who travel from village to village to do as many operations as possible. For these ambulatory circumcisers, performing the operation is a primary source of income (Personal communication). In other studies still, Circumcisers have indicated their involvement in the operation as a service to the community (Daffeh et al. 1999).

Currently, nationally representative studies on the actual rate of prevalence of FGM in the country are inadequate. Also limited are the studies on the types of mutilation practised such as the MRC study, which was only part of a larger community-based study to look at the prevalence of reproductive morbidity in rural African women whilst the studies of various organisations have reached different conclusions as to the motives Circumcisers have for doing the operation.

The set of values and practices, which constitute a culture, are not static but depend upon the consensus of the group. Over time people collectively can and do change their cultures. Programmes, which seek to address cultural issues such as FGM, therefore need to analyse the forces at work in order to tap into this evolutionary process.

#### **Box 4: Prevalence Study**

- There is currently no nation-wide study documenting the prevalence, types and practice of the FGM.
- A nation-wide study is needed to complement existing studies and determine the actual rate of prevalence of FGM, the types of mutilation practised as well as the real motivations for the practice, starting from the assumption that human behaviours and cultural values, however senseless or destructive they may look, have meaning and fulfil a function for those who practise them.

## **Socio-demographic Factors**

FGM is deeply rooted in the cultural and traditional life of the Gambian population and cuts across ethnic lines, geographical boundaries, religious affiliation and educational and economic status.

### **Age**

A number of studies have sufficiently documented the age at which FGM is performed on girls and the mechanics or rationale for the timing for the operation. The studies indicate that communities that practice FGM as "religious obligation" perform it during infancy. In contrast, when the practice is explicitly referred to as an "initiation rite" for entrance into womanhood and preparation for marriage, it is performed later, near puberty or just after it. The Sarahules, for instance, are reported (Daffeh J et al. 1999) to perform the operation as a "religious obligation" in the first week of the baby's life,

latest the seventh day. In other ethnic groups a day old baby may even be operated on in a mixed age group setting. This is, however, dependent on whether the community abides by community arrangements – initiation rite of passage.

The studies also indicate that Circumcisers will operate on all girls in a community during the prescribed period in order to clear the backlog of candidates for the operation if the last initiation rite, for example, took place seven years ago. In such cases, every child in the community between ages 0-7 years may be subjected to the operation, even if the baby were born on the very day the operation is planned to take place (Daffeh J et al. 1999) There are some instances, though, when adolescents are taken. This is mainly applicable to girls who are living away from home and on return are subjected to the practice, the late age notwithstanding.

## **Ethnic and Regional Affiliation**

The prevalence of the practice of FGM is highest in rural communities, particularly the dispersed settlements where there is ethnic homogeneity (Daffeh J et al. 1999). These include the Sarahule communities in the Upper River Division (URD), the Mandinka communities in the Lower River and North Bank Divisions (LRD/NBD), and some of the Fula communities in the Central River Division (CRD).

Ethnic origin is an important factor in the maintenance of the practice. For instance, some Wollofs who practise FGM migrated to The Gambia from Senegal Oriental while those originally from Sine Saloum, also in Senegal, do not practise FGM even though they are Muslims. Moreover, not all categories

of Fula practise FGM even though studies have shown that the ethnic group generally has about the second highest rate of practice of FGM in the country (Daffeh J et al. 1999:7), Bafrow Baseline Report 1997:29).

The Fula ethnic group comprises a number of sub-groups - the Hobobehs, originally from Jolof in Senegal settled in the Baddibu area; Torankas, originally from Futa Toro in Guinea settled in the Niani and Nianija Districts; Tukuleurs from Futa Jallon also in Guinea settled in the Fulladus and the Kabadas in the Kiangs while the Jawarinkas from Guinea-Bissau settled in the Fulladu area. The Hobobehs and the Jama don't practise FGM. All other sub-groups within the Fula category (Torankas, Peuls, Futas, Tukuleurs, Jawarinkas, Lorobehs, Ngalunkas and Daliankos) practise FGM.

Within the Serer ethnic groupings, the Njefenjefe do not practise FGM although the Niumikas from the same ethnic group do. Also, while the Jola Foni practise FGM the Jola Casa, originally from the Casamance Region of Senegal, do not practise FGM

The prevalence of the practice based on ethnic and regional affiliation has significant strategic importance in the search for viable approaches to the elimination of the practice. Past and present strategies of organisations involved in the anti-FGM campaigns in the country have consisted in starting such campaigns right in the centres of distribution, that is, in the areas of high concentration of the practice. Gamcotrap's "Operations Rescue" project funded by UNICEF is located in the Central and Upper River Divisions (Gamcotrap PRA Report 1999). These regions correspond, respectively, to concentrations of the Sarahule and Fula

communities among whom the practice of FGM is among the highest in the country.

Equally, a number of Bafrow's project activities are concentrated in areas of high distribution of FGM such as the Central River Division (Health Education, Passage Rites, Well Woman Clinic); Lower River Division (My Baby Tree project, Passage Rites); and Western Division (Passage Rites, Well Woman Clinics etc.).

Experience from other countries has shown that the rate of discontinuation of FGM is faster in communities at the fringes of the distribution (Mackie 2000). Anti-FGM organisations in The Gambia could, for instance, collaborate and start in those communities not in the centre of the distribution and bordering the regions of Senegal where the widely acclaimed TOSTAN Project has been successfully introduced.

## Rural and Urban Settings

A number of studies of limited sample size (Bafrow 1997) indicate that the practice of FGM is more prevalent in the rural areas than in urban settings to the extent that in some rural communities, particularly the dispersed but homogenous settlements, the entire female population has undergone the practice or are potential candidates. These include the Sarahule communities in the URD, the Mandinka communities in the LRD and NBD, as well as the Fula communities in the CRD.

The situation in urban settings has not been the subject of systematic research and documentation although it is believed that the closer one gets to the capital city, Banjul, the

less the resistance to the elimination of the practice (Bafrow Baseline Report 1997).

In urban settings, it may be necessary for anti-FGM campaigns to concentrate on the most prestigious status groups that still practise FGM because their shift could inspire a shift among those who aspire to join those status categories.

## Religion

The predominantly Muslim population of The Gambia perceive FGM as a "religious obligation" in Islam (Daffeh et al. 1999). However, not all Muslim groups in the country practice FGM. These communities genuinely believe that the custom is demanded by their faith. Extensive research by international organisations (WHO 1996) has concluded that the Quran itself does not refer to FGM, and that the majority of the Muslim world does not follow the practice.

In any case, Muslims generally view FGM in complementary terms to male initiation and circumcision, although in both cases, at least in urban areas, there is less emphasis on ritual seclusion and the learning of ethical or cultural codes than on the physical operation itself. Some families and entire communities that adhere to a more orthodox interpretation of Islam insist on "cutting without ritual" because they consider traditional circumcision rituals as un-Islamic (Hernlund 2001).

So far the involvement of religious leaders in the anti-FGM campaign has been limited because of the ultra-sensitive nature of the subject of FGM. Consequently, a strong Islamic pro-FGM lobby has been allowed to exist in the country although the Islamic scholars themselves are divided on the authenticity of the Hadith regarding FGM.

Convinced religious leaders and scholars in the country can become key advocates for the change. They could be called upon to help interpret and explain the references to female circumcision in the Hadith, providing a clear lead to their communities to stop the practice, while basing their teaching on authentic holy texts.

## Education

According to anecdotic accounts, educational background does not have a significant bearing on whether people practise FGM or not in The Gambia. The assertion is based on interviews with four educated respondents who stated that they had made up their minds about the practice long before the debate and had warned their families “drastic measures would be taken against any family member who took their daughters for FGM” (Daffeh J et al. 1999).

### Box 5: Involving Religious Leaders

- Countering religious opposition to the elimination of FGM has proved to be a complex area for anti-FGM campaigners in the country to address and is often sidestepped because the subject is ultra-sensitive and emotionally charged.
- There is need for the anti-FGM campaigners in The Gambia to work constructively and in trust with religious forces by identifying and supporting those positive forces within the Islamic community so that religious leadership in the anti-FGM campaign can be, and must be seen to be, responsive to efforts to eliminate FGM in the country.

## Anthropological Factors

The motivations behind the practice of FGM in The Gambia are complex and there are a number of possible explanations for continuation of the practice.

### Chastity and Avoiding “Shame”

FGM is believed to be associated with positive moral values (Bafrow Baseline Report 1997). Chastity and modesty are required in women as a means of protecting them against bringing shame upon the family by avoiding pre-marital sex or abstaining. Thus, Type II mutilation is practised in cases where the intention is to preclude pre-marital sex whilst “sealing” that is done with the very specific intention of precluding pre-marital sex is tantamount to Type III mutilation.

It has been generally recognised that it easier to bring about a shift in the practice of FGM in communities in which there is no exaggerated emphasis on chastity and fidelity, than in communities where FGM is strongly connected to the modesty code.

### Rite of Passage

In almost all the literature, FGM in some Gambian communities is considered a “rite of passage to adult womanhood and represents a medium for the transmission of long held values, attitudes and norms of behaviour to the effective performance of the role of mother, wife, home manager”. It is also an “opportunity for peer group formation and networking, which serve as future mechanisms for the exchange of views and sharing of experiences on common problems” (Samba 1999, Daffeh et al 1999). In the

communities where FGM as ‘rite of passage’ is still emphasised, the festivities play a major role in attracting the would-be candidates and luring others to undergo the practice.

However, with reduction in the age at which the operation is carried out nowadays, some studies have concluded that FGM as ‘rite of passage’ is becoming less important since babies, infants and very young girls cannot be taught these rites neither can they be prepared for marriage (Hernlund 2000, Daffeh et al. 1999).

### **Marriageability**

From anecdotal accounts, it is only after undergoing FGM that a girl is rendered marriageable (Daffeh J et al. 1999). Therefore, in the communities that practise it, FGM and virginity are strong requirements for marriage. Girls are “sealed” to ensure that they remain virgins until they are married and most males would not marry a girl who has not undergone the practice. The situation is much more demanding in polygamous marriages in which ‘un-cut’ women who enter polygamous marriages with partners from ethnic groups that practice FGM are more prone to undergo the practice for fear of being despised by their mates. Polygamy thus obliges women from non-practicing backgrounds to undergo the practice.

### **Social Standing**

Almost all the literature (Bafrow 1997, Gamcotrap 1999, Daffeh et al. 1999) is agreed that female genital mutilation has become a class phenomenon among Gambian women in that it distinguishes those who have undergone the operation from those who

have not. Those who have tend to regard themselves as superior in all respects to those who have not and there are “strict codes of conduct about whom they should mix with and who not and where they should go to or not” (Daffeh J et al. 1999).

### **Identity, Gender and Sexuality**

Existing studies (Bafrow 1999, Gamcotrap 1999, Daffeh et al. 1999) are conclusive on the fact that in The Gambia, FGM is a woman’s affair as women make the decisions themselves with little or no male involvement. Type II Mutilation, for instance, is practised as one of the means to avoid pre-marital sex and to curb the woman’s sexual feelings. The concern that men’s energies would be used up if they married uncircumcised women is particularly so in polygamous relationships. And although women do not see FGM as a means by which men control women’s sexuality, to Gambian men it is an important consideration (Daffeh et al. 1999).

### **Economic Factors**

Analysis of a number of in-depth interviews indicates that economic reasons prevail in different facets of the practice (Touray 2001, Gamcotrap 1999, Bafrow 1997). However, the conclusions reached in a number of these studies differ. Bafrow’s ‘Economic Empowerment Programme’ was initiated “primarily to provide alternative sources of income for circumcisers” (Baseline Report 2001). For others, Circumcisers gain some incentives either in cash or kind, which is used to supplement family incomes (Gamcotrap 1999). Yet still, for most Circumcisers, FGM is not the main source of livelihood although the financial benefits that accrue from it

tempt them to continue the practice (Touray 2001).

It is generally believed that issues such as FGM can be tackled indirectly by working to meet women's other gender needs, thereby challenging their subordinate position in society. Greater equity can be achieved and the worst manifestations of gender discrimination confronted, if women are enabled to achieve greater economic self-reliance (Unicef, Involving People 2000).

#### **Box 6: KAP Studies**

- The programme activities of a number of NGOs are based on the maintenance of the rite of passage without cutting. These programmes have not been evaluated to provide reliable information and data as to their effectiveness and impact on anti-FGM campaigns.
- Most accounts of the proportion of women and men in favour or opposed to FGM are anecdotic and existing studies are inconclusive on the effect of FGM on sexuality.
- Anecdotic accounts in studies touching on the factors that motivate circumcisers to engage in the practice of FGM are conflicting.
- There is need to go beyond anecdotic accounts in order to generate more representative and reliable information and data on:
  - a.* Extent of support and the reasons for public opposition to FGM;
  - b.* Extent to which the dual and engendered definition of sexuality (as procreation for women and as recreation for men) applies in the Gambian context;
  - c.* How the power relations between men and women influence maintenance of the practice;
  - d.* Linkage between economic considerations and the practice of FGM.

## FGM and Sexuality

There are few studies that have examined the effect of FGM on women's sexuality and fewer still have looked at its effect on that of men. The gap exists because it has been found very difficult to assess the psychological consequences of a practice that is a cultural taboo and shrouded in secrecy. Moreover, the communities that practice it are very reticent to admit any physical or negative consequences, physical or psychological.

## Male and Female Attitudes and Perceptions

There are differences in male and female attitudes to and perceptions of FGM. When asked about their feelings towards FGM, 30% of the female respondents in one study (Singhateh 1985) said it was an important tradition that must be maintained. About 45% also said they would circumcise their daughters.

Another study (Daffeh J et al 1999) indicates that many male respondents would not marry women who have not undergone the practice. While still another study found that while male attitudes and perceptions have changed just a little among female adults, they have not changed significantly among male adults (Bafrow KAP 1995).

Skamstad (1985) blames the slow pace of progress in elimination on the divided nature of Gambian women; others attribute the varying attitudes to the "patriarchal" or "male-dominant" nature of Gambian society (Daffeh J et al. 1999). In such a society, women are socialised to respect whatever their men say or want.

There is need to further investigate these conclusions in order to establish a clear linkage between sexuality and male attitudes and perceptions of FGM. There is also need to establish how FGM instils moral meanings of womanhood and why so many women value and perpetuate these practices. Failure to establish such linkages could lead to a backlash in anti-FGM campaigns.

Strategies emanating from such studies should be able to concentrate initially on women as primary target group – because FGM is women's business and they more actively perpetuate FGM than do men. Once won over, they could persuade husbands, grandparents and religious and political leaders.

### Box 8: Male Involvement

- Males' sexual preferences combined with families' desire to ensure their daughters' marriageability is a major barrier to elimination of the practice of FGM. There is need to involve men more in efforts to bring about change in the practice.

## Decision-making

Studies in The Gambia that have tried to explore the process of decision-making in FGM have highlighted the centrality of the nuclear family - parents and other siblings - or extended family - aunts, uncles, grandparents - (Touray 2001, Gamcotrap 1999, Bafrow 1997).

Since the studies have conclude that FGM is a woman's business, decision-making for

undergoing the operation is in large part made by mothers although there are instances where it is a joint decision by both mother and father with the latter “only informed to obtain his blessings”. Other decision-makers are female members, particularly grandparents.

Since the accounts of the decision-making process in the literature are anecdotic, there is need to carry out decision research for anti-FGM campaign strategy development. For, it is much more important to understand the nature of decision-making rather than simply attitude change.

Understanding how decisions are made within a particular socio-cultural environment has clear implications for the organisations that are attempting to motivate and reinforce behavioural change towards elimination of female genital mutilation. By identifying decision-participants, power distribution in decision-making and other influential factors, a step would have been taken toward characterising, respectively, the audience for communication activities and identifying appropriate channels of influence and messaging the issue of FGM to be addressed.

**Box 9: Decision Research**

- So far decision research has not figured prominently among the activities of the organisations involved in the anti-FGM campaign in the country. Using information from such research in the design of communication activities presents an opportunity to enhance the effectiveness of anti-FGM campaigns.

## Medical Outcomes

The immediate and long-term health consequences of FGM have been observed in various health institutions in a number of African countries. In The Gambia, what is known about the prevalence of immediate complications of the operations performed was, until recently, mostly anecdotic. These accounts (Touray 2001, Daffeh J et al. 1999, Gamcotrap 1999, Bafrow 1997, Singhateh 1985) describe extremely serious bleeding, infections and even death. In the MRC community-based study only one (1) girl aged 12 died of bleeding a day after circumcision (MRC unpublished data).

The immediate complications of FGM are believed by the population to be caused by inadequate ceremonial preparations by parents, or because of something shameful about the daughter. The result is that these types of information are kept secret.

On the long-term reproductive health consequences of FGM, the MRC study found that “women who had undergone FGC had a significantly higher prevalence of Bacterial Vaginosis (BV)... and a substantially higher prevalence of herpes simplex virus 2 (HSV2)... suggesting that cut women may be at increased risk of HIV infection” (MRC 2001). However, “commonly cited negative consequences of FGM such as damage to perineum or anus, vulval tumours, painful sex, infertility, prolapse, reproductive tract infections (RTIs) were not significantly more common in cut women”.

The MRC study is the first community-based study in The Gambia in which precisely defined reproductive morbidities have been compared between women who have had traditional genital surgeries and those who

have not. The number of women with Type III operations was too low to specifically examine their effect on morbidity. The “severity of reduction and the closure of the vulva in Type III operations mean that the immediate and long-term physical, psychological and sexual consequences may be more common and more severe than the Type II mutilation studied” (MRC 2001).

**Box 10: Health Consequences Research**

- Local anti-FGM campaigns often cite the prevalence of death and serious damage to health resulting from the practice of FGM. Sometimes the information is based not on credible local research but on interested claims from the international anti-circumcision literature, which extrapolates from case studies of the consequences of infibulation.
- There is need to undertake nationwide research to establish the immediate, medium and long-term psychological and obstetric sequelae of FGM in The Gambia.

## Emerging Trends

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There is growing recognition that the way FGM is practised today in The Gambia has changed a great deal from the way it was “traditionally” done, particularly in regard to the ritual context – or the lack thereof – in which genital mutilation is performed as well as the age at which girls are operated upon.

### Types

As to the actual practice of cutting, one study (Gamcotrap “Best Practices” 1999:31) has observed that some Circumcisers who have participated in sensitisation workshops have continued the practice but “with some modification consisting of cutting the tip of the clitoris instead of the more customary deep cutting to remove the clitoris and part of the labia minora”.

### Age

Another development in is the tendency to circumcise girls at a younger age. Interviews with several Gambian women’s groups indicate that this trend might very well also be in part a reaction to campaigns against the practice (Hernlund 2001). Another contributory factor to the lower age of female circumcision, the interviewees argue, is that young girls are seen as less capable of “fighting back.” Many believe that the younger the girl is, the “easier” the procedure will be for both her and the circumciser. Thus, the age at which a girl is circumcised obviously affects the extent to which she undergoes a period of cultural education in addition to the physical procedure.

### Rite of Passage

As a general trend, girls in The Gambia are being operated on with less ritual and at younger ages. The trend to less ritual and younger ages appears to undermine the hypothesis that FGM is explained as an “initiation rite” (Hernlund 2001).

Many young girls are now circumcised alone or with a few other girls in the ‘compound’ or courtyard in town with little or no training and ritual. Studies indicate that this shift is due to the desire to avoid the expense of lavish celebrations when girls are taken quietly and privately. School girls circumcised during holidays return to school and thus have no time for a lengthy seclusion. For girls circumcised against their will and those of their parents, no celebration follows especially if the girls were considered “too old”. There are instances also where circumcisers who had agreed to stop carrying out the operation nevertheless continue to perform it in secret. Finally, some families and entire communities who adhere to a more orthodox interpretation of Islam insist on “cutting with ritual” as un-Islamic (Hernlund 2001).

### Medicalisation of the Operation

Some studies have indicated that many Gambians want girls, like boys, to have access to “safer” clinic circumcision. Girls in The Gambia are never taken to hospitals and clinics to be circumcised and the Gambian Medical and Dental Association (GMDA) strongly condemns the medicalisation of the FGM, as do all most of the groups campaigning against the practice (Hernlund 2000).

**Box 11: Determinants of Emerging Trends**

- The exact dynamics of the shift towards less orthodox and severe types of circumcision are unknown. More research needs to be done to determine these dynamics.
- The younger age at which girls undergo genital cutting nowadays in The Gambia seems to support the conclusion that the three elements of female circumcision – “the genital cutting of the initial day, seclusion during which training takes place and the celebration through which the girls are returned to their communities” – have in many cases become conceptually separated from one another. This needs further investigation through research.

## Current Approaches

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Female genital mutilation provides a powerful example where the programmes of NGOs in The Gambia are trying to tackle one of the most culturally charged issues in the country. Current efforts consist mainly in playing up the health consequences, which is a temptation towards medicalisation of the procedure although in 1982, the WHO issued a policy statement stating that under no circumstances should a medical practitioner perform FGM. FGM was increasingly being recognised as a source of major psychological trauma, not solely of physical risk and there is now growing international awareness and legislation by governments, accompanied by advocacy from political leaders. However, legislation and political support have to be met by a radical shift in the cultural valuing of FGM within communities.

## Medical Consequences

The educational campaigns of a number of NGOs in the country focus on the actual or potential “harmful effects” of the practice of FGM. The campaigns are designed to improve knowledge of potential adverse outcomes (Gamcotrap 1999, Apgwa 1998, Bafrow 1997).

These programmes highlight the immediate and long-term negative consequences such as “acute pain, haemorrhage from the clitoral artery, shock due to sudden loss of blood and pain, acute urinary retention, dislocation of joints, infection, failure of the wound to heal due to lack of medical treatment, recurrent urinary tract infection, infertility, prolonged

labour during childbirth etc” (Bafrow Baseline Report 1997).

Similarly, Bafrow’s Community mobilisation for Health Promotion/Well Woman programme is aimed at increasing women’s knowledge of the “pathological and scientific basis of diseases” to enable them understand and conceptualise the various health messages coming to them. Gynaecological and sexual health counselling provides information, counselling and treatment on reproductive health problems, detection of symptoms and social development of the girl-child as part of the “rites of passage” (Bafrow Evaluation Report 2001).

The problem with the medical consequences approach implies that FGM is pathological and the solution therefore lies in a sort of campaign-style attack on the problem. By basing health information on sound research data rather than implying that severe long-term health consequences are common, activists are likely to make their claims more credible to practising communities and therefore more effective.

The MRC study, albeit a community survey, has shown that commonly cited negative consequences of FGM such as damage to perineum or anus, vulval tumours, painful sex, infertility, prolapse and other reproductive tract infections are not significantly more common in cut women in The Gambia.

## Human Rights

MRC study suggests that while anti-FGM campaigns based on the damaging health consequences of the operation are less controversial in most practising communities than an approach based on human rights it

recommends that “efforts to eradicate the practice should incorporate a human rights approach rather than rely solely on the damaging health consequences of FGC”.

The basis of rights-based strategies is that FGM must be abolished because it is a serious violation of bodily integrity usually inflicted on young girls who are not in a position to choose or give informed consent. The elimination of FGM is also often considered as one component of the need to address many of the rights of women and girls, especially in societies where serious gender inequalities exist.

The human rights approach based on the Rights of the Child also advocates that each child should be given the opportunity “to develop physically, mentally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity” as well as be protected from “all forms of neglect, cruelty and exploitation”.

## **Economic Incentives**

Programmes to compensate the cutters (primarily by retraining them) have been initiated by almost all the local organisations involved in the elimination of FGM in the country. Apparently, they have not all succeeded in reducing the prevalence. One reason for the popularity of this strategy is the tendency to explain negative outcomes with the question, ‘who benefits’?

The Association for Promoting Girls and Women’s Advancement (APGWA) provides health care for women and their children through a visiting nurse midwife. These general activities aimed at women’s welfare are part of the Association’s campaign against

FGM. Under the project, circumcisers are not directly paid for ceasing the practice; rather they receive material benefits distributed to the communities that agree to discontinue the practice and of which they a part. APGWA also operates an urban training centre and three multi-purpose village centres, each of which includes a skills training centre, a kindergarten offering free tuition and lunch, as well as income generating activities such as fishing, gardening, raising poultry, and operation of corporative shops.

Likewise, Bafrow’s Economic Development Programme was designed to provide economic opportunities for circumcisers first and then the community in general. The aim is to provide funds for income generating activities as an ‘alternative’ source of support to income derived from practising FGM. Bafrow’s income generating project in Dumbutu in Kiang West, Lower River Division, was inspired by the urgent need to combat the practice of FGM and “improve the health status of women and children in the village” (Bafrow 1999).

An Alternative Employment Opportunities feasibility study was commissioned in 2001 by the Inter-Africa Committee on Traditional Practices to look into the possibility of providing an alternative employment opportunity for converted circumcisers. Twelve circumcisers, identified by Gamcotrap from three administrative divisions, took part in the study. The study found, inter alia, that all twelve circumcisers were willing to give up the practice of FGM, if assisted with an alternative source of earning a living (Touray 2001).

In general, paying people to change their attitude does not work and the more money is paid, the less the subjects’ attitudes changes

(Manstead and Hewstone 1995). One can purchase many things in this world, but it is common sense that genuine attitude change is not one of them.

However, practical gender needs are the needs women identify in their socially accepted roles in society. These needs do not challenge, although they arise out of, gender divisions of labour and women's subordinate position in society. They are a response to immediate perceived necessity, practical in nature and often concern inadequacies in living conditions such as water provision, health care and employment.

## Initiation without Cutting

In their effort to find an acceptable way to promote the elimination of FGM, a number of local organisations have advocated the practice of 'initiation' (the tutoring period where songs and practices are learned by the initiates) 'without cutting'. The rationale for the approach is that it would preserve the cultural elements of FGM (the proper tutoring of young girls) but without the "painful, dangerous, and unhealthy operation" (Bafrow Baseline Report 1997).

In 1996 Bafrow started a programme to encourage communities to return to holding pre-puberty rituals for young girls while stressing "traditional" values such as virginity before marriage and respect for elders. By 1997, however, these replacement rituals had not been performed because no community was deemed ready for the experiment (Hernlund 2001).

Similarly Gamcotrap, stressing the importance of preserving positive traditional practices while working to eliminate those that are

harmful to women and children, has developed and implemented public ritual projects in which *Ngasingbas* publicly "put down the knife".

One of the goals of APGWA is to campaign against FGM. However, the Association also aims to "encourage people in cultural programmes to promote awareness and appreciation for the traditions of The Gambia and the Sub-region" (Apgwa pamphlet). In 1998, Apgwa conducted a Youth Camp in Basse on Traditional Practices. The Basse workshop brought together fifty-six girls from Basse itself and seven other surrounding villages. The age of the girls ranged from 9-20 years with an average age of 14.6 years.

The objective of the workshop was to push the age of initiation up to where the girls are "old enough to understand". All the girls had previously been circumcised when they were babies. Through this initiative, Apgwa hoped that the twelve girls would provide a transitional group - that the girls will choose only non-cutting initiation for their future daughters and that subsequent events may catch girls who have not yet been circumcised (Hernlund 2000).

The literature on culture and human rights suggests that ritual is ascribed with the power of preserving past traditions but that in a varied context around the world, people are also asking to what extent ritual is capable of dealing with the new and 'present' world. It is no longer possible to follow the model of a 'modern' nation-state, which cuts across tribal boundaries and conventions, and then agree that tribal traditions should be applied to judge the human rights conduct of the modern state. The problem with cultural relativism is that it ignores "the right to choose" and subsumes all members of a

society under a framework they may prefer to disavow (Tharoor 2001).

Viewed from this prism, some individuals and communities have begun to question the need for FGM, and many others are aware that the practice has come under global assault as an alleged health hazard and human rights violation. Some of the approaches used by local organisations, therefore, are based on the hope that the revitalised ritual, operating within culturally appropriate ideas of “tradition” will prove effective in providing such a way of dealing with the present.

The literature shows that not everyone agrees that the ritual is more important than the mutilation. To some people the idea of “ritual without cutting” does not make sense because there is nothing to celebrate if the girls have not been cut. Others, males in particular, argue that rituals are un-Islamic and inappropriate in the first place, and still others complain that the lavish celebrations are a waste of resources and should be discouraged. Moreover, the content of initiation pedagogy is no longer uncritically accepted. What is taught to the girls during seclusion is based on “patriarchal values” and geared to “turning them into submissive wives and mothers” (Hernlund 2000).

Perhaps, alternative rituals are not broadly applicable, but in The Gambia this approach deserves serious consideration as one strategy not only to influence the practice of FGM but also to more broadly contribute to women’s empowerment and aid in the maintenance of what is perceived as positive traditional practices to diffuse often volatile debates over cultural autonomy and authenticity.

## Operations Research

The MRC study focused on the long-term reproductive morbidity found in the community and only on Type II cutting. The consequences of genital cutting for maternal mortality and morbidity were not examined apart from asking about stillbirths and examining childbirth-related damage to the pelvic structures. Similarly, apart from comparing the prevalence of painful sex (as reported by the women) between cut and uncut women, the study did not touch on sexual functioning or well being. Another health consequence of FGM that could not be examined was the parental transmission of HIV at the time of the operation because of the use of one cutting tool for a cohort of girls.

Apart from the MRC research, little else exists by way of reliable research on FGM using social, iterative and participatory research methods. Some of the basic steps most often skipped or performed at a minimum level, but which we can least afford to overlook, are the baseline analysis and formative research required to define what programmes should communicate to whom, through which channels. This research, which may be both quantitative and qualitative, is currently lacking.

**Box 12: Enhancing Current Strategies**

- The relationship between FGM and long-term reproductive morbidity remains unclear and needs to be researched further.
- Despite the significant efforts made by local organisations to bring the anti-FGM campaign into the public domain, very few have as yet implemented programmes specifically based on a well-defined human-rights approach to the elimination of the practice of FGM.
- While the medical consequences, rights-based, economic incentives, initiation without cutting and basic research are all key strategies in the anti-FGM campaign arsenal, there are no objectively verifiable indicators of the effectiveness and impact to evaluate the programmes based on those approaches.

# Stakeholders

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In addition to Government agencies, there are other in-country organisations and groups, which can be expected to contribute to and gain from the elimination of female genital mutilation in The Gambia.

## Government

A number of government institutions have directly or indirectly or are poised to contribute to the campaign to eliminate FGM in the country.

The original rationale for the establishment of the National Women's Bureau was to serve as the executive arm of the National Women's Council itself established by an Act of Parliament in 1980. The Bureau had the enormous advantage of being set up as a legal entity and placed under the Office of the Vice President to give it greater visibility.

The Bureau currently receives institution strengthening support from the DfID-funded "Mainstreaming of Poverty and Gender Project" (MPGP), ADB-funded "Community Skills Improvement Project", and the United Nations Population Fund (UNFPA). MPGP support will target the areas of fellowships and logistics to improve capacity and ultimately to improve the quality of services and resources provided by the Government to the poor, especially women.

The Bureau also has a number of stakeholders to which it can look for human, budgetary and material resources to ensure its effective functioning. Among these groups are government institutions, bilateral and

multilateral donor agencies, national and international Non-Governmental Organisations (NGOs), private sector and community-based organisations (CBOs).

There is a large pool of human and financial capacity and advocacy strength residing within the domestic NGO and CBO sector. The task of the Bureau will be to harness these resources to form a critical mass so that through mass mobilization and popular participation critical issues of gender equality facing women could be tackled and resolved. Enabling effective partnerships and coordination among these bodies would also provide the needed synergies that the Bureau would need for effective plan implementation.

## NGOs & Private Sector

There are some non-governmental and private sector organisations at the leading edge of the anti-FGM campaign in the country. They operate from their headquarters in Banjul and the Kombos are well supported by dedicated staff and volunteers who give considerable leadership and presence.

The creation of Gamcotrap in 1984 as the first NGO involved in the anti-FGM campaign, was followed by the creation of other organisations, including the Foundation for Research on Women's Health, Productivity and the Environment (Bafrow) as well as the Association for Promoting Girls and Women's Advancement (Apgwa).

When the Senegalese Government, in collaboration with the WHO, UNICEF, UNFPA, organised a meeting in Dakar in 1984 on traditional practices, the Government was represented by the Women's Bureau. The outcome of the meeting was the

establishment of the Inter-African Committee (IAC) on Traditional Practices. Due to the perceived need to address FGM separately from the broader goals of the Women's Bureau, the Gambian Committee of the IAC was set up. The name was changed in 1992 to the Gambian Committee on Traditional Practices (Gamcotrap).

**Gamcotrap** was the first NGO to mount sensitisation and information campaigns aimed at eradicating harmful traditional practices affecting the "health of women and children, in particular FGM" (Gamcotrap, "Best Practices" 1999). Its other objectives include the identification and promotion of positive cultural practices, improvement of the socio-economic situation of women and children, and the promotion and protection of the human rights of women and girls.

Gamcotrap's "Operations Rescue" project begun in 1997 and funded by UNICEF is part of a long-term education and communication strategy to eradicate the practice of Female Genital Mutilation and other harmful traditional practices in the Gambia. The Project, located in two administrative divisions where the practice is most prevalent (Central and Upper River Divisions), "examines the relationship between traditional practices and infant and maternal mortality as well as ways to transform culture without destroying it" (Gamcotrap PRA Report 1999).

Among the intervention strategies of the project are "training, advocacy and social mobilisation; research, documentation of best practices and capacity building." The pilot project provides essential information on the views of those involved in the practice – circumcisers and the women themselves (both as receivers and promoters of the practice). Appropriate forms of income generation, implemented under the project, are seen as

creating the possibility of circumcisers "giving up the practice more rapidly" (Annual Report 1999).

Gamcotrap's human rights based anti-FGM education and advocacy strategy hit a snag in 1997 when the State issued a directive that instructed the restriction of the use of state media to broadcast information on the medical hazards associated with FGM but should instead always broadcast issues that were in support of FGM (Gamcotrap "Best Practices" 1999). As a result, a large number of very young girls, encouraged by pro-FGM religious leaders, were circumcised. Gamcotrap's open letter to the Head of State on the issue remain unanswered although the Vice President and Secretary of State for Health, Social Welfare and Women's Affairs subsequently convened a meeting with other concerned organisations to discuss and clarify the Government's position. The Vice President emphasised that DoSH is aware of the health hazards of FGM and would therefore continue to sensitise the public against its practice. At a National Assembly meeting six months later, some sensitised assembly members raised the issue for debate at the end of which the Government declared that its policy was to discourage FGM (Daily Observer, 7 July 1997).

Gamcotrap has collaborated with Action Aid/The Gambia in organising essay and poster competitions in schools throughout the Gambia. Three essays on the effects of FGM on women's reproductive health were published in Action Aid's quarterly development magazine, *Yirima Kibaro* (Vol.8, No.1, June 1998).

Gamcotrap signed a Memorandum of Understanding (MOU) with DoSH and DoSE to sensitise and educate various target

populations. It also collaborates with the PHNP to implement community level activities geared towards the elimination of FGM in The Gambia (Touray 2001).

**Bafrow** is another NGO involved in the creation of knowledge and awareness about the effects of harmful traditional practices. The major components of its programme are campaigns against FGM, training and information services on responsible parenthood, research, and counselling services. Bafrow has identified a number of “strategies for overcoming” FGM, including the provision of “alternative avenues of economic empowerment”.

The concept has been introduced in the Greater Banjul Area, Kombo St. Mary and the Lower River Division. Bafrow believes that the practice of FGM is maintained “because of ignorance and pressure from family and ethnic groups and out of fear of not conforming with social norms and thus becoming an outcast” (Baseline Report 1997).

Bafrow’s programme is also based on the view that much more people may support a programme that “would eliminate the cutting while maintaining the positive cultural practices”. A major finding of the Baseline Report of 1997 is that although people hold on to the practice because it is part of their tradition, they are amenable to positive change (Baseline Report 1997). In line with Bafrow’s policy of redirecting the thrust of FGM from physical cutting to teaching of positive cultural practices therefore, its programmes have sought alternative avenues of economic empowerment of women through “Credit and Group Organisation”(Baseline Report 1997).

Bafrow’s approach to the elimination of FGM is that it has certain positive aspects such as the training in good motherhood and these

must be promoted while the negative physical cutting aspect should be eradicated.

The Economic Development Programme of Bafrow is a package of activities aimed at providing circumcisers with an alternative way of earning a living having stopped the practice of FGM that has been “their main source of income” (Bafrow: Skills Development for Circumcisers 1999).

The **Medical Research Council** of the United Kingdom (MRC/UK) is involved in extensive health research in The Gambia. One of its latest research publications is “*The long-term reproductive health consequences of Female Genital Mutilation in rural Gambia: a Community-based Survey* (in Journal of Tropical Medicine and International Health” Vol.6 No.8 pp 643-653, August 2001). The paper examines the association between traditional practices of FGM and adult women’s reproductive morbidity in rural Gambia. The research found that the prevalence of the Herpes Virus 2 (HSV2) was substantially higher in cut women, suggesting that cut women are likely to be at increased risk of HIV infection (MRC 2001:651). The type II cutting practised in the study area was not associated with significantly increased prevalence of damage to perineum or anus, vulval tumours, painful sex, infertility, prolapse, STI (apart from HSV2) or endogenous infections apart from Bacterial Vaginosis (BV).

Under its Poverty Alleviation and Social Justice programme, **Action Aid** has helped to improve the status of women and the girl-child in particular. Action Aid collaborates with other organisations in reducing the incidence of FGM and other harmful traditional practices affecting women and children. The programme includes sensitisation of community-based

organisations, key influential leaders from selected institutions, and support for maintenance of efforts at the community level.

The **Association for Promoting Girls and Women's Advancement** (Apgwa) was created in 1992 by a group of female farmers, professional women, and businesswomen in the informal sector. Its objective is to assist "less fortunate Gambian women and young girls". The organisation receives funds from various donor agencies and private individuals in Germany as well as from the association's local fund-raising activities. Although one of the goals of the association is to campaign against FGM, the group also aims to "engage people in cultural programmes to promote awareness and appreciation for the traditions of The Gambia and the Sub-region (Apgwa pamphlet). Health care activities carried out targeting women and their children also include the campaign against FGM. Circumcisers are not directly paid for not cutting, but material benefits distributed to communities that agree to discontinue the practice seen as one element contributing to the success of the campaign (Hernlund 2001). Other relevant activities of Apgwa include the organisation of youth camps on traditional practices.

The female wing of the **Gambia Teachers' Union** (GTU) conducts campaigns to incorporate information on harmful traditional practices in the schools' curricula and to educate the public on these issues. The Union has carried out a series of sensitisation campaigns among female teachers in the various regions and produced and disseminated materials on harmful traditional practices.

Any strategy for addressing harmful traditional practices including female genital mutilation needs to be conceived, owned, and implemented by government and in-country organisations and supported by The Gambia's traditional and potential development partners.

## Bilateral & Multilateral Agencies

At the country level the various UN agencies (UNICEF, WHO, UNFPA etc.) because of their work in the areas of health, women and children and reproductive health have supported programmes in collaboration with Government.

The **WHO** assumes the lead and coordinating role for the campaign against FGM and supports the Department of State for Health (DoSH) in the delivery of Maternal Child Health and Family Planning (MCH/FP) services. In 1998, the WHO in collaboration with the Government of The Gambia (GOTG) launched in Banjul its *Regional Plan of Action to Accelerate the Elimination of Female Genital Mutilation in Africa*.

**UNICEF** is the lead agency in the country with respect to the rights of children, especially girls. The overall goal of UNICEF's 2002 – 2006 Programme of Cooperation with the Government of The Gambia is "to contribute to the survival, development, protection and participation of children and women in the context of the national development of The Gambia" (UNICEF 2000).

The multi-sectoral approach to the implement of the programme facilitates the promotion of

partnership and alliance building involves stakeholders interested in children and women's well being and development. The health component of UNICEF's 1999-2003 managed to generate dialogue and discussions on FGM at all levels. However, "lack of consensus and political commitment on how to approach the intervention were major constraints that faced the government and the development partners" (UNICEF 2000).

The **United Nations Population Fund** (UNFPA) is the lead agency in reproductive health issues. In addition to Government, the agency collaborates with NGOs in the elimination of traditional practices including FGM through sensitisation campaigns targeted at religious leaders, health workers, youth, and traditional communicators. UNFPA has also supported the integration of Population and Family Life Education (POP/FLE) activities into the school curriculum. In addition the content of the POP/FLE includes the topic of harmful traditional practices including FGM.

# Opportunities and Challenges

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The experience of the anti-FGM campaign in the country by various stakeholders has raised many opportunities and occasions to further advance the cause of the need to eradicate FGM in The Gambia.

Despite the absence of a clearly defined official policy on harmful traditional practices in general and FGM in particular, there is evidence of official positions and attitudes on the issue in a number of public pronouncements and in statements in national socio-economic development plans regarding the future of FGM in the country: Such pronouncements and indications provide an opportunity to develop appropriate strategies for advocacy.

The **1999 – 2009 National Policy for the Advancement of Gambian Women** redefines the role of the National Women's Council and the Bureau, its executive arm, to include information gathering, dissemination, research and analysis. In addition, the Bureau is mandated to assist members of the Council in monitoring trends, forging links with other institutions on the socio-economic and political front, reviewing Bills, legislation, policies and programmes. The fragmented nature of the anti-FGM campaign to date has been one of the main obstacles to significant progress in the elimination of the practice in the country. Designation of the Bureau as the national lead agency for coordinating women's issues is an opportunity for providing the necessary backstopping to institutions and organisations concerned with the issue of female genital mutilation.

In addition, Objective 9 of the Policy is to “eliminate all forms of discrimination and violence against women and girls”. This objective is in consonance with the 1981 UN Convention on the Elimination of All forms of Discrimination against Women (CEDAW) as well as the 1993 UN Declaration on the Elimination of Violence Against Women, which advocates for the abolition of harmful traditional practices against women and includes FGM within its scope. It is expected that organisations involved in the anti-FGM campaign would buy into this objective to guide their programme activities.

The topic “Female Circumcision”, for instance, forms part of the Grade 10-12 pupils' textbook on Population and Family Life Education (POP/FLE) course. This is the first attempt by government to address the issue by introducing the topic in the school curriculum, although it is hesitatingly dealt with. In the past the education system has shied away from sex education because of its culturally sensitive nature (Daffeh J et al 1999).

The Maternal Child Health (MCH) Unit of the Department of State for Health (DoSH) has drafted a Reproductive Health Policy which is before Cabinet for consideration.. Like the National Policy on Women, one of the six priority areas of the Draft Policy is gender issues and male involvement in reproductive health programme delivery, including addressing gender-based discrimination and violence and FGM.

The introduction of the Baby Friendly Checklist into the health system implemented by Gamcotrap also has the potential to provide data for research into FGM and at the same time bridge the gap between advocacy groups and anti-FGM health workers. The

pilot project funded by UNICEF is currently suspended due to lack of funding (Private communication). The project is innovative and needs to attract continued support.

The UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) at the World Health Organisation has launched a research initiative focusing on the socio-cultural aspects of female genital mutilation. This initiative will support studies in a number of priority topics including *'Understanding factors underlying the persistence of the practice'*; *'Understanding the decision-making process for FGM'*; *'Understanding the links of gender and sexual constructs to FGM'*; and *'Assessing the changes in the practice of FGM'*. HRP has invited researchers to submit full research proposals related to the priority topics with focus on the situation in Africa (WHO 2002).

The GOTG/UNICEF Country Programme (2002-2006) equally provides an opportunity for greater in-country partnerships. One of the objectives of the Health and Nutrition component of UNICEF's 1991 - 2001 Programme of Cooperation with the Government of The Gambia was "to reduce the incidence of female genital mutilation in two Administrative Divisions. Funds for the activity could not be utilised because the "decision on the FGM situation remains unclear preventing the use of funds allocated for the specific planned activities" (Annual Report 2001).

Nevertheless, in the next programme cycle (2002-2006), UNICEF will support government to "conduct comprehensive study to investigate links between FGM and health outcomes". The strategy will consist in "adopting a change from focusing directly on

the abolition of FGM to the consideration of the subject of FGM within the wider debate on the rights of women and in particular, harmful traditional practices affecting women" (Annual Report 2001:13).

An excellent opportunity for Senegambia trans-border cooperation in the anti-FGM campaign has been provided by the visit of a five-man Parliamentary Delegation from Senegal to The Gambia from 16-19 July 2002. The delegation met with high Gambian authorities on trans-border cooperation to eliminate FGM (CILSS, Réseaux des Parlementaires du Sahel sur la Population et le Développement 2002). From 28-30 July 2002, the Coordinators of the Network of Senegalese Parliamentarians and the Regional Network of Journalists visited the regions of Fatick and Kaolack to meet administrative authorities and local journalists to define the messages of the media campaign and draw up the programme of activities. These messages will be broadcast over radio and newspapers in Fatick and Kaolack and from the 25-27 September 2002 inclusive, public meetings will be held at the Senegambia border at Némanding situated at six kilometres from the Gambian border in the province of Tambacounda and in the District of Foundiougne. Participants will be invited from each of ten villages at the rate one representative per village to the meeting. The Parliamentary delegation to The Gambia will discuss the modalities of the Gambian participation.

The visit, which is sponsored by the widely acclaimed TOSTAN Project in Senegal, offers a unique opportunity for organisations involved in the anti-FGM campaign to benefit from "Best Practice" through trans-border collaboration and exchange of experience visits. If the Senegalese process continues to

deliver dramatic results, then proven techniques should be extended to co-ethnics in the border areas of Gambia with Senegal.

Despite these fine opportunities, there are many challenges, which need to be minimised and/or overcome.

Official position and attitudes towards elimination of FGM is ambiguous and ambivalent. In May 1997, the Gambian Government issued a decree that banned the broadcasting on state radio and TV of any programmes “which either seemingly oppose female genital mutilation or tend to portray medical hazards about the practice” (Hernlund 2000).

After massive protests – in particular from Gamcotrap, aided by an international letter-writing campaign organised by the New York-based Equality Now – the decree was lifted, although with so little publicity that many people are still unclear about what is or not legal to broadcast.

Furthermore, the Head of State in his annual address marking the 1994 July 22 military takeover contradicted an earlier statement of the country’s Vice President to the effect that the government’s policy was to “discourage such harmful practices” and that NGOs would not be prevented from working against the practice. The Head of State later restated his government’s position as being “opposed to FGM” but stressed that any campaign must be conducted in a “culturally sensitive manner” (Hernlund 2000).

More recently, in reaction to the Senegalese ban, the Head of State publicly criticised anti-FGM campaigns, arguing, “Female circumcision is a choice” and warning that women activists “cannot be guaranteed that

after delivering their speeches, they will return to their homes” (The Daily Observer, January 25, 1999). The Vice President has since restated that government supports ongoing “awareness programmes” but that “you can’t legislate culture and tradition” (The Gambia: A Special International Report Prepared by the Washington Times Advertising Department”, February 18, 1999).

Another major obstacle to the elimination of FGM in the country is a backlash and reaction to international pressure. The inflow of increasing amounts of aid money earmarked for the elimination of FGM has led to a number of symposia, workshops, and conferences addressing the issue. Mixed reactions to this sudden increase in discourse, ranges from the belief that outside help is speeding up the elimination of FGM to rage at what is perceived as imperialist meddling in what should be an internal matter (Hernlund 2000).

It is against this backdrop that a pro-FGM lobby, using religious and traditional arguments to influence people, exists in the country. Among them are Muslim religious leaders who are respected within their communities and within the Muslim community in general. They hold important positions in the country and have access to the media. As these are a primary source of information for most people, the pro-FGM lobby has a wide edge over the anti-FGM advocates and is therefore a force to be reckoned with.

# Strategies and Recommendations for Action

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Based on the national context for the elimination of female genital mutilation, future strategies should be able to fulfil three basic needs:

- a. The need for Government to clearly define an official position on harmful traditional practices, including FGM.
- b. The need to systematically and fully research and document the immediate, medium and long-term health, psychological and obstetric sequelae of FGM in The Gambia.
- c. The need to create greater public knowledge and awareness about harmful traditional practices including FGM, based on credible research findings, documentation, and “Best Practices”.

In operationalising the recommended strategies, particular attention should be given to the following activities directed at three categories of audience:

## The General Public

- Address FGM within the wider context of harmful traditional practices.
- Educational information must be from a credible source and must be non-directive.

- Non-directive educational campaigns modelled on the widely acclaimed TOSTAN Project in Senegal should be studied with a view to adapting it in The Gambia, starting with the areas of FGM at the common borders.
- Campaigns of broad publicity should be initiated because it is important that international, national and local attitude change should continue to amass;
- Publicise the declarations in Senegal and initiate exchange of experience visits. If the Senegalese process continues to deliver dramatic results, then proven techniques should be extended to co-ethnics in neighbouring Gambia.
- Improve the quality of public health education messages and information by presenting it in ways that acknowledge the knowledge and experience of local experts and residents;
- Discuss specific consequences of locally practised forms of FGM.

## Policy-makers

- Organise formal conferences for Secretaries of State and other key politicians to present them with the results of in-country research, documentation studies and “Best Practices” to convince government to clarify its position on the elimination of harmful traditional practices including FGM

## Special Target Groups

- Initially concentrate on women as primary target group – because FGM is women’s business and they more actively perpetuate FGM than do men. If they are won over, they will persuade husbands, grandparents and religious and political leaders.
- Males’ sexual preference combined with families’ desire to ensure their daughters’ marriageability is a major barrier to the elimination of the practice of FGM. There is need to involve more men in efforts to bring about change.
- Islamic religious leaders are not in agreement on whether or not FGM is a religious obligation. Organise national debates or forums for confronting opposing views and reaching a consensus.
- It may be easier initially to trigger change in communities where FGM is shallow, that is, in communities towards the edges of the distribution without the exaggerated emphasis on chastity and fidelity, than in communities where FGM is deep, that is, in communities at the centre of the distribution that are strongly connected to the modesty code.
- In urban settings, concentrate on the most prestigious status groups because their shift will inspire a shift among those who aspire to join those categories.
- Researchers and research organisations should estimate the level of effects on individuals as well as families of FGM practices in the population at large, bearing in mind the variants.
- Organise forums for leading journalists and other producers of mass media to encourage continuous publicity through their publications as to the needs and requirements for elimination of traditional practices including FGM.

# Conclusion

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The Gambian Government has an obligation to eliminate FGM as a harmful traditional practice that affects women. In addition to any moral and/or social obligation Government may have in this regard, the assumption is that the State obligation is also legal. This assumption is grounded in the belief that the international human rights law freely adopted by The Gambia, through sovereign acts like ratification, has created legal obligations on the Government to eliminate FGM.

Current efforts by government and non-governmental organisations, though commendable, have had little or no significant impact on the magnitude of the practice of FGM in the country. Part of the reason for this is the fragmented nature of the way the problem itself is perceived and the resultant interventions. There is no policy framework within which FGM can be handled at national sub-national levels.

Moreover, little analysis has been done to rationalise involvement or non-involvement of individual government departments in understanding the anthropological dimension and the campaign to eliminate the practice of FGM. Neither is there a framework for ensuring that existing interventions are actually reinforcing and address all aspects of the problem. The problem of FGM itself and its causes remain a matter of many theories whose relationships are not fully understood, forcing many interventions to focus on symptoms rather than the root causes of the problem. As a result systems and structures that support the perpetuation of the practice unfortunately remain in place.

An integrated approach to the elimination of FGM presents real opportunity for reversing these shortfalls. The approach enables government to reconsider FGM as a social and complex problem to which government has an obligation to respond with an appropriate policy, implementation plan and adequate resources. The overall framework should be able to combine strategies that respond to the needs of subjects of FGM (women and girls) and deal with practitioners (*Ngamanors* and *Ngasingbas*), while at the same time facilitating a clearer understanding of the problem, and changing societal values and attitudes so that FGM no longer receives structural support.

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