



COUNTRY PROFILE:
FGM IN SENEGAL

JUNE 2015

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



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FOREWORD

The 16th of June is the International Day of the African Child, in remembrance of the children killed in the Soweto Uprising in 1976 while protesting for their right to be educated in their own language and against the apartheid regime in South Africa. Nearly 40 years on, we mark this day to draw attention to the lives of African children and to raise awareness of the need for good quality education for them. Therefore it is fitting to release 28 Too Many's latest research report on FGM in Senegal on this day. FGM is normally carried out on girls under the age of 14 and in many cases this marks the end of a girl's attendance at school, thus denying her rights to an education.

It has been ten years since I came across FGM while working in Sudan and began to work to end it, and the positive progress since then is significant. Yet, we still have over 125 million women and girls alive today who have experienced FGM in Africa and the Middle East. Still, more stories of FGM emerge from Thailand, Asia and other diaspora countries and, unless we act, FGM will continue to affect another 30 million women and girls by 2025 – one girl being cut every ten seconds.

However, there is growing momentum in the global and African-led movements to end FGM, and activists and campaigners are making headway and moving us further toward the tipping point of FGM ending. It is important that we research and understand these changes and share knowledge of successful interventions. Through comprehensive research we can accelerate progress towards ending FGM in Senegal, regionally in West Africa and globally.

In Senegal FGM is a social norm, which is practised to guarantee social acceptance and is part of cultural identity. Although reasons for FGM are varied across ethnic groups, many Senegalese women believe FGM benefits cleanliness and hygiene; aids marriage prospects; preserves virginity and is a religious requirement. There is a strong link between FGM and religion in the north of Senegal, with historically powerful influencers upholding the practice. The reality is that FGM

causes infections, infertility, haemorrhage, pain, depression and psychological trauma but, even with the known risks, the practice continues. In 2014, 52.2% of women with FGM believed it should continue and this is despite 48.5% of women and girls aged 15-49 believing it had no benefits (2005).

This Country Report on FGM in Senegal shows that 25.7% of girls and women (aged 15-49) have experienced FGM (DHS/MICS, 2010-11). This rate has changed little in recent years and similar rates measured by residence continue with 23.4% having FGM in urban areas and 27.8% in rural settings. Another factor is that in some cases women from non-practising ethnic groups may be cut due to their area of residence. For example, 35% of Wolof women undergo FGM in Matam compared to non-practising Wolof in other areas.

FGM in Senegal is usually performed on young girls – 88.95% of Soninke perform FGM at 1 year old; 48.6% of Diola at ages 2-4 years, and 29.1% at ages 5-9 years. Many perform the 'sewn closed' type of FGM, with 91.4% of FGM being performed by traditional circumcisers. This 'sewn closed' method is similar to FGM Type III and causes severe birth complications.

Senegal criminalised FGM in 1999, and knowledge of this law is now widespread. In addition the Government launched a national action plan in 2009 in collaboration with the UNJP, which is in line with the Millennium Development Goals and aimed to eradicate FGM by 2015. Also there are many International and National NGOs working to end FGM in Senegal, and as we continue to work with many of them featured in this report, it is encouraging that there is significant attitude change reported in areas of NGO intervention.

I am pleased to share 28 Too Many's *Country Profile: FGM in Senegal* which is our ninth report in-country. We are grateful to all the NGOs and activists who have contributed and provided information on current anti-FGM projects in Senegal. In particular, we thank Tostan, The Orchid Project, Sister Fa and also The Grandmother Project for sharing the case study shown overleaf,

which details how FGM can end when the harmful element is removed from other positive aspects of Senegalese cultural tradition.

As this report is published, I will be in Senegal, having travelled from The Gambia before heading to Mali to further my understanding of FGM in West Africa. I am looking forward to meeting

again with our partners from the Inter-African Committee on Traditional Practices and the NGOs working in the region to understand how we can support the change that is taking place to ensure that future generations of girls live free from FGM.

Dr Ann-Marie Wilson
28 Too Many Executive Director

THE GRANDMOTHER PROJECT

The strength of the Grandmother Project (GMP) programme in Senegal called Girls' Holistic Development (GHD) lies in reinforcing African cultural traditions while talking about the harmful effects of some practices. They do this by introducing dialogue on a range of difficult topics concerning girls' development such as early marriage, teen pregnancy and FGM. These dialogue sessions offer traditionally non-communicating groups an opportunity to come together and speak out about challenging issues. Sessions were first facilitated between different genders and generations in small homogenous group discussions, followed by whole village plenary meetings. The project recognises that to achieve lasting change in community norms there must be consensus between family and community members.

The GHD explicitly targets older women as catalysts of change, seeing them as a solution to community norms which harm girls rather than an obstacle to be overcome. The project treats these grandmothers with unconditional high regard and includes them in all aspects of the programme. As one younger woman explained:

'Grandmothers are the ones to take the girls to be cut and parents only find out afterwards. A project that deals with FGM in a community must involve grandmothers because they are the ones that make decisions about FGM in the family and they are the ones with the strongest attachment to this practice.'

Results from the first two years of the project show that attitudes had significantly shifted in all aspects of child welfare, notably about FGM where the percentage of grandmothers who viewed it as a cultural (rather than a religious) obligation fell from 86% to 5%. The figures for their view that it was a religious obligation also fell from 75% to 5%. One said, *'Our ancestors taught us that girls should be cut to be more faithful to their husbands, but we no longer believe that....There are at least 30 girls born in our village in the last two years who are not cut.'*

The areas of the whole programme that GMP identified as most important to this change were: respect given to grandmothers, continued intergenerational dialogues, introduction of information about FGM, rather than messages of abandonment, and that cutters were never identified or stigmatised.

'We have decided that the traditional approach is not the best. We need to change our ideas, we need to change with the times' (GMP quoted in WorldView, 2014).



Fig. 1: Grandmother Project's activities in Vélingara, Tambacounda Senegal (Mariette Baynton © Grandmother Project Facebook Page)

BACKGROUND

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

PURPOSE

The prime purpose of this Country Profile is to provide improved understanding of the issues relating to FGM in the wider framework of gender equality and social change. By collating the research to date this Country Profile can act as a benchmark to reflect the current situation. As organisations continue to send us their findings, reports, tools and models of change, we can update these reports and show where progress is being made. While there are numerous challenges to overcome before FGM is eradicated in Senegal, many programmes are making positive active change.

USE OF THIS COUNTRY PROFILE

Extracts from this publication may be freely reproduced provided that due acknowledgement is given to the source and to 28 Too Many. We invite comments on the content, suggestions on how the report could be improved as an information tool, and seek updates on the data and contact details. For referencing this report, please use: 28 Too Many (2015) Country Profile: FGM in Senegal. (www.28toomany.org/countries/Senegal/)

ACKNOWLEDGEMENTS

28 Too Many is extremely grateful to all the FGM practising communities, local Non-Governmental Organisations (NGOs), Community-Based Organisations (CBOs), Faith-Based Organisations (FBOs) and International Organisations who have assisted us in accessing information to produce this Country Profile. We thank you as it would not have been possible without your assistance and collaboration. 28 Too Many carries out all its work and research as a result of donations, and is an independent objective voice unaffiliated to any government or large organisation. That said, we are grateful to the many organisations that have supported us so far on our journey and the donations that enabled this Country Profile to be produced. For more information, please contact us on info@28toomany.org.

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We are grateful to the rest of the **28 Too Many** Team who have helped in so many ways, including **Caroline Overton** and **Louise Robertson**.

Mark Smith creates the custom maps used in 28 Too Many’s country profiles. **Rooted Support Ltd** donated time through its Director Nich Bull in the design and layout of this report. Thanks also go to **Malcolm Crawford** for volunteering his time as proof reader.

Photograph on front cover: ‘Stunning Faces’ © Jessie Boucher (www.jessieetlaurent.com)

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

LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARP	Alternative Rites of Passage
CBO	Community Based Organisation
CEDAW	Convention on the Elimination of Discrimination against Women
CEP	Community Empowerment Programme
CMC	Community Management Committee
CRC	Convention on the Rights of the Child
DHS	Demographic and Health Survey
ECN	Empowered Communities Network
ECOWAS	The Economic Community of West African States
ENDA	Environmental Development Action in the Third World
EPI	Extended Programme of Immunisation
FBO	Faith-Based Organisation
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
GBV	Gender Based Violence
GDP	Gross Domestic Product
GHD	Girl’s Holistic Development Project
GII	Gender Inequality Index
HIV	Human Immunodeficiency Virus

HTP	Harmful Traditional Practice
ICCPR	International Covenant on Civil and Political Rights
ICESR	International Covenant on Economic, Social and Cultural Rights
INGO	International Non-Governmental Organisation
MDG	Millennium Development Goal
MFDC	Movement of Democratic Forces in the Casamance
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
NGO	Non-Governmental Organisation
SIGI	Social Institutions and Gender Index
TB	Tuberculosis
TBA	Traditional Birth Attendant
UN	United Nations
UDHR	Universal Declaration of Human Rights
UNCSW	United Nations Commission on the Status of Women
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children’s Fund
UNJP	United Nations Joint Programme
US	United States of America
WHO	World Health Organisation

INGO and NGO acronyms are found in Appendix I.

EXECUTIVE SUMMARY

This Country Profile provides comprehensive information on FGM in Senegal, detailing current research on FGM and providing information on the political, anthropological and sociological contexts in which FGM is practised. It also reflects on how to strengthen anti-FGM programmes and accelerate the eradication of this harmful practice. The purpose of this report is to enable those committed to ending FGM through the provision of information, to shape their own policies and practice to create positive, sustainable change.

It is estimated that 25.7% of girls and women (aged 15-49) have undergone FGM in Senegal (DHS/MICS, 2010-11). This rate has not changed significantly in recent years (UNICEF, 2013). There is only a slight variation in FGM prevalence by place of residence, with 23.4% of women and girls having had FGM in urban areas and 27.8% in rural areas. However, the majority of Senegalese residents reside in rural areas and Dakar, the capital, contains 49% of the country's urban population and has a prevalence rate of 20.1%. The regions with the highest prevalence rates are in the south and east: Kedougou (92%), Matam (87%), Sedhiou (86%) and Tambacounda and Kolda (both 85%). The regions with the lowest prevalence are in the west: Diourbel (1%), Thies and Louga (both 4%), Kaolack (6%) and Fatick (7%). These regional differences have complex roots beyond ethnicity and are partly due to historical, political, economic, and colonial influences.

Determining changes in prevalence rates is problematic because there were different methods of measurement used in datasets for 2005, 2010-11 and 2014. Generally, the Mandingue have the highest rate of practise, followed by the Soninke, Poular and Diola. The Wolof have the lowest rate. As discussed in this report these rates of practise vary significantly according to the regions in which people reside. Moreover, there are issues associated with self-reporting FGM status, particularly due to the criminalisation of FGM. Between 2010 and 2014 there were conspicuously high percentage drops reported in all ethnic groups.

FGM is practised for differing reasons in Senegal. For example, some of the Diola of Upper Casamance have adopted Islam and other traditions from the Mandingue in the past 60 years and FGM is part of initiation into their Islamic women's secret society (*ñakaya*). Some Poular and Mandingue are reported to practise FGM to ensure their daughter's virginity at marriage. For the Soninke, FGM is performed usually during the first few weeks after birth without ceremony and is viewed by around 20% of the ethnic group's population as a religious requirement.

More generally, FGM is seen as part of cultural identity, yet 48.5% of women and girls aged 15-49 believed FGM had no benefits (DHS, 2005). Men aged 45-49 have the highest support for the continuation of FGM and women of the same age range have the lowest support. Young women have the highest support for continuation at 23.3% (DHS, 2014). Of women that have had FGM there is a 52.4% rate of support for continuation, versus a low 2.6% rate of support among women who have not had FGM. This support varies by urban and rural residence, wealth quintiles, and mother's education.

FGM is practised mainly on infants and young girls. For example, 88.9% of Soninke girls were cut between birth and their first birthday (DHS/MICS, 2010-11). However the Diola are more likely to cut girls later at 48.6% between ages 2 and 4, and 29.1 % between the ages of 5 and 9. Daughters from younger women are less likely to be cut than daughters from older women (over age 25) (Kandala and Komba, 2015). The Demographic and Health Survey (DHS) does not collect data on type of FGM performed in Senegal; it is only determined whether or not a woman was 'sewn closed' (analogous to Type III). Many women surveyed did not know what type of FGM they had. For daughters aged 0-9 the group with the highest percentage of daughters having been 'sewn closed' is the Soninke (33%). With regards to practitioners, traditional circumcisers are most prevalent (91.4%), followed by non-specified practitioners (7.6%) and traditional birth attendants (1%). There is no reported medicalisation of FGM.

Senegal criminalised FGM in 1999 following an amendment to the Penal Code. The National Reproductive Program has been in place since 1997 to support efforts to abolish the practice. With respect to the knowledge of the law against FGM, reports show that there is very widespread awareness of the law (Shell-Duncan *et al.*, 2013; UNICEF *et al.*, 2010). A study on FGM was launched in 2000, led by the Minister of Family and National Solidarity. The Government also adopted an Action Plan in 2005, and a second in 2009 in collaboration with the United Nations Joint Programme (UNJP), to eradicate FGM by 2015.

There are numerous International Non-Governmental Organisations (INGOs) and NGOs working to eradicate FGM using a variety of strategies, including a harmful traditional practices (HTP) approach, addressing health risks of FGM, promoting girls' education, and using media. For example, Tostan uses their Community Empowerment Programme (CEP), while the Grandmother Project uses a community intergenerational dialogue approach. Singer Sister Fa works with several NGO partners and uses her music to promote the abandonment of the practice. Furthermore the Comité Sénégalais sur les Pratiques Traditionnelles (COSEPRAT) works to offer alternative sources of income to excisors. A comprehensive overview of these organisations is included in this report.

We propose measures relating to:

- Adopting culturally relevant programmes. In Senegal, while there needs to be a strong national and international message against FGM, change needs to take hold within communities and address the local drivers for FGM.
- Sustainable funding. This is an issue across the development (NGO) sector; organisations working against FGM in Senegal need to work with Government programmes and also reach out to others for opportunities to partner.
- Considering FGM within the Millennium Development Goals (MDGs), which are being evaluated this year, and re-positioning FGM in a status of high importance in the post-MDG framework at a global level.
- Facilitating education and supporting girls through secondary and further education
- Improving access to health facilities and managing health complications of FGM
- Increased enforcement of the FGM law and ensuring those responsible for FGM are prosecuted
- Fostering the further development of effective media campaigns which reach out to all regions and sections of society
- Encouraging faith-based organisations (FBOs) to act as agents of change, and to challenge misconceptions that FGM is a religious requirement and be proactive in ending FGM
- Increased collaborative projects and networking between different organisations working to end FGM to strengthen and reinforce messages to accelerate progress

Further research is needed in the following areas:

- Measuring the veracity of self-reported change in FGM prevalence among children, as the figures are even questioned by the DHS themselves.
- With so many communities declaring abandonment further investigation, including a measure of the significance of abandonment, is required.
- Changes in the methodologies used by the DHS in each of their surveys make it difficult to draw comparisons between data and between countries.
- Medical studies on the consequences of FGM in the Senegalese context

INTRODUCTION

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

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) is defined by the World Health Organisation (WHO) as referring to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. FGM is a form of gender-based violence and has been recognised as a harmful practice and a violation of the human rights of girls and women. Over 125 million girls and women alive today have had FGM in the 28 African countries and Yemen where FGM is practised and 3 million girls are estimated to be at risk of undergoing FGM annually (UNICEF, 2013).

HISTORY OF FGM

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

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

GLOBAL FGM PREVALENCE AND

PRACTICES

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

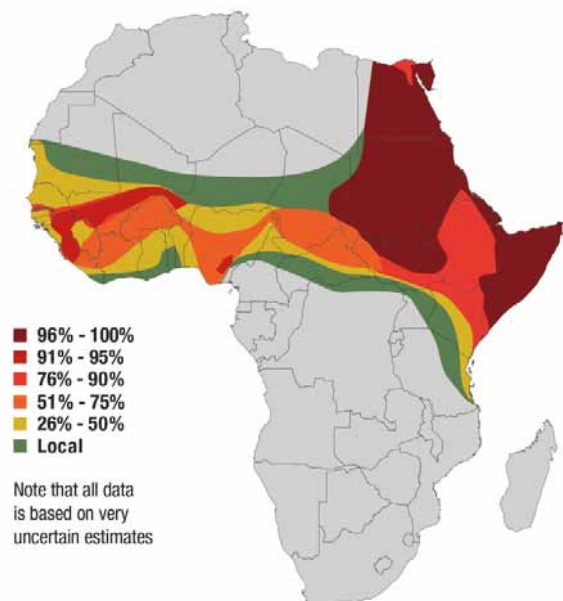


Fig. 2: Prevalence of FGM in Africa (Afrol News, 2006)

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

Type I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Note also that the term 'excision' is sometimes used as a general term covering all types of FGM.
Type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation.

The reports on FGM for Senegal (DHS and the Multiple Indicator Cluster Survey (MICS)) do not follow the WHO classifications. In the reports they discuss whether women and girls have or have not been 'sewn closed', a form analogous to Type III. The prevalence rates for the other three categories are unknown. FGM is often motivated by beliefs about what is considered appropriate sexual behaviour, with some communities considering that it ensures and preserves virginity, marital faithfulness and prevents promiscuity/prostitution. There is a strong link between FGM and marriageability with FGM often being a prerequisite to marriage. FGM is sometimes a rite of passage into womanhood and necessary for a girl to go through in order to become a responsible adult member of society. FGM is also considered to make girls 'clean' and aesthetically beautiful. Although no religious scripts require the practice, practitioners often believe the practice has religious support. Girls and women will often be under strong social pressure, including pressure from their peers, and risk victimisation and stigma if they refuse to be cut.

FGM is always traumatic (UNICEF, 2005). Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores

in the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections, cysts, infertility, an increased risk of childbirth complications and newborn deaths, and the need for later surgeries. For example, a woman with Type III infibulation needs to be cut open later to allow for sexual intercourse and childbirth (WHO, 2013).

The eradication of FGM is pertinent to the achievement of six MDGs: MDG 1 – eradicate extreme poverty and hunger; MDG 2 – achieve universal primary education; MDG 3 – promote gender equality and empower women; MDG 4 – reduce child mortality; MDG 5 – reduce maternal mortality and MDG 6 – combat HIV/AIDS; malaria and other diseases. The post-MDG agenda is currently under discussion and it is hoped that it will include renewed efforts to improve the lives of women.

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

The Country Profile also offers some analysis of the current situation and will enable all those with a commitment to ending FGM to shape their own policies and practice to create conditions for positive, enduring change in communities that practise FGM. We recognise that each community is different in its drivers for FGM and bespoke, sensitive solutions are essential to offer girls, women and communities a way forward in ending this practice. This research report provides a

sound information base which can contribute to determining the models of sustainable change necessary to shift attitudes and behaviours and bring about a world free of FGM.

During our research, we have met many anti-FGM campaigners, Community Based Organisations (CBOs), policy makers and key influencers. 28 Too Many wish to continue and build upon our in-country networking to enable information sharing, education and increased awareness of key issues, enabling local NGOs to be part of a greater voice to end FGM, locally and internationally.

NATIONAL STATISTICS

GENERAL STATISTICS

This section provides an overview of the general situation in Senegal and highlights a number of indicators which are indicative of the country context and development status.

POPULATION

14,951,888 (Country Meters, June 1, 2015)

Median age: 18.4 (2014 est.)

Growth rate: 2.6% (UNICEF, 2013)

HUMAN DEVELOPMENT INDEX

Rank: 163 out of 187 in 2013 (UNDP)

HEALTH

Life expectancy at birth (years): 63 (UNICEF, 2013) or 60.95 (World Factbook)

Infant mortality rate (per 1,000 live births): 43 deaths (UNICEF, 2015)

Child mortality rate (per 1,000): 60 (UNICEF, 2013)

Maternal mortality rate: 320 deaths/100,000 live births (UNICEF, 2013);

Fertility rate, total (births per women): 4.52 (2014 est.)

HIV/AIDS – adult prevalence rate: 0.5% (UNICEF, 2013 est.)

HIV/AIDS – people living with HIV/AIDS: 39,000 (UNICEF, 2013)

HIV/AIDS – deaths: 1,900 (2012 est.) (World Factbook)

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

Total: 52% Female: 38.7 %; Male: 61.8% (UNICEF, 2013)

Youth (15-24 years): 59% Female: 59%; Male: 74% (UNICEF, 2013)

GDP (IN US DOLLARS)

GDP (official exchange rate): \$15.36 billion (2013 est.)

GDP per capita (PPP): \$2,100 (2013 est.)

GDP (real growth rate): 4% (2013 est.)

URBANISATION

Urban population: 42.5% of total population (2011)

Rate of urbanisation: 3.32% annual rate of change (2010-15 est.)

ETHNIC GROUPS

Although Senegal has more than 20 ethnic groups, more than 90% of the population belongs to five dominant ethnic groups: Wolof 43.3%, Pular 23.8%, Serer 14.7%, Diola 3.7%, Mandinka 3%, Soninke 1.1%, European and Lebanese 1%, Other 9.4% (World Factbook)

RELIGIONS

Muslim 94%, Christian 5%, Other 1% (World Factbook)

LANGUAGES

French (official)

Several of the Senegalese languages have the legal status of 'national languages': Balanta-Ganja, Hassaniyya, Jola-Fonyi, Mandinka, Mandjak, Mankanya, Noon (Serer Noon), Poular, Serer, Soninke and Wolof.

MILLENNIUM DEVELOPMENT GOALS

The eradication of FGM is pertinent to six of the UN's eight MDGs. Throughout this report, the relevant MDGs are discussed within the scope of FGM.



Fig. 3: Millennium Development Goals

POST-MDG FRAMEWORK

As the MDGs are approaching their 2015 deadline, the United Nations (UN) is evaluating the current MDGs and exploring future goals. After 2015, the UN will continue its efforts to achieve a world of prosperity, equity, freedom, dignity and peace. Currently, the UN is working with its partners on an ambitious post-2015 development agenda, and striving for open and inclusive collaboration on this project (UN website). In August 2014, the Open Working Group presented a report proposing a list of 17 goals and 169 targets (versus the 8 goals and 21 targets of the MDGs), with new areas covering climate change, sustainable human settlement, economic development, jobs/decent work, national and global governance (UN, 2014). In December 2014, the UN Secretary General endorsed the 17 goals but called for them to be consolidated into six essential elements (people, dignity, prosperity, justice, partnership and planet) (UN, 2014b).

FGM will not be stopped in Senegal by the end of 2015, though it is nonetheless encouraging that the MDGs have ensured a persistent focus on areas related to FGM. The post-2015 agenda will undoubtedly provide renewed efforts to improve women's lives. Additionally, the African Union's declaration of the years from 2010 to 2020 to be the decade for African women will certainly assist in promoting gender equality and the eradication of gender violence in Senegal.

POLITICAL BACKGROUND

HISTORICAL

The Senegalese region has been inhabited since the Paleolithic era. The first migration waves occurred from the north and east, with the last waves being the Wolof, Fulani and Serer ethnic groups. The area was once part of the Ghana Empire, and the Kingdom of Tekrur. In the 13th and 14th centuries, it belonged to the Mali and Jolof (Djolof) Empires. By the mid- 15th century, Europeans were trading in the Senegambia region. The Dutch West India Company gained control of the island of Gorée in 1627 and the French and English also competed for control of Gorée and St. Louis. Following the conclusion of the Seven Year's War Senegal was returned to France. In the colonial period Senegal had a significant role in the slave trade.

During French colonialism there were four main communes, Saint Louis, Dakar, Gorée and Rufisque, and there was a single seat for a deputy in the French parliament. This remained the only parliamentary representation from Africa anywhere in a European legislature until 1940. In 1848 residents were granted full French citizenship, however, there were significant legal and social barriers. Labelled *originaires*, African-born residents retained their so-called personal status in African and/or Islamic Law. It was only the few who attained higher (French) education – called *évolué* – who gained citizenship. In 1959 there was a brief merger of Senegal and French Sudan, which created the Mali Federation, but this dissolved in 1960. April 4, 1960 marked Senegal's independence as a republic led by President Léopold Senghor of the Senegalese Progressive Union (Socialist Party of Senegal). Senghor retired in 1980 and was succeeded by Abdou Diouf (serving from 1981 to 2000). At this time there was also a brief confederation of Senegambia (1982-89).

CURRENT POLITICAL CONDITIONS

Senegal has remained one of the most stable African democracies and has a long history of international peacekeeping and regional mediation. For example, in the 1960s and 70s Senegal sought international peacekeeping assistance to deal with Portuguese military from Portuguese Guinea violating their borders. Senegal has eleven administrative regions and has a President as the head of State and a Prime Minister as the head of Government. In 2000, the opposition leader, Abdoulaye Wade, won the election.

Macky Sall succeeded Wade in the 2012 elections, which were deemed free and fair. Yet, police violence at political rallies resulted in 25 injuries and deaths during the election campaign. The Sall Government continues to investigate the Wade administration on corruption charges and misappropriation of Government funds (US Dept. of State, 2013).

ANTHROPOLOGICAL BACKGROUND

Traditional African societies are based on community and conformity to social norms; these values are not taught in Western-style education nor upheld through media. Instead, the younger generation are taught individualism and personal aspirations and this impairs communication between older and younger generations as older members feel unable to relate and fear that their knowledge is irrelevant in modern society (Goodpaster, 2009; GMP, 2012)

Communities in the north and south worry about an intergenerational gap growing and an associated loss of culture (O'Neill, 2012; GMP, 2012). A grandmother from the Casamance region is reported to have claimed *'We are no longer really black except by our skin colour. We are not white either. We have ceased being ourselves and we no longer know who we are'* (GMP, 2012).

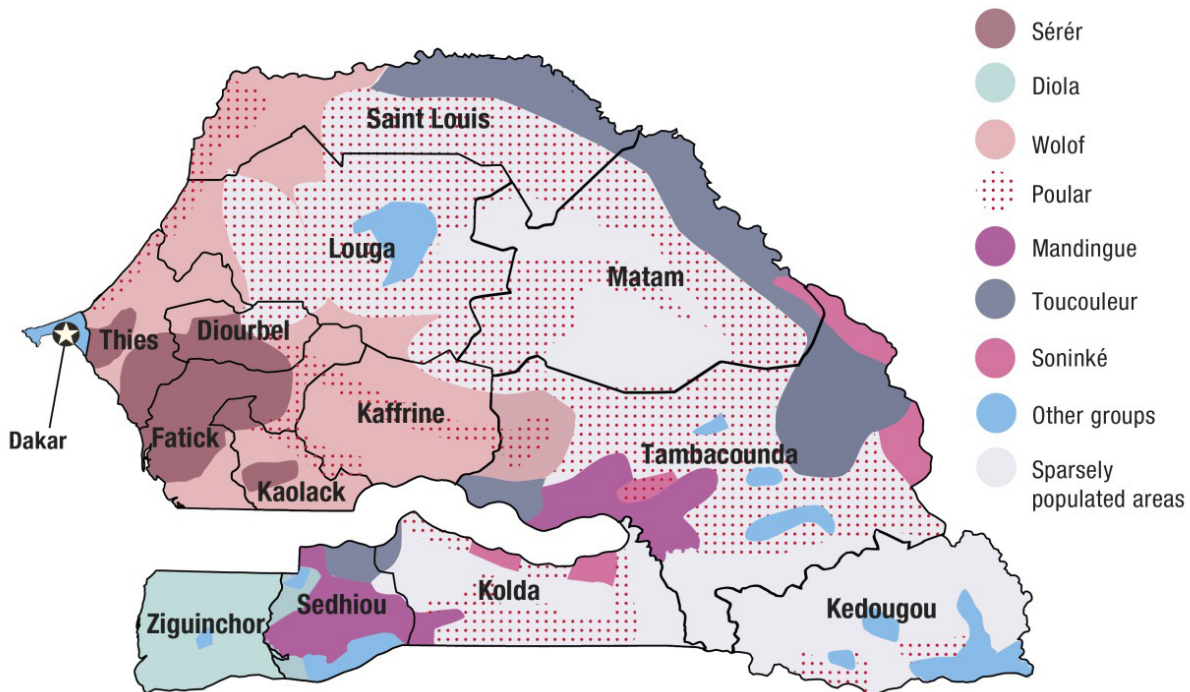


Fig. 4: Ethnic groups in Senegal (© 28 Too Many)

This report uses the spellings of ethnic group names used by the DHS for continuity. The percent distribution of ethnic groups is as follows: Wolof 43.3%, Poular 23.8%, Serer 14.7%, Diola 3.7%, Mandingue 3%, Soninke 1.1%, European and Lebanese 1%, other 9.4%.

In this section the reported prevalence of FGM is given from three DHS/MICS reports – 2005, 2010 and the latest information from 2014. These three sets of data are given to illustrate that in some cases there appears to be a significant fall in prevalence. Such a significant drop across such a short period of time is unlikely however, and this may have resulted from methodological differences between reports and not taking into account the younger cohorts, who are most likely to be cut.

ETHNIC TENSIONS

In general there is little tension between ethnic groups in Senegal as the ethnic groups are largely associated, with many shared customs. This is reinforced by joking relationships which pair groups in a bond of mutual insults, and these are taken in good humour and help emphasis differences and their acceptance. An example of this is found between the Serer and Toucouleur, and the Serer and Diola.

However, conflict persists in the Casamance region inhabited by the Diola (Jola). The previous President (Wade) announced in 2004 that he would sign a peace treaty with separatist factions in the Casamance region (The Movement of Democratic Forces in the Casamance MFDC), who have created conflict since its establishment in 1985. This is due in part to the region being



Note: Regions have the same name as their main towns

Fig. 5: Regional Map of Senegal (© 28 Too Many)

inhabited by different ethnic groups, mainly the Jola (who are animists or Christians), who do not share in Senegal's national identity and socio-economic interests. The region is remote and borders The Gambia. The worst years of conflict thus far were between 1992 and 2001, which saw over 1,000 battle-related deaths. Violence again broke out in 2007 resulting in refugees fleeing to Guinea-Bissau. The Government estimates that, as of 2013, there were 10,000 internally-displaced persons, while humanitarian agencies estimate the number to be as high as 40,000. The US Department of State (2013) reported that MFDC rebels have been accused of planting landmines, kidnapping civilians, robbing, and harassment. Senegal has further expressed concern that The Gambia's President Jammeh's connections with the Diola in the Casamance will exacerbate the separatist movement, with the possibility that it will join The Gambia (Levinson, 1998; Minority Rights Group International, 2008).

(including FGM, which is viewed as part of the religion by the Mandingue) (Dellenborg, 2000).

FGM is prevalent among the Diola ethnic group, with a recorded rate that falls from 60% in 2005 to 49% in 2014 of women aged 15-49 having undergone the practice.



Fig. 6: Diola women (©Voyager en Casamance)

ETHNIC GROUPS

DIOLA/JOOLA/JOLA

The Diola have many sub-group identities, which are highly fragmented and distinctive within Senegal and The Gambia. None have a caste system and political organisation is typically at village level (Minority Rights Group International, 2008). The Diola historically were reported to have largely rejected Islam for traditional beliefs or preferred Christian conversion. During the Soninke-Marabout wars in the 19th century they resisted efforts to abandon their traditional beliefs in favour of Islam (Burke, 2002; Access Gambia, undated). This stance has changed for the Diola who live in Upper Casamance (which borders The Gambia) where in the 20th century, due to a number of political and economic reasons, they were forced to change their agriculture to cash cropping groundnuts similar to the Mandingue who live in the same area and had arrived at the end of the 19th century. These interactions with their new neighbours led to the adoption of numerous traditions, customs and their religion

POULAR (PEULH, FULA, TUKOLOR)

The Poular are traditionally pastoralists, originating from the Upper Senegal River region and forming the second largest ethnic group in Senegal. The DHS reports group Poular together with the Tukolor, though the groups are closely related, yet distinct. Combined, they account for 23.8% of the population.

The origin of the Poular people – also known as Fulanis, Fulbe and Puel – is debated, with Poular oral tradition placing their ancestry with Caucasians or Semites entering the West Africa region. Other accounts link their origins to intermarriage between Saharan Berbers and Serere and Wolofs. Poular were reportedly among the first to embrace Islam, and the Tukolor are known for their religious zeal and for adopting Islam earlier than the Poular (Burke, 2002)

FGM is widely practised by Poular communities across Senegal, with a falling rate from 62.1% in 2005 to 54.5% in 2010 down to 51.8% in 2014 of women aged 15-49 reportedly cut. Some Poular practise Type III to ensure their daughter's virginity at marriage (14.6% of women and 22% of daughters aged 0-9 with FGM were reported sewn closed in 2010).



Fig. 7: Peulh village women (André Thiel cc)

MANDINGUE/MANDINKA/MALINKE/ MANDINGO

The Mandingue account for 3% of the population. They are also known as the Mandingos or Malinke and have their origins in Mali, reportedly spreading throughout West Africa between the 13th and 16th centuries. The Mandingue are organised into four social groups – slaves, artisans, commoners and nobles, though nowadays slaves exist only in name. Commoners are 'free-born' and are comprised of farmers, traders and clerics, while nobles are members of the royal household or potential holders of power. The artisan group is comprised of griots, blacksmiths, carpenters and leather workers. Marriage between class groups is traditionally restricted, with marriage from other castes to members of the artisan group strictly prohibited.

FGM is widely practised by the Mandingue with a 81.9% prevalence rate reported in 2010 which in 2014 was reported at 64.4% among women aged 15- 49. This is a highly improbable statistic given the very short time period between surveys. Some Mandingue practise 'sealing' analogous to Type III to ensure their daughter's virginity at marriage, with 9.8% of women and 13.1% of daughters with FGM reported sewn closed (DHS/MICS, 2010-11). Most Mandingue girls traditionally went through an initiation ritual called *ñyaaka* between the ages of four and ten, which involves FGM. However, in 2010, 94% of girls aged 0-9 were reported cut before four years old.

SONINKE

The Soninke comprise 1.1% of the population. The Soninke are exclusively Muslim and their origin is unclear.

FGM is widely practised by the Soninke; recorded rates of FGM for women aged 15-49 are 64.9% in 2010, with reported fall in prevalence of a third to 42.9% in 2014. FGM is usually performed in the first weeks of life without ceremony and is viewed as a religious practice by 24.2% and 23.9% of women and men respectively (DHS, 2014). The Soninke had the highest rate of the practice referred to as 'sealing' analogous to Type III to ensure their daughter's virginity at marriage; 36% of daughters aged 0-9 with FGM were reported sewn closed in 2010, falling improbably in two years to 10.9% (DHS continuous, 2012).

SERERE (SERRER; SERER)



Fig. 8: A 'false lion' (*simb*) dancer who participates in the ceremony prior to matches of traditional wrestling (cc license Erica Kowal, 2006)

The Serere are a minority, accounting for 14.7% of the population. They are reported to be the most traditional people in Senegal, resistant in the past to adopt Islam and slow to adapt to modernisation (Berg *et al.*, 2009). While many Serere have adopted Islam, some are Christian and others are reported to have been reluctant to adopt Islam. Socially, the Serere are organised into five class groups – the ruling noble class, soldiers, commoners (the *Jambur*), artisans and slaves. FGM is practised by the Serere in Senegal at a low rate of 2.4% among women aged 15-49.

WOLOF

The Wolof (also known as Jollof/Jolof) account for 43% of the population and constitute the largest ethnic group in Senegal and are widespread across the Senegambia region. The Wolof language is widely spoken throughout the country either as

a first or second language and is increasingly the language used by politicians to get across their messages. Islam is the predominant religion of the Wolof. Wolof social organisation is complex and historically rigid, based on division of society into royals, noblemen, the freeborn and slaves, as well as sub-divisions within these basic groups (Access Gambia, undated). Education and wealth have led to some relaxation of the social divisions by redefining people's social statuses along different lines other than caste. Traditionally, marriage is prohibited between the different castes, although there is evidence of intermarriage between ethnic groups.

The FGM prevalence rate among women aged 15-49 is 1.3% - representing the lowest prevalence of the ethnic groups. As noted in the Overview of FGM this figure varies considerably by region in which the Wolof live (e.g. up to 35% in Matam).



Fig. 9: Wolof children from Dakar (Guillaume Colin and Pauline Penot cc)

OVERVIEW OF FGM IN SENEGAL

This section gives a broad picture of the state of FGM in Senegal. The following sections of the report give a more detailed analysis of FGM

prevalence set within their sociological and anthropological framework, as well as efforts towards abandonment.

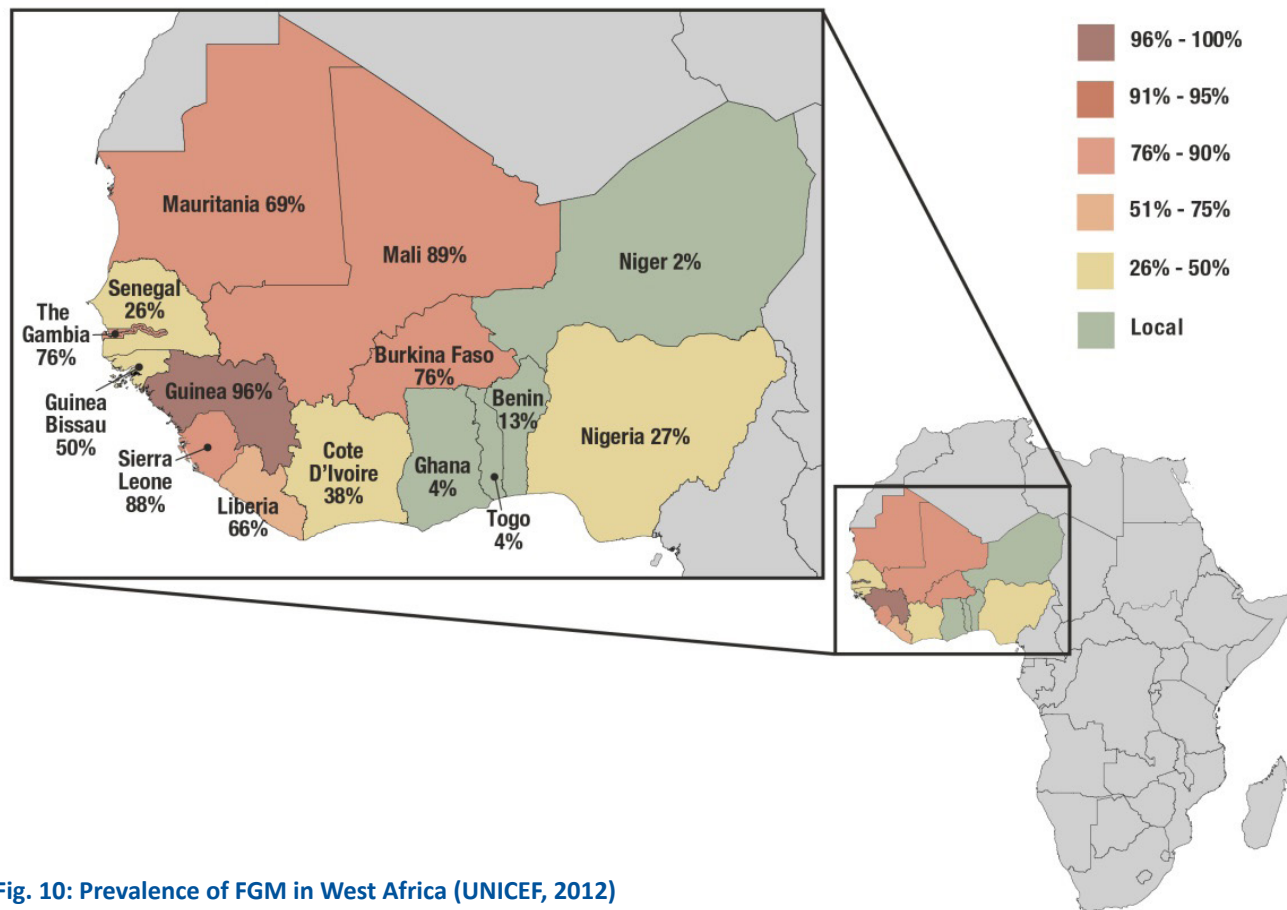


Fig. 10: Prevalence of FGM in West Africa (UNICEF, 2012)

A Note on Data

UNICEF highlights that self-reported data on FGM needs to be treated with caution since women may be unwilling to disclose having undergone FGM due to the sensitivity of the subject or its illegal nature. In addition, they may be unaware that they have been cut or the extent of the cutting, especially if it was carried out at a young age.

The DHS data does not directly measure the FGM status of girls aged 0-14 years, however, pre-2010, the DHS surveys asked women whether they had at least one daughter with FGM. This data cannot be used to accurately estimate the prevalence of girls under the age of 15 (UNICEF, 2013). From

2010, the DHS methodology changed so that women are asked the FGM status of all their daughters under 10 or 15 years depending on the country. Measuring the FGM status of this age group who have most recently undergone FGM or are at most imminent risk of undergoing FGM gives an indicator of the impact of current efforts to end FGM (or potentially the effect of laws criminalising the practice which make it harder to report that FGM was carried out). However, unless they are adjusted these figures do not take into account the fact that these girls may still be vulnerable to FGM after the age of 14 years. In the case of Senegal the DHS/MICS 2010-11 reports on the status of daughters 0-9 years only, meaning a cohort of girls is missing from the data.

NATIONAL STATISTICS AND TRENDS

RELATING TO FGM

The estimated prevalence of FGM in girls and women (aged 15-49 years) is 25.7%. Senegal is classified as a moderately low Group 3 country according to the UNICEF classification, which have 26-50% FGM prevalence. UNICEF states that no significant changes in FGM prevalence can be observed in Senegal since the first survey in 2005 (UNICEF, 2013).

Statistics on the prevalence of FGM are compiled through large scale household surveys in developing countries – the Demographic Health Survey (DHS) and the Multiple Indicator Cluster Survey (MICS). For Senegal they are DHS 2005, DHS/MICS 2010-11 and the continuous DHS for 2012 and 2014.

In respect to knowledge of the law against FGM, both Shell-Duncan et al. (2013) and UNICEF et al. (2010) find a widespread awareness of the law.

PREVALENCE OF FGM IN SENEGAL BY PLACE OF RESIDENCE

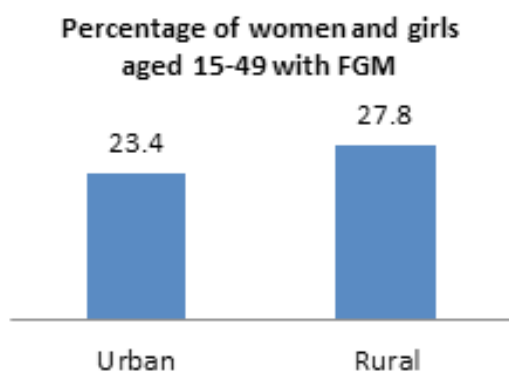


Fig. 11: Percentage of women and girls aged 15-49 with FGM (DHS/MICS, 2010-11)

Figure 11 shows that there is a 4.4 percentage point difference in FGM prevalence between those women and girls living in rural areas compared to those living in urban environments. The population of Senegal in 2013 was mostly rural at 55% of the total (nearly 7.5 million people). This rate conceals significant regional disparities. The Dakar area, with an urban population rate of 96%, includes almost half of the country's urban population (approximately 3 million people). It is followed by the Thies region with a 49% urban rate (RGPHAE, 2013).

Regional differences in Senegal of FGM prevalence (Figure 12) is not simply explained through ethnic group demographics of an area, rather it appears to be a function of historical, political, economic and colonial influences on the peoples and how they identify with the state as it was and is in its modern form. Modernity is feared by many in remote rural locations, such as the Fouta Toro in northern Senegal and Casamance, as it appears to undermine traditional values, such as the respect for elders, which is a cornerstone of many traditional African societies (Dellenborg, 2000 and O'Neill, 2012). Similarly, in the Fouta Toro, 'NGO's can be seen as outsiders bringing a subtle form of cultural colonialism disguised as development. The state is seen to be corrupted by the international community' (O'Neill, 2012). This stance allows FGM to become a symbol of resistance and thus prevalence remains high.

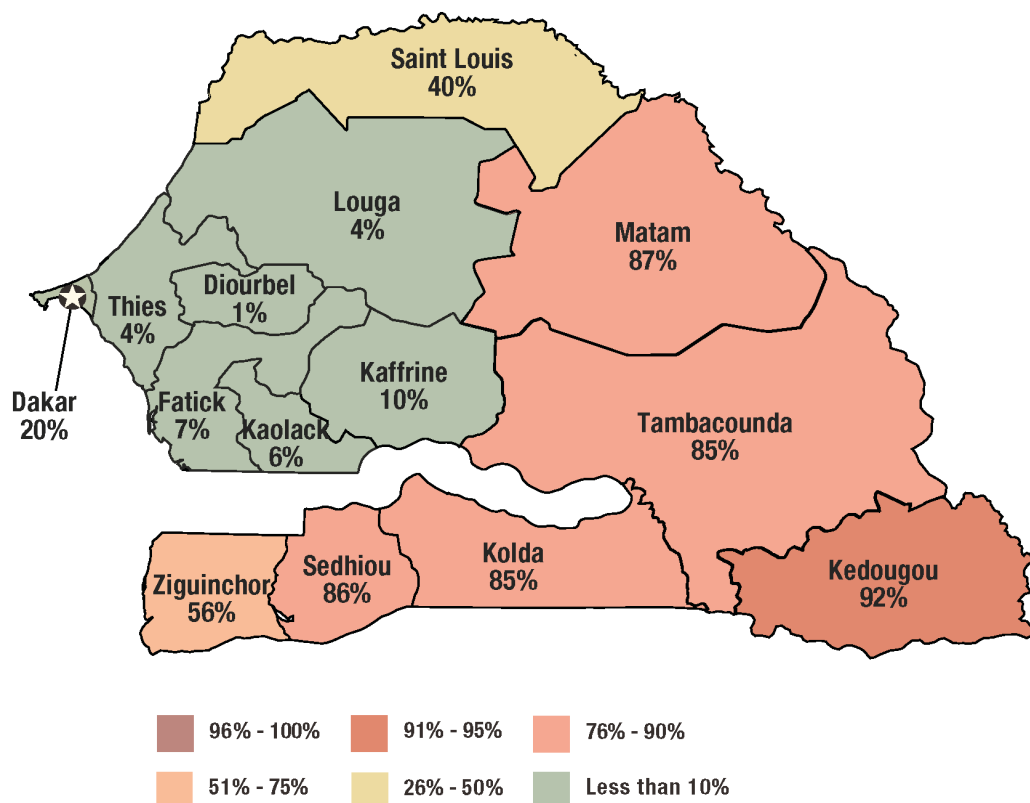


Fig. 12: FGM prevalence in Senegal by region (© 28 Too Many)

PREVALENCE OF FGM BY ETHNICITY

	2005	2010-11	2014
Wolof	1.6	0.9	1.3
Poular	62.1	54.5	51.8
Serer	1.8	2.2	2.4
Mandingue	73.7	81.9	64.4
Diola	59.7	51.5	46.2
Soninke	78.2	64.9	42.9

Table 1: Prevalence percentages of FGM by ethnicity measured in different datasets (DHS, 2005; 2010-11; 2014)

Table 1 demonstrates a problem with self-reported data on FGM prevalence. In the four years between the 2010 data and the 2014 continuous DHS data the percentage of women aged 15-49 with FGM in the different ethnic groups has apparently dropped by around 20%. Also of note is the increase in the Mandingue figures from 73.7% in 2005 to 81.9% in 2010 to a low of 64.4% two years later. A study in Ghana explores the problem with reliance on self-reporting of FGM and the factors that may affect the answers given

at any one time. The report in 2003 from Ghana interviewed the same 2000 women at a five-year interval on FGM status. In the interim, the law that had just been passed against FGM in Ghana before the first survey was widely publicised. Thirteen percent of women, who had stated in the first survey that they had FGM, denied this status five years later. The report states:

Investigation of the possibility of response bias assumes growing importance as the legislation and informational campaigns against the practice increase, possibly affecting survey-response validity...When the goal of an intervention is to stop the practice, the intervention may simply change women's responses to survey questions about their circumcision status. Anti-circumcision laws are also likely to change the reliability of self-reported data. Although no generic solution exists for this problem, results must be interpreted with caution, because research aimed at evaluating means of

preventing the practice will be compromised if social-mobilization interventions affect the propensity for denial as much as or more than they affect the practice itself (Jackson et al., 2003).

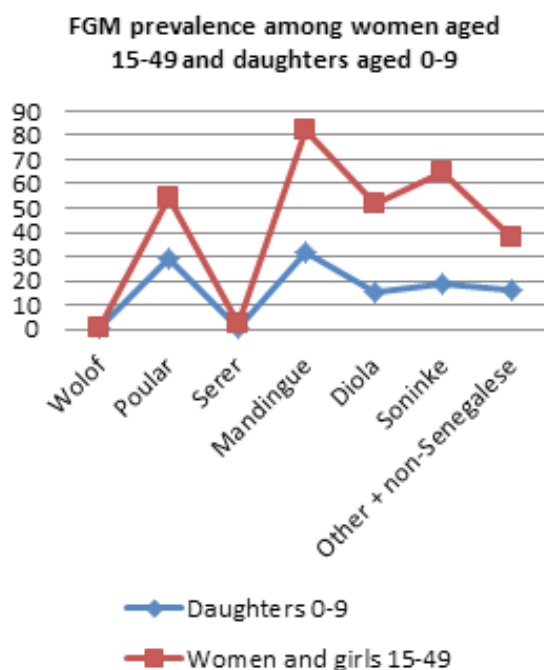


Fig. 13: FGM prevalence among women aged 15-49 and daughters aged 0-9 by ethnic identity (DHS/MICS, 2010-11)

Figure 13 shows that figures are strikingly different for FGM prevalence of daughters (aged 0-9) and women (aged 15-49), but there is an age cohort missing from the data which is girls aged 10-14. A study published in 2015 by Kandala and Komba using DHS data showed that the odds of being cut was (in order) highest among rural Mandingue, Soninke, Diola and then Poular women. For daughters, however, the odds ratio that they would be cut was consistently higher for daughters from the Poular/Fulani ethnic than their Madingue and Soninke counterparts.

	Wolof	Poular
Dakar	0.2	33.0
Ziguinchor	6.0	76.0
Diourbel	0.0	2.0
Saint-Louis	4.0	67.0
Tambacounda	17.0	93.0
Kaolack	0.4	13.0
Thies	0.3	10.0
Louga	0.0	12.0
Fatick	1.0	16.0
Kolda	30.0	92.0
Matam	35.0	91.0
Kaffrine	1.0	45.0
Kedougou	*	95.0
Sedhiou	*	95.0

Table 2: Variability of FGM prevalence within two ethnic groups (Wolof and Peulh) depending on the region of Senegal in which they live by percentage (UNICEF, 2013)

Table 2 using data from 2010-11 highlights that, in Senegal, the region in which a woman was born largely determined her risk of being cut. If born in Louga to a Poular family, for example, only 12% of women were cut, compared to 91% in Matam. Similarly, the rate of FGM rose for Wolof women in these two regions from 0% in Louga to 35% in Matam. It is posited by UNICEF (2013) that women from minority groups within the different regions adopt the social behaviour of the majority groups. This appears to be the case of the Diola in Upper Casamance who live closely with the Mandingue, where in the past 50 years they have adopted Islam as their religion and the women have taken on initiation into the Islamic form of women’s secret society (*ñaakaya*), which includes FGM. The women strongly defend their right to initiation on religious grounds, due to having lost their central ritual role as guardians of agricultural and human fertility when the men converted to Islam for political and economic reasons. The men are now not in favour of FGM, and the women view this as the men trying to undermine women’s autonomy and men see this as a route to ‘tastier’ sex (Dellenboeg, 2000).

PREVALENCE OF FGM IN SENEGAL BY AGE

Age Range	DHS/MICS 2005	DHS/MICS 2010	DHS/MICS 2014
Aged 15-19	24.8	24.0	21.1
Aged 20-24	28.0	24.3	21.5
Aged 25-29	28.4	26.1	27.9
Aged 30-34	30.1	24.9	28.2
Aged 35-39	30.5	29.0	24.9
Aged 40-44	30.3	26.9	27.2
Aged 45-49	30.6	28.5	25.7

Table 3: Prevalence of FGM by age cohort from three DHS surveys

Table 3 shows the prevalence of FGM among all women aged 15-49 from three separate DHS surveys. The coloured cells show a cohort as it ages across the time span. It should be noted that the cohort between 2010 and 2014 is not a full five years. The percentage of women reporting that they have FGM has changed in the nine years covered by the three reports. The percentage of FGM in those aged 15-19 in 2005 has increased as they entered the 25-29 age cohort in 2014 from 24.8% to 27.9%, while those aged 25-29 in 2005 reported a 3.5 percentage point fall in FGM. Similarly, the 35-39 age cohort reported less FGM as they moved into the 45-49 age group from 30.5% to 25.7%.

FGM is practised mainly on children in infancy and, though this has always been the case in groups such as the Poular and Soninke, it is increasingly

the case in nearly all ethnic groups. Table 4 shows that within the group of 15-49 year-olds, 16.9% were cut aged 5-9 among the Mandingue, whereas only 6.4% of girls 5-9 years were cut. The notable exception is among the Diola with 26.2% of older women and girls cut between age 5-9 and an increased number of girls cut at this age (29.1%). It is not possible to make a full comparison of the data for age at which women were cut with data for girls aged 0-9, as the age categories used were not the same (DHS/MICS, 2010-11).

Further information on the likelihood of girls being cut comes from the 2015 study by Kandala and Komba, which analysed the DHS/MICS 2010-11 data on FGM. It shows that daughters from younger women (age group less than 25 years) were less likely to be cut than daughters from older women.

Ethnic Group	Ages at which FGM was Performed on Daughters				Number of Daughters
	0-1	2-4	5-9	Don't Know/ Missing	
Wolof	*	*	*	*	10
Poular	69.9	25.3	4.4 (10.7)	0.4	783
Serer	*	*	*	*	8
Mandingue	62.1	31.5	6.4 (16.9)	0.0	151
Diola	22.4	48.6	29.1 (26.2)	0.0	40
Soninke	88.9	8.6	0.0 (5.1)	2.5	31
Other + non-Senegalese	59.7	33.4	5.9 (20.3)	1.0	135

Table 4: Percent distribution of age at which FGM was performed on daughters aged 0-9. (* denotes that there were not enough girls in the data to make a valid inference). Numbers in brackets refer to the percentage of women aged 15-49 questioned in the survey who were cut at this age (DHS/MICS, 2010-11)

TYPES OF FGM PRACTISED IN SENEGAL

Data was collected in the DHS/MICS 2010-11 on whether a woman was cut and if so whether she was also 'sewn closed'. This does not allow us to know whether those not sewn closed had undergone FGM Type I, II, or IV.

A comparison between the percentage of women and daughters sewn closed (Type III) cannot be made as there is a high proportion (on average 23.6%) of women with FGM who either did not know the type of FGM they had or for whom data is missing. Of those that knew, 13.8% reported being sewn closed. Among girls aged 0-9 this figure was 21.3% with strong ethnic group variation as shown in Figure 14. In the published continuous DHS 2012, this figure had dropped to a reported 6.8%. As was noted in the report, this fall is not possible in the time period as the majority of the cohort remained the same. The report suggests that the order of questions used in the two reports (which had changed) could have influenced the results and it cautions *'one should therefore be very careful in analyzing the results and interpreting changes that may not be real'* (DHS, 2012).

Percentage of daughters (0-9 years) whose genital area is sewn closed

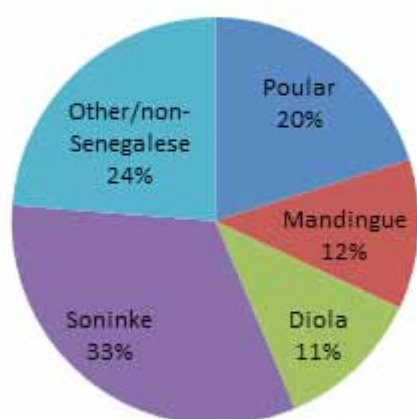


Fig. 14: Percentage of daughters (0-9 years) whose genital area is sewn closed (DHS/MICS, 2010-11)

PRACTITIONERS OF FGM

There appears to be no reported medicalisation of FGM in Senegal, though there has been a slight change in the type of traditional practitioner women use. The categories of practitioner reported in 2010-11 DHS were traditional circumciser (91.4%), traditional birth attendant (1%) and other non-specified traditional practitioner (7.6%). This 'other' category has grown from 0.2% in 2005. Also in 2005 a reported 1.3% of women were cut by a health practitioner.

SOCIOLOGICAL BACKGROUND

ROLE OF WOMEN

Article 7 of Senegal’s 2001 constitution guarantees equality between women and men. However, discriminatory practices persist, despite a legal framework that does much to protect women’s bodily integrity. While in urban areas laws protecting women are generally respected, rural areas are dominated by customary and religious practices and few women are aware of their legal rights (SIGI, 2014).

Senegal was ranked 41st out of 86 in the 2012 Social Institutions and Gender Index (SIGI), with a value of 0.23 (SIGI, 2012). This score represents a decline from the 2009 SIGI ranking, which placed Senegal 52nd out of 102 countries, with a SIGI value of 0.11 (SIGI, 2009). The 2014 SIGI data shows a slight improvement with the county’s value at 0.19, with the level of gender inequality categorised as medium (SIGI, 2014). The Gender Inequality Index (GII) is a measure of gender-based inequalities in economic activity (measured by market participation), empowerment (measured by number of women in Parliament and attainment of higher education) and reproductive health (measured by maternal mortality and adolescent birth rates). Senegal’s GII value of 0.537 ranks it 119th out of 151 countries in 2013, which shows a slight improvement from 0.554 in 2010 (UNDP, 2014).

The Family Code provides a minimum age at marriage of 16 for women and 18 for men, but an exemption can be granted by the President of the regional court after investigations. The payment of dowry is legal and while marriages between brothers-in-law and sisters-in-law is forbidden, the practices of *levirate* and *sororate*, (whereby a man inherits his dead brother’s widow or his dead wife’s sister respectively) is legal as the marriage is dissolved by death.

Customary and civil marriages co-exist in Senegal. Polygamy is allowed and the husband may marry up to four women. Marriage registration is

obligatory. According to the 2010-2011 DHS, 35% of women were in a polygamous union. Forced marriage is prohibited and personal consent for marriage must be given even where the person is a minor. Having sexual relations with girls under the age of 13 is prohibited under Penal Code, Art. 300. However, such unions are reportedly common, especially in rural areas through arranged and religious marriages (SIGI, 2014). The 2010-2011 DHS reports that 16% of women age 25-49 were married by age 15, 40% were married by age 18 (DHS/MICS, 2010-11).



Fig. 15: Women in Simbandi (Tpafrica.it cc)

PHYSICAL INTEGRITY

Women’s physical integrity is protected mainly through the Senegal’s 1999 revised Penal Code, which criminalises domestic violence, sexual assault and rape.

Domestic violence is punishable with up to five years in prison and a fine. Where the act of domestic violence causes lasting injury the prison term increases to twenty years and life imprisonment where it results in death. The 2010-2011 DHS reports that 60% of women agreed that her husband was justified in beating her for one of the proposed reasons. The majority of women who approved their partner’s violence felt it was justifiable on the grounds of refusing to have sex with him (46.0%), arguing with him (44.5%), neglecting the children (40.1%), going out without informing him (39.9%), and burning the food (24.4%).

Although rape is criminalised under the Penal Code, spousal rape is not recognised by the law. Very few rape cases are taken to court, and of those that are few result in a conviction. In part, this is because sexual violence and rape remain taboo topics and cases are often settled out of court. The penalties for rape include fines and a prison sentence ranging from 5 to 10 years.

RESOURCES AND ENTITLEMENTS

Women's resources and entitlements are guaranteed by the Constitution and Family code. The default marital property regime for civil marriages is the separation of property, and it is the original owner who legally administers property during the marriage. However, the Family Code states that men are legally head of the household and as such tend to have greater access to agricultural inputs. Despite legislation, bequests – including land inheritance – are common, and ownership is primarily obtained through paternal lineage. Customary practices relating to land ownership that discriminate against women are specifically banned under the constitution, and yet, in practice, continue to limit women's access to land (SIGI, 2014).

Women and men have the same legal rights to bank accounts and bank loans (Family Code Art. 374), but in reality women often struggle to obtain loans. In response to the difficulties rural women face in accessing credit the Government has launched a large-scale microfinance initiative. Relatively low levels of French literacy also complicates access to bank loans and credit; French is the official language of the country and yet only 1 or 2% of Senegalese women speak it (compared to 15-20% of men) (SIGI, 2014).

CIVIL LIBERTIES

The Constitution provides for freedom of movement for all citizens. However, married women do not have the right to choose where to live as this right falls exclusively to their husbands. Despite the freedom of movement survey, data suggests that daily movements are constrained.



Fig. 16: Women in Diebategunda, Cassamance (tpafrica. it cc)

According to the 2010-2011 DHS, 52.9% of women reported that it is primarily their husbands who decide whether they can visit family and relatives (DHS/MICS, 2010-2011).

Women in Senegal enjoy full political rights to vote and stand for election. Members of Senegalese political parties, women's organisations and NGOs have pushed for a gender quota in electoral lists. In May of 2010 the National Assembly adopted the Law on Equality of Men and Women in Electoral Lists, and in the 2012 elections that followed 64 women were elected as members of the 150-seat parliament (or 42.7% of seats), up from 33 after the previous 2007 election. The legislation aims to achieve equality at all levels by requiring political parties to submit alternating lists of men and women candidates, with a male-female ratio of 50%. Candidate lists that fail to comply with the provisions of the law (parity and gender alternation) are not admissible (SIGI, 2014).

HEALTHCARE SYSTEM

Healthcare is provided by both the Government and private healthcare providers. The aim is to provide free healthcare for all to improve the key health indicators identified in the MDGs. The health system has three distinct levels: Central (Ministry and Government departments), Intermediary (medical regions that monitor private and public facilities) and Peripheral (75 health districts which provide local healthcare). Senegal has 22 hospitals, 78 health centres, 986 public health posts and 144 private health posts. There is approximately 1 health post per 13,083 inhabitants, and there are around 2,000 health huts (USAID, 2009-2018). For each 10,000 inhabitants, Senegal has one doctor, four nurses/midwives, and three hospital beds (WHO, 2010). Senegal needs to further develop health infrastructure to ensure consistency in access between districts, urban and rural areas and promote health for the general population. This investment will help Senegal continue to make progress with the health related MDGs.

Life expectancy in Senegal is 63 (UNICEF, 2013), with a maternal mortality rate of 320 deaths per 100,000 live births (ranked 28th in the world), an infant mortality of 44 per 1,000 live births (UNICEF, 2015) and an under 5 mortality of 55 per 1,000 live births (UNICEF, 2015).

There has been a drive for health sector-wide approaches including the Plan National de Développement Sanitaire 2009-2018 and the Ministry of Public Health and Prevention Extended Programme of Immunisation (EPI) Comprehensive Multiyear Plan 2012-2016. It has been suggested that a high turnover in positions in the health ministry and senior administration disrupts policy progress (WHO and UNFPA, 2011). The suggested lack of stability adds additional challenges in working to strengthen the infrastructure.

HEALTH AND THE MILLENNIUM

DEVELOPMENT GOALS

GOAL 4: REDUCE CHILD MORTALITY

The aim for Senegal along with other African countries is to reduce child mortality by two-thirds. Data suggests that there have been meaningful reductions in child and infant mortality overall in Senegal (Gueye and Ndiaye, 2012, United Nations Economic Commission for Africa *et al.*, 2014).

GOAL 5: IMPROVE MATERNAL HEALTH

This goal was to reduce the maternal mortality ratio (MMR) by three quarters. Senegal is reported to have a ratio of 320 maternal deaths per 100,000 live births as of 2013; although this is significantly less than the Africa as a whole it remains short of the anticipated reduction in MMR to 218 deaths. The Ministry of Public Health and Prevention (2012-2016) reports disparity between rural and urban areas, suggesting that rural areas experience a higher MMR as these are often both the poorest and most isolated. Access to skilled healthcare professionals is key to the promotion of maternal health and early recognition of complications. Data from 2011 suggests that 65.1% of births were attended by skilled healthcare staff.

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

This goal requires that HIV/AIDS, malaria and the spread of other diseases, particularly Tuberculosis (TB), is reversed. Progress has been made in all of these areas with continued downward trends in incidence, prevalence and death rates but work needs to continue to ensure the continuation of this progress. The United Nations Programme on HIV and AIDS (UNAIDS) Global Report (cited in United Nations Economic Commission for Africa *et al.*, 2014) highlighted that there has been a reduction in condom use. This has the potential to increase the spread of HIV and negatively affect overall health.

The Senegal National Program Against Malaria arranged provision of mosquito nets through health facilities, subsidised sales and free distribution campaigns (DHS/MICS, 2010-11). These are important contributions that can help in achieving other related MDGs.

WOMEN'S HEALTH

FGM TREATMENT

There are no known health benefits of FGM as it involves removing normal, healthy tissue which then impacts of the normal functioning of the female body. Removal of the healthy tissue may result in short and long term difficulties with, for example, passing urine, menstruating, recurrent infections, painful sexual intercourse, medical complications when giving birth and the potential for psychological trauma. Mental health problems may include post-traumatic stress disorder, anxiety, depression and psychosexual issues.

Traditional 'circumcisers' are reported to perform the majority of FGM in Senegal (Gueye and Ndiaye, 2012). They are reported to use a variety of tools such as scissors, razor blades or broken glass to excise the genitalia usually without anaesthetic (UNFPA, 2014). They may also cut a number of girls at a time; increasing the risk of cross infection (for example, HIV) along with the high risk of haemorrhage making FGM a public health issue (Kandala and Komba, 2015, Hernlund and Shell-Duncan, 2007).



Fig. 17: A girl from the Casamance region, a region of Senegal which practises FGM (Tpafrica.it cc).

There is little evidence that girls/women seek treatment for either the short or long-term complications of FGM. This could be a result of traditional cultural beliefs that FGM forms part of the cultural transition to womanhood and therefore the effects of FGM may not be openly discussed or recognised. Women may also believe that health consequences are due to witchcraft or God's will (Hernlund and Shell-Duncan, 2007) leading women to accept the physiological and psychological effects of FGM, rather than seeking support and treatment. There is also the practical issue of accessing health facilities with the skills and resources to provide treatment.

A pilot scheme in Dakar offering reconstructive surgery for FGM survivors was being freely offered for a limited period in 2012 (Lazuta, 2012, Hussain, 2014). It was unclear how many women accessed this surgery as it was described as a 'handful'. Although reconstructive surgery offers some hope for women, it is important to note that this depends on the severity of the FGM and if the cutting is too severe success may be limited (Hussain, 2014).

Although the Government has criminalised FGM it is now likely to be done at a younger age and in secret (Hernlund and Shell-Duncan, 2007). This makes it less obvious to people who may report the practice but may impact on the families' health seeking behaviours.

REPRODUCTIVE HEALTHCARE

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

According to the 2010-11 DHS 9.3% of girls in the 15-19 year age group were married before 15 years old; this is a percentage decrease compared to other age groups demonstrating that the age

of marriage is currently rising (Bahoum, 2012). The age of marriage is important because this is usually a time when girls/women begin sexual relationships and embark on child rearing. The DHS EDS-MICS 2010/2011 also found that 9.6% of girls in this same age group had sexual intercourse before 15 years of age (Bahoum, 2012).

Contraceptive prevalence is considered a significant factor preventing the reduction of adolescent birth rates; Senegal has a contraceptive prevalence of 17.8% and has a world ranking of 141 (World Factbook). Some women have to be discrete in the use of contraceptives as there can be spousal pressure to have children. Some husbands ask healthcare workers to stop supplying contraceptives to their wives, this perhaps due to the social and cultural pressures for large families (US Dept. of State, 2013).

According to the DHS/MICS 2010-11, 93% of women received antenatal care by a healthcare provider. The recommended number of appointments is four and 50% of women attended these, 4% of women attended only one (Camara, 2012). Attendance was found to be higher in urban areas compared to rural areas.

REPRODUCTIVE HEALTH COMPLICATIONS

There are many reproductive health complications surrounding FGM and the lack of women's healthcare. Women may have to travel significant distances to reach a healthcare professional or a fully functioning medical facility and many do not have access to modern transportation; this is particularly problematic in rural areas (Frankel *et al.*, 2008; WSSCC, 2015; Diop and Askew, 2009). It also results in women either having a delay in receiving healthcare assistance or never receiving professional support. This is a significant issue for women who experience obstructed labour (dystocia) and this risk increased with adolescence and for women who have been infibulated (UNFPA, 2014)

There is a likelihood of infection from FGM both in the short and long term. Any unhealed

or open area leaves conditions suitable for the multiplication of harmful bacteria. This can lead to infections such as; urinary tract infections, cysts, abscesses and pelvic inflammatory infections (WHO, 2012, UNFPA, 2014). There is also evidence to suggest that menstruation may be a key time when there is an increased vulnerability to infections, particularly if there are poor hygiene facilities (WSSCC, 2015).

Haemorrhage is a known birth complication for women who have had FGM of all types due to the inelasticity of the scar tissue. This can lead to tearing during delivery, increased risk of an episiotomy (a cut between the vagina and anus to ease delivery) and a higher risk of caesarean section (WHO, 2012). There is also a greater risk of post-partum haemorrhage, meaning that a blood transfusion may be required. Unless close to a large medical facility, it is unlikely that this will be available due to issues relating to ethics, the availability of screened blood and the cold storage required to maintain the quality of blood products (WSSCC, 2015).

It is estimated that around two million women and girls across Asia and sub-Saharan Africa are affected by fistula (hole that has formed between two body organs), a condition caused by long and obstructed labour (WHO, 2014). Dystocia is more common in adolescence due to immaturity of their reproductive system. The Fistula Foundation (undated) suggest that 75% of women who have an obstetric fistula have been in labour for three or more days. The prolonged pressure from the baby getting stuck in the birth canal damages the tissues between the vagina, the urethra and/or the rectum, resulting in urinary and/or faecal incontinence. As well as being physically devastating fistula is a socially debilitating illness; sufferers may be mocked and ostracised due to the smell and leakage. Fistula can often be successfully treated by surgery.

There do not appear to be any dedicated fistula clinics or medical facilities that specialise in this type of surgery in Senegal. NGOs such as Tostan

and the Fistula Foundation have been providing support and training to help with the treatment, with Tostan running Fistula repair surgery camps (Tostan, 2015). Tostan has also launched a campaign to raise community awareness of this debilitating but treatable condition.

A multi-country modeling study was set up to estimate the increased costs in obstetric care due to increased obstetric complications as a result of FGM. The annual cost was estimated to be US\$3.7 million and ranged from 0.1% to 1% of government spending on health for women aged 15-45 years (WHO, 2011).

PLACE OF DELIVERY

De Bernis *et al.* (2000) suggest that it is the skill of the person attending the birth that may have the most significant impact on infant and maternal mortality and morbidity. This study found that when trained personnel, in particular midwives, were in attendance they recognised complications of pregnancy and delivery earlier leading to more timely interventions and improved outcomes. They also found lower mortality rates at the regional hospital in their study compared to the district health facility suggesting that both level of training and equipment availability further improves outcomes.

The DHS/MICS 2010-11 data found that 93% of women living in urban areas and 60% in rural areas delivered in a health facility. This shows that 73% of the female population go to a health facility to give birth (Camara, 2012). The majority of women in health facilities are attended by a healthcare professional (88%) compared to only 5% of women who give birth elsewhere (Camara, 2012); this disparity again impacts most women living in the most rural areas.

FGM is known to increase the risk of birth complications including maternal and infant mortality (Krause *et al.*, 2011, WHO, 2012). The complications increase depending on the severity of the FGM with infibulation resulting in the

most harmful outcomes. There is a significantly greater need for a caesarian section and other interventions for women who have experienced FGM (UNFPA, 2014) making the attendance of skilled healthcare professionals with access to appropriate equipment essential for this group.

INFANT MORTALITY

Senegal has an infant mortality rate of 43 per 1,000 live births (World Factbook). Infant mortality has decreased by 45% according to the DHS 2010-11 data and Gueye and Ndiaye (2012) describe this as the most significant decrease since the 2001 data collection. They also note that there are significant differences in child and infant mortality rates dependent on the area where a child is living, with children residing in urban areas fairing better than those in rural areas. There was considerable regional variation with southern areas demonstrating higher mortality rates compared to other regions in Senegal.

In a multi-country survey, the WHO (2006) demonstrated that death rates among new-born babies are higher in mothers who have had FGM. There was an increased need to resuscitate babies whose mothers had had FGM (66% higher in women with Type III). The death rate among babies during and immediately after birth was also much higher for those born to mothers with FGM: 15% higher in those with Type I; 32% higher in those with Type II; and 55% higher in those with Type III. The study estimated that FGM leads to an extra one to two perinatal deaths per 100 deliveries.



Fig. 18: Women and baby in Diebate Kunda (Tpafrica.it cc)

EDUCATION

The adult literacy rate in Senegal for 2009-2013 is 52% (UNICEF, 2014) and the youth literacy rate (ages 15-24) from 2009- 2013 for males was 74%, and for females 59% (UNICEF, 2013). These low rates are due to the challenges with quality of education and enrolment. Education is available from pre-school to university with the Constitution guaranteeing free and compulsory education from 6 to 16 years old (US Dept. of State, 2013). Although education is compulsory, lack of schools and teachers means this is not a reality (Niemi and Cete 2012).

Since independence secular education has followed the French model. This includes: Pre-primary (3-6 years old), primary (ages 7-12), secondary middle school (ages 12-16) and secondary high schools (ages 17-18). The ages of pupils in each class vary due to the country's repeat year system (Taniguchi, 2014). The most widely used language in Senegal is Wolof, however, the curriculum is taught in French. Yet, only 20% of the population is literate in French, excluding the majority of the population from jobs in the public and private sectors and from participation in politics (Chafer, 2003). Arabic or Qur'anic schools are more popular; however research suggests that the Arabic language is rarely spoken out of this context (Niemi and Cete, 2012).

Private education is also available in Senegal, and there has been a rise in attendance in this sector. Private schools have improved rates of gender equality, are equipped and obtain better results, but are accessible mainly to the wealthy. Their growing numbers now demonstrate increasing divides and secular (public) school is seen as a route for those who cannot afford private education (Delaunay, 2012). Private schools in Senegal can be secular, Catholic, Protestant and French-Arabic (Oxford Business Group, 2008).

ENROLMENT AND ATTENDANCE

The Senegalese Government implemented a ten-year Education and Training Development



Fig. 19: Students in Senegal (Wikiwand cc)

Programme from 2001 to 2011. Assistance towards this programme came from international donors and allowed for increased access to education through the building of primary, middle, and junior high schools (USAID, 2014). This saw a rapid rise in primary school enrolment rates and resulted in more girls enrolling than boys. Results also showed a drop in the number of pupils re-sitting the year and a rise in those going to secondary school. Although this progress is positive the USAID notes that quality of education in Senegalese schools still has a long way to go. Schools still rely heavily on teachers who do not have appropriate training and the number of students achieving the basics in French and Mathematics remains low.

Barriers such as birth certificates can be an issue when trying to enrol children in school and to register them for exams. It is common in rural communities for families not to have registered the birth of their child due to logistical difficulties, or for fear of having to leave their small holding to travel to register. Birth certificates are also not free and this can act as a deterrent for many.

Following Senegal's independence, the gap between female and male enrolment has narrowed. Enrolment for girls in primary school is slightly higher than boys, and there are disparities between enrolment in urban and rural areas. The United Nations Educational Scientific and Cultural Organization (UNESCO) reports show that the

percentage of enrolled students compared to the percentage who complete the cycle, puts Senegal near the bottom of their list for African countries. In primary school only 50% of pupils begin in first grade and complete the cycle. Pupils drop out of school commonly during the transition from primary to secondary education and also during secondary education. In 2010 UNESCO reported that the net school enrolment rate was 75%, 78% girls and 73% boys (Taniguchi, 2014). Between 1996 and 2003 primary school attendance for girls was 44% and for boys was 51%. Moreover, between 2008 and 2012 it was reported that for secondary school participation, net enrolment ratio for males was 34.9% and for females was 32.3% (UNICEF, 2013).

Primary schools outnumber secondary schools across Senegal, resulting in many students having to leave their homes to continue their education. This is costly and students often have to pay for transport, school fees and books. Children in rural areas often face long walks to school, and this can affect parents' decisions to send their children to school (Our Africa, undated; SOS Children's Villages, 2012.). Girls in particular are affected by the location of middle schools as parents are reluctant to allow them to travel long distances (Brewer, 2013).

Net attendance ratios show the percentage of all children within the eligible age for each level of education who actually attend school at that level. Table 5 shows this data by sex, residence and wealth quintile. The data shows a disparity in attendance at primary level between rural

and urban 43.6% and 72.2% respectively and at secondary level with 16.7% rural attendance and 43.8% urban. More girls than boys attend primary school (56.1% and 52.3% respectively) and more boys attend secondary education. All figures show that just under half of all primary aged children do not attend school and around 70% of children aged 11-16 are not in school.

MADRAHSSAS (ISLAMIC EDUCATION)

Ninety-four percent of the Senegalese population are Muslim. Traditional Qur'anic education is free and schools begin enrolling pupils between the ages of 3 and 5 years. The majority of education at Islamic schools is to teach pupils to recite the Qur'an by heart, which does not require an understanding of Arabic (André and Demonsant, 2009). With a lack of governmental control in Qur'anic schools there is no guarantee that children will receive proper schooling and a basic education (Niemi and Cete, 2012). The Prime Minister has reported that *'One of the policies that we're trying to implement is to come up with the idea of upgrading the Koranic schools, giving them a curriculum where we would mix Koranic teaching with modern teaching, with math and French, and try to give training to the teachers'* (PBS.org, 2014).

The ultimate aim of this school is to prepare the children to become good Muslims. The main values transmitted are obedience, respect, and submission. Pedagogical strategies may include corporal punishment and often begging for food, which is supposed to allow students to experience humility and solidarity, both highly valued in Sufi Islam

André and Demonsant, 2009

Residence Location	Primary school NAR			Secondary school NAR		
	Female	Male	Total	Female	Male	Total
Urban	73.3	71.2	72.2	43.4	44.2	43.8
Rural	45.9	41.3	43.6	15.4	18.0	16.7
Poorest	44.4	37.7	41.0	9.5	12.9	11.1
Wealthiest	69.3	70.8	70.0	51.6	54.3	52.9
Total	56.1	52.3		27.4	29.4	

Table 5: Net attendance ratio (NAR) of children attending either primary or secondary school (DHS, 2010-11)

There is ongoing concern that some pupils called Talibes in Madrasahs are living in terrible conditions to learn the humility associated with Sufism. Qur'anic schools are free to the users and the teachers say that to provide for the students that they have to beg for up to 10 hours a day to earn their keep. In 2014 it was estimated that there were at least 30,000 of these students begging, a problem the government finds hard to address due to some religious leaders attacking reforms as anti-religious.



Fig. 20: Talibes pupils. Talibein Velingara (cc Bary Pousman, Wikimedia)

GENDER PARITY

Gender parity has been achieved in primary education; in fact it is in favour of girls with 104 to every 100 boys enrolling. However, the number of girls remaining in school decreases as their education progresses. In 2009, 27% of girls were enrolled in secondary education, equating to a ratio of 79 girls to 100 boys. Thus, Senegal is still far away from gender parity (UNESCO, 2011).

There is progressive political support for pursuing gender parity in education. As part of the Research Triangle Institute's Project, a gender integration guide was introduced. Gender equality was also taken into account by the Ministry of Education's guidelines for teacher transfers and incentives were put in place for the recruitment and retaining of female teachers particularly in rural areas (USAID, 2014). Moreover, in 2012, the country held elections following the passing of a gender parity law which requires a minimum of 50% of their candidates in local and national elections to be female. The country now has a female Prime Minister, and female lawmakers have increased from 22% to 43% (Lee, 2013).

USAID has made girls' education a priority within their USD\$19 million education programme, and the Senegalese Government has stated its policy of equal access to education for both boys and girls. It is agreed that educated girls are more likely to have better jobs and healthcare for themselves and their family, and are more likely to marry at a later age. A joint project between UNESCO and the Senegalese government has allowed 160 classes to open, providing extra support for illiterate learners and supplementary classes for girls who face difficulty in their schooling.

Although improvements around girls' education are being made, pregnancy, early marriage, household responsibilities and family pressure still mean that girls have to justify continued education. If families are not able to afford to send all their children to school it is common to see daughters removed before sons. Sexual harassment can also be a reason for dropping out. In certain areas Senegalese girls are kept out of school to earn additional income.

Women's positions in society are also affected by people's perceptions of socio-cultural 'norms', and this is another reason for the high dropout rate. The lack of female role models and gender-aware teachers has led to a lower performance of female students. The role and position of women in society also contributes to the low literacy rates

of girls and women (Niemi and Cete, 2012).

A figure issued by the Ministry of Education put the percentage of teen pregnancy due to sex with teachers at 40% presenting a significant deterrent on families sending their teenage girls to school. The Grandmother Project actively fosters relations between schools and grandmothers in the communities, which breaks down social fears and misunderstanding within communities regarding the value of education.

EDUCATION AND THE MILLENNIUM

DEVELOPMENT GOALS

The Senegalese Government has supported the MDGs through public programmes in areas such as water, health and education. Progress has been made on access to primary education, gender parity in primary education, maternal health and access to water in rural and urban areas. However, growth is slow and irregular, and the speed of progress is insufficient to reach the MDGs including achieving gender parity in post primary education by the end of 2015 (Diagne *et al.*, 2011).

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

Senegal has made progress toward reaching this goal and it is reported that food security has improved for 1.3 million children under the age of 5 through community nutrition programmes. 300,000 children have also received weekly micronutrients and de-worming medication (The World Bank, undated). Senegal has been placed as a top ten achiever in percentage point progress for this MDG category (MDG Report Card, undated).

GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

Guaranteeing primary education has improved, growing from 54% in 1994 to over 82% in 2005. However, inequalities have not disappeared, but have shifted to the secondary education level (Delaunay, 2012). It is expected that Senegal will meet its MDG of universal primary education by

2015 (Oxford Business Group, 2011). In an attempt to reach the MDG of universal schooling, around 1,992 teachers were recruited directly from university, with a diploma but without educational training. Regional in-service teacher training roles were created by the Ministry of Education in Senegal to complement teacher recruitment (Niemi and Cete, 2012).

GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

The Senegalese Government has made steps toward ensuring women's land ownership in rural areas, and Senegalese women now have as equal rights as men to pass on their nationality to their children. The Prime Minister is also working to improve access to family planning. The MDG of equality between the number of boys and girls enrolling in primary school has been achieved, however obstacles still remain and there are still more boys than girls completing primary school (Lee, 2013).

EDUCATION AND FGM

Several studies suggest that *'educational attainment alone did not change attitudes and practices, rather that it acted as a mediating variable through which other processes, such as the diffusion of new information, operate'* (UNICEF, 2008). Education's effects may not be immediate or direct, but it is believed to be the best long-term intervention to address FGM. Data from the DHS 2010-11 shows that percentage of daughters aged 0-9 years who had had FGM decreased from 15.4% with mothers with no education, to 7.5% with primary educated mothers, and to 3.4% of mothers with secondary or higher education.

Incorporating education about FGM into the Senegalese curriculum is an ongoing process. According to a 2011 United Nations Population Fund (UNFPA) and UNICEF report, the Government was on course to integrate FGM education into the curriculum of all schools and colleges; however by 2013 it appeared that little had changed (US Dept. of State, 2013). There are ongoing calls for the

Senegalese Government to act on this, although it is reported that the 'Group for the Study and Teaching of the Population' had started training teachers to incorporate FGM into the curriculum (Lazuta, 2013).



Fig. 21: Great day at School in Kaplack (Angela Sevin cc)

Well-known Senegalese rapper, singer and FGM survivor Sister Fa has been using her music to educate youth on FGM across Senegal. She first began touring the country in 2008 and recently completed her third tour 'Education Without Cutting'. The Group for the Study and Teaching of the Population are following in Sister Fa's footsteps by also targeting youth in Senegal.

RELIGION

Around 94% of Senegal's population identifies as Muslim, 4% as Christian and the remaining 2% as either practising an indigenous religion, or not adhering to any religious principles. Despite formal adherence to Islam or Christianity, at the spiritual level, one witnesses a sort of religious syncretism, where on the surface people are adherents to Islam or Christianity, but their ancestral beliefs are lived daily and determine the behaviour of people (Fall, 1997). Religious freedom is protected in the Constitution, which defines the state as secular (IRF, 2012), however, while the Constitution and the Economic Community OF West African States (ECOWAS) protocol proclaim secularity, the reality in Senegal does not reflect this; many legal reforms opposing Islamic belief have successfully been fought, and the Family Code has an obvious bias towards Muslim law (Camara, 2009).

The interfaith peace and lack of religious tensions in Senegal can be explained by four factors. Firstly, there is the Senegalese conception of *Teranga*, an expectation of and pride in tolerance and camaraderie. Secondly, religions are not exclusionary; middle class Muslim children often attend Catholic schools and important public figures, such as the head of state, are often Catholic or are in dual-faith marriages. Thirdly, the Christian population is so small that it cannot be realistically viewed as a threat to the well-being of the Muslim majority. Finally, religious leaders often collaborate on issues of mutual concern affecting the communities (Nesper, 2015; IRF, 2012).

Islam arrived in Senegal as early as the 9th century; however the Islamic monks at this time only converted the ruling elite, which gave the impression that Islam was a 'religion of princes'. During the slave trade and European colonialism Islam began to be the religion of the oppressed and opponents of colonisation. Religion and the state had a clear separation, and the Islam of the Brotherhoods became the religion of liberation, offering people hope, support and identity (Gierczynski-Bocandé, undated).



Fig. 22: Sufi Islam religious leader (© Jessie Boucher)

Roman Catholicism first came to Senegal shortly after the Portuguese arrived in 1444. The input of Catholicism was sporadic until the French St. Joseph sisters arrived in 1819. Converts have mostly been from the Serer and Diola people, who are generally concentrated in the southwest but can also be found in Dakar. The Roman Catholic Church is the largest church in Senegal (sim.org). The first record of Protestant influence in Senegal is 1862 when a French governor in the south asked the Paris Missionary Society to provide a chaplain. The first baptisms took place 11 years after this first missionary was sent to Senegal (WEC Senegal, undated).

RELIGION AND FGM

FGM predates the major religions and is not exclusive to one religious group. FGM has been justified under Islam, yet many Muslims do not practise FGM and many agree it is not in the Qur'an. Within Christianity the Bible does not mention FGM, meaning that Christians in Senegal who practise FGM do so because of a cultural custom.

Religion	% who think FGM is required by religion	Number of women
Muslim	17.6	13,708
Christian	5.4	561
Other/no religion	14.2	51

Table 6: Among women who have heard of FGM in Senegal, percentage who think that the practice is required by religion (DHS/MICS, 2010-11)

Religion	Should be continued	Should be discontinued	Depends	Number of women
Muslim	17.1	78.3	4.6	13,708
Christian	4.3	90.2	5.6	561
Other/no religion	18.9	69.3	11.8	51

Table 7: Percent distribution of women in Senegal who have heard of FGM by opinion on whether the practice should be continued, according to religion (DHS/MICS, 2010-11)

There are no available statistics on men's opinions on FGM according to religion.

In 2009 a FGM practitioner was prosecuted for performing FGM on a 16-month-old girl. This caused outrage among local communities and around 200 Marabouts (local Islamic preachers) spoke out in defence of the woman and the practice. Preachers in the north of Senegal have been reluctant to denounce FGM, with one preacher even issuing a fatwa in favour of the practice. However, in 2010, leading Islamic clerics in neighbouring Mauritania took a stand and issued a fatwa condemning FGM (UNICEF, undated).

MEDIA

PRESS FREEDOM

Senegal was ranked 62nd out of 180 countries in the 2014 Reporters without Borders world press freedom index because critical reporting is routinely suppressed by authorities through the use of defamation, libel and insult. Article 8 of the 2001 Constitution protects both freedom of expression and freedom of the press, and Article 10 protects freedom of expression through speech, writing, images and peaceful marching. These freedoms have occasionally been restricted by authorities under Article 80 of the Penal Code, which prohibits threats to national security (a phrase that is only vaguely defined). *Exclusif* magazine and the private daily *Le Quotidien* have both been suspended for defamation and fined; the managing director of *Exclusif* was also given a suspended prison sentence. Such measures have left reporters wary and prone to self-censorship.

President Sall has vowed to decriminalise defamation following his election in 2012. While this promise has not yet been met, the press freedom climate in Senegal has steadily improved since Sall came to power (US Dept. of State, 2013; Freedom of the Press, 2014).

MAIN NEWS OUTLETS IN SENEGAL

Radio and television have a greater reach than the internet and newspapers, due to high levels of illiteracy. In addition, most newspapers are unaffordable on an average salary (African Media Barometer, 2013), and only 19% of the population have internet access, though this number continues to grow (International Telecommunications Union, 2012). Radio is the dominant form of news transmission with approximately 80 community, public, and private commercial radio stations (US Dept. of State, 2013). There is a discrepancy between media access in urban and rural areas as neither government nor media companies have taken steps to improve media access in rural areas (African Media Barometer, 2008). Radio is the most utilised medium in rural areas, whereas Senegalese

private television is more popular in urban areas.

Major news outlets include:

Le Soleil; Sud Quotidien; Wal Fadjri; La Gazette; Le Messenger; Le Populaire; L'Observateur;

Online news sources include:

Actu Sen; Arenebi; Au Senegal; Dakar Actu; Dakar Info; Devoir Citoyen; Home View Senegal; Info Sen; Journal de Dakar; Leral; Leuk Senegal; Nettali; Rewmi; Sen 24 Heures; Sene News

Radio stations include:

Bambilorfm; Africa No.1; Lamp Fall FM; Chaîne Nationale RTS; Nostalgie FM; Love FM; Radio Dakarbouge; Pikine Diaspora Radio; RFI Afrique; Radio Futurs Medias; Zik FM; Sud FM

ACCESS TO MEDIA

The Government has been developing telecommunications in the past few years and mobile phone access has been steadily increasing. The number of mobile phones rose from 9.38 million to 10.71 million between 2011 and 2012, reaching 88% mobile penetration. The country had 528,358 internet subscribers by the end of June 2012, there were 375,556 mobile internet users, and 95,412 people were connected to ADSL lines (itnewsafrika.com, 2012).

The DHS 2010 reports that 74% of households own a radio and 52% a television. Senegal is in 10th place for Facebook usage in Africa, with 4.69% of the population using the site (usembassy.gov).

Media exposure at least once a week	Female	Male
Reads a newspaper	12%	24%
Watches television	62%	73%
Listens to radio	63%	75%
All three media	10%	22%
No media	-	-

Table 8: Exposure to media by gender (DHS/MICS, 2010-11)

The figures for watching television or listening to radio are almost the same, but this data masks the large difference in exposure to media between urban and rural residences. 87.9% of urban women compared to 37.3% of rural women watch TV once a week. Radio exposure is closer with 69.3% of urban woman hearing it at least once a week compared to 56.7% rural. Those with no exposure to media in a week comprise 6.9% of the urban population and 33.3% rural (DHS/MICS, 2010-11).

MEDIA AND ANTI-FGM CAMPAIGNS

According to the African Media Barometer (2008), there has been an increase in grassroots movements for ending violence against women and girls (VAWG). Sister Fa is a prime example of female empowerment in the media. Sister Fa began rapping in 2000 and started her project 'Education sans Excision' (Education without Cutting) in 2010, working in conjunction with NGOs like The Orchid Project, Tostan, and World Vision. She has toured villages in Senegal mainly performing in secondary schools, sensitising and educating people about the harmful effects of FGM. The tour was promoted on a popular TV show with DJ Sega on Walfa Djiri TV station. When Sister Fa makes public radio and television appearances she often faces antagonism and public threats, but she refuses to let such threats prevent her from speaking out against FGM (trust.org).

The Orchid project in the UK is supporting work with Tostan in the use of IT, specifically mobile devices such as tablets, to film people in one village or community talking about why they have chosen to abandon FGM and this is then shown on the tablet in another village to spread the abandonment campaign. This method of using current information technology also facilitates education about IT (28 Too Many communication with The Orchid Project).

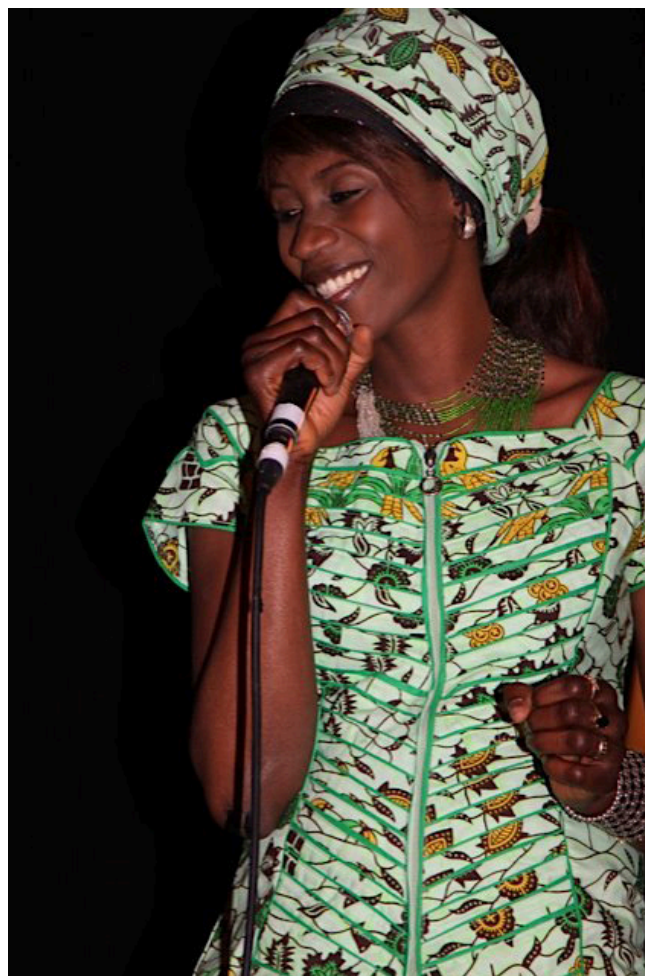


Fig. 23: Sister Fa, a Senegalese singer and campaigner for ending FGM (with permission© Sister Fa's Facebook Page)

**ATTITUDES AND KNOWLEDGE
RELATING TO FGM**

There is little variation in women’s knowledge about FGM, either by region or ethnicity. 90.4% of the Wolof women had heard of FGM, whereas only 1.3% have undergone FGM. Similarly, in the central region, 87.6% of women knew of FGM, but only 6.3% had undergone it (DHS, 2014).

The highest support in the 2014 data for continuation of FGM is found among men aged 45-49, the lowest among women of the same age group. Overall, 11.4% of men expressed an opinion it should continue compared to 15.9% of women. Support in the youngest cohort of women has risen over the years and now is the largest support for continuation at 23.3%. Of women who have had FGM, 52.2% believe it should continue compared to 2% of support in those women not cut. Support varies between urban and rural residence of women, approximately 10% and 20% respectively and across wealth quintiles from 28.2% to 5.6% for the poorest to the richest respectively (DHS, 2014).

UNICEF (2013) acknowledges that answers in formal surveys regarding questions about continuing FGM are opinions held at only one point in time. Responses can moreover be influenced by intense exposure to abandonment messages and the desire of the respondent to give the ‘correct’ answer. The report quotes research by Hernlund and Shell-Duncan in Senegal which states that attitudes of support by communities as well as individuals may potentially move between support to abandonment and in some instances back again. They claimed that *‘the construction of a person’s ‘opinion’ about the practice is more correctly an ongoing positioning vis-à-vis fluctuating needs and realities, representing contingencies that affect decision-making’* (UNICEF, 2013).

Figure 24 shows that of women that know about FGM, more than 59% of women within each ethnic group reported a belief that it should stop. The exception is the Mandingue, where 47.3% of women expressed that FGM should stop. The distribution of women that believe that FGM is a religious requirement is similar to that of women who believe that FGM should be continued, with

Percent distribution of women's beliefs about FGM by ethnic group

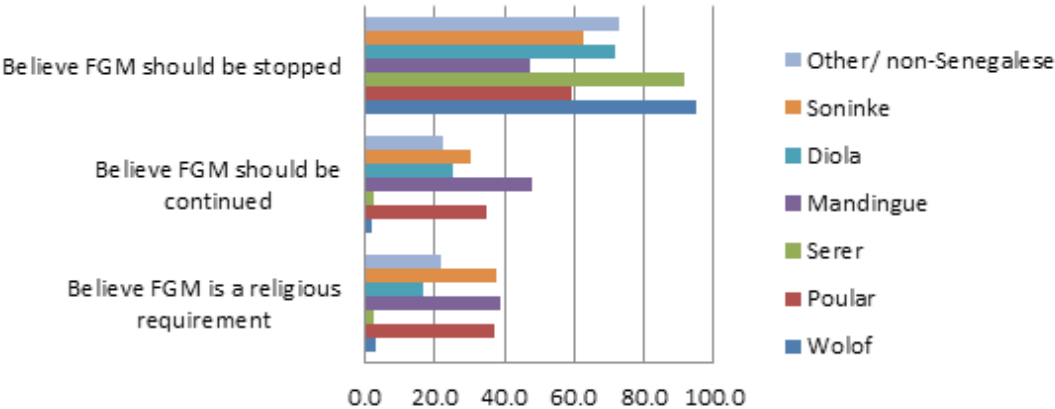


Fig. 24: Percent distribution of women’s beliefs about FGM by ethnic group (DHS, 2010-11)

small differences. Of Soninke women, 37.8% believe it is a religious requirement though fewer women think it should continue (30%). The reverse position is seen among the Diola and Mandingue, where more women believe FGM should continue (25% and 48% respectively) than believe it to be a religious requirement (16.8% and 38.8% respectively). These figures show that for some groups there are cultural values of more importance than religious considerations holding the practice in place, and that among other groups, though they believe it is a religious requirement, they still believe it should stop. These figures show that more than one approach to facilitate abandonment is required. The biggest difference in attitudes towards continuation of FGM is seen between those women who have been cut and those with no FGM, 52.4% and 2.6% respectively.

Both Tostan's Community Empowerment Programme (CEP) and the Girl's Holistic Development Programme of the Grandmother Project have had a significant impact on women's reported support for FGM abandonment. By January 2013 7,200 communities across Senegal who had directly or indirectly participated in Tostan's CEP, declared their intention to abandon FGM. Tostan is keen to point out, *'That's not to say that 100 percent of the community supports or embraces the declaration...but it is a milestone that signifies a readiness for change and lays a foundation for the community members to continue working together in their efforts to abandon the practice entirely'* (Tostan, 2015).



Fig. 25: Human Rights drawings at a public declaration, Kendougou (with permission ©Tostan Senegal)

The Grandmother Project took a baseline survey of attitudes in the 20 villages in Vellingara where they worked in 2008 at the beginning of the Girl's Holistic Development Programme. After two years they asked mothers and grandmothers 'would you be ashamed to have an uncut daughter?' to which they originally replied 'yes' (45% of mothers and 47% of grandmothers); this fell during the programme to 3% of mothers and 5% of grandmothers. A second question asked about the 'cultural obligation to perform FGM', which elicited a 'yes' from 88% of mothers and 85% of grandmothers and fell to a low of 9% and 5% respectively.

REASONS FOR PRACTISING FGM AND ITS PERCEIVED BENEFITS

FGM is a social norm tradition, often enforced by community pressure and the threat of stigma. Although communities in which FGM is found in Senegal may have different specifics around the practice, within each practising community it manifests deeply entrenched gender inequality.

SOCIAL ACCEPTANCE /CULTURAL IDENTITY

Many women in Senegal view FGM as part of their cultural identity and the law against it as an attack on their culture, imposed as a twofold cultural imperialism by both 'whites' and the Senegalese Government (O'Neill, 2012). The DHS 2005 was the last survey to ask about perceived benefits and in this survey 45.3% of women who had FGM felt it was important for social recognition.

FOR CLEANLINESS/HYGIENIC REASONS

It is reported by some women that uncut women smell bad (O'Neill, 2012). However, in 2005 when the DHS asked directly about the benefits of FGM, 6% of all women agreed it benefitted cleanliness and hygiene with 20% of women with FGM having this belief.

BETTER MARRIAGE PROSPECTS

Marriage between different ethnic groups is not uncommon and also between groups that have different or no FGM practices. In these cases, some of the women will be socially excluded until they are cut. In 2005 when the DHS asked directly about the benefits of FGM 7.1% of women with FGM agreed it improved marriageability.

PRESERVE VIRGINITY

The high levels of FGM Type III, sewn closed, among some ethnic groups is reflected in the groups that believe FGM helps preserve virginity. In the DHS 2005 approximately 20% of the Poular and Soninke women felt this to be true. In conversations with excisors in the Fouta Toro, northern Senegal, O'Neill reports that some believe that the incantations repeated during the performance of FGM will mean that no man will be able to penetrate the girl until she marries (O'Neill, 2012).

RELIGIOUS REQUIREMENT

In total 15.5% of all women and girls (aged 15-49) who had heard of FGM believed it was a religious obligation. This can be compared to 44.1% of women with FGM who believe it is a religious requirement. Among young women and girls (aged 15-24) the view was the highest (DHS, 2014). The 2014 figures reported varied by the women's education and wealth. The rate fell progressively from a high of 23.8% of the poorest women to 7.4% of the wealthiest. Similarly, the rate fell from 17.4% of women with no education to 7.8% of those with secondary level education or higher. Men's attitudes were also measured with a total of 13.1% of men (aged 15-49) believing it was a religious obligation with similar results by social background characteristics as the women.

NO BENEFIT

In 2005 48.5% of all women and girls aged 15-49 who had heard of FGM believed it had no benefits, compared to only 17.8% of women in this age group who had had FGM themselves.

LAWS RELATING TO FGM

INTERNATIONAL AND REGIONAL TREATIES

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

Senegal has ratified several international human rights conventions, which provide a strong basis for the characterisation of FGM as a violation of international human rights. The ratification of these conventions places a legal obligation on Senegal to work towards fully adhering to the provisions of these conventions with the aim of eradicating FGM:

- Convention on the Elimination of Discrimination Against Women (CEDAW) including the Optional Protocol, which it ratified in 1985 and 2000 respectively.
- Convention on the Rights of the Child (CRC) including the Optional Protocol, which it ratified in 1990 and 2004 respectively.
- Universal Declaration on Human Rights (UDHR), which is cited in the Preamble of the country's Constitution.
- International Covenant on Civil and Political Rights (ICCPR) including the Optional Protocol, both of which it ratified in 1978.
- International Covenant on Economic, Social and Cultural Rights (ICESR), which it ratified in 1978.
- African Charter on the Rights and Welfare of the Child, which it ratified in 1988.
- Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of the Women in Africa (the 'Maputo Protocol'), which it ratified in 2004.
- African Charter on Human and People's Rights (the 'Banjul Charter') which it ratified in 1982.

The African Union declared the years from 2010 to 2020 to be the Decade for African Women. As a member of the African Union, Senegal is expected to consolidate its efforts to promote and protect the rights of women.

In December 2012 the UN passed a historic and unanimous resolution calling on countries to eliminate FGM, and in 2013 the 57th UN Commission on the Status of Women agreed on conclusions including a reference to the need for states to develop policies and programmes to eliminate FGM as well as other forms of violence against women (UN, 2012). In proving its commitment and fulfilling its legal obligation to eradicate FGM Senegal will need to adopt and implement laws, policies and programmes that work towards the elimination of FGM and all other forms of violence against women.

The CEDAW and the CRC explicitly prohibit traditional practices that discriminate against women and harm children. Under the ICCPR, FGM is a violation of a person's physical integrity, liberty and security of person. Under the ICESCR, FGM is a violation of the right to health. The Banjul Charter under Article 16 includes the right to health and to physical integrity.

The African Charter on the Rights and Welfare of the Child requires that a child has the right to *'the best attainable state of physical, mental and spiritual health.'* Article 21 of the Charter requires member states of the African Union to abolish customs and practices harmful to the *'welfare, dignity, normal growth and development of the child and in particular: (a) those customs and practices discriminatory to the child on the grounds of sex or other status'*. The Maputo Protocol also explicitly refers to FGM under Article 5 whereby, *'state parties shall prohibit and condemn...through legislative measures backed by sanctions, (b) all forms of female genital mutilation, scarification and paramedicalisation of female genital mutilation and all other practices in order to eradicate them'*.

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

NATIONAL LAWS

AGE OF SUFFRAGE, CONSENT AND MARRIAGE

Age of Suffrage:

The age of suffrage is specified in the Constitution as 18, and is provided for under Article 3.

Age of Consent:

The Constitution does not detail age of sexual consent and it is not made clear in any national laws, though it is understood to be 16.

Marriage Age:

According to Article 111 of the Family Code 1973, the minimum age for marriage for girls is 16. However, marriage of girls under 16 is allowed given an age waiver by the President of the Regional court after investigation. Parental or guardian consent must also be sort for marriages of minors according to Article 103 and 104 of the Family Code. Islamic religious marriages are recognised by law. According to Article 18 of the Constitution and Article 103 of the Family Code both parties to the marriage must give free consent and forced marriage is a criminal offence.

CONSTITUTION

The Constitution does not specifically prohibit FGM. It however provide for the fundamental right of the person. Article 7 states that *'Every individual has the right to life, to liberty, to security...notably to protection against all physical mutilations.'*

FGM is recognised as a physical mutilation not performed for any medical purpose; and given the practices harmful physical and psychological consequences it could arguably be considered a violation of the law under these provisions.

NATIONAL LAWS AGAINST FGM

In January 1999 an amendment to the Penal Code (Article 299) criminalised FGM in Senegal.

The law specifically prohibits the violation of ‘the integrity of the genital organs of a female person.’ The law is applicable to anyone ‘*who violates or attempts to violate the prohibition*’ and anyone who ‘*provokes these sexual mutilations or gives instructions for their commission.*’ The penalty includes imprisonment for six months to five years, or where cutting results in death, hard labour for life.

LEGAL SYSTEM AND LAW ENFORCEMENT

Senegal’s legal system is based on French civil law. Customary and personal law are not recognised by the Constitution as valid sources of law (SIGI, 2014).

Advocacy on abandoning FGM has existed in Senegal since the 1990s. In 1997, the Ministry of Health launched a National Reproductive Programme, which contains a sub-programme on FGM and violence against women. The general objectives of the programme are to ‘*support the struggle to abolish FGC/M and other forms of violence against, women, girls and adolescents in order to protect their reproductive health, promote respect for their fundamental rights and improve their social and economic status*’ (Rahman and Toubia, 2000).



Fig. 26: Administrative authority figure with an end FGM scarf (with permission © COSEPRAT)

STRATEGIES TO END FGM AND

ORGANISATION PROFILES

BACKGROUND

Though the ban on FGM was legislated in 1999, campaigns against the practice have existed in Senegal as early as 1984. The Inter-African Committee (IAC) was established in Dakar in 1984, and they sought to change social values and raise awareness of HTPs, specifically FGM. The IAC’s main focus is eliminating the practice through raising awareness and education.

Tostan, founded in 1991 by Molly Melching, has also been widely recognised for their work campaigning against female genital cutting (FGM) in Senegal. During the 1980’s, while working in the Peace Corps and finding that international development methods were ineffective, Melching and a team of Senegalese cultural specialists, established the Community Empowerment Program (CEP), which led to the founding of Tostan in 1991. Demba Diawara, a village chief and Imam who worked with Tostan in 1997-8, successfully managed to make 13 communities in Senegal publically declare to end FGM. Diawara credits this ‘widespread change’ to the understanding that ‘*a person’s family is not their village*’, and that all of one’s social network (both local and global) must be involved in enacting change (*The Guardian*, 2013).

GOVERNMENT POLICY AND SUPPORT

With the accession to power of President Wade in 2000, the new Minister of Family and National Solidarity directed a new study of FGM. The goals of the study included developing an integrated approach to the fight against the practice; identifying those scattered groups working against the practice and their methods; tracking and assessing the situation of those women who have publicly abandoned the practice; reviewing the extent of the practice and assessing the impact of the 1999 law criminalising the practice (US State Report, 2001-2009).

In the same year the Government produced and adopted Action Plan 2000-2005, according to which FGM was hoped to be eradicated in Senegal by 2015. The main aims were to improve networking and coordination among actors involved in efforts to combat the practice, explaining the legal framework to them and integrating FGM into formal and non-formal education. The subsequent demographic study following the adoption of the Action Plan showed that FGM was at a prevalence of 28% in Senegal. An evaluation of the Action Plan conducted in 2008 noted that of approximately 5,000 villages previously practising FGM, 3,300 had pledged to end the practice by 2008 in public declarations (Kandala and Komba, 2014).

A second Action Plan, 'National Action Plan for the Acceleration of the Abandonment of FGM 2010-2015', was launched in 2009 by the Prime Minister with the help of UNFPA/UNICEF Joint Programme. The objective remains the complete eradication of the practice by 2015 (UNFPA, undated).

ANTI-FGM INITIATIVES NETWORKS

Senegal has a strong network of NGOs working to end FGM. Supported by the UNJP since its inception in 2008, Tostan in partnership with others (including the Orchid Project) attempts to co-ordinate efforts and monitor progress. The Government has also engaged with NGOs since the adoption of the Plan for National Action for the Abandonment of the Practice of Sexual Mutilation in 2000. As well as Tostan, these organisations include the IAC through COSEPRAT, the Association of European Parliamentarians with Africa (AWEPA) and the Environmental Development Action in the Third World (ENDA).

OVERVIEW OF STRATEGIES TO END FGM

A broad range of strategies have been used by different types of organisations to encourage the abandonment of FGM. More information can be found on our [Overview of Strategies to end FGM Factsheet](#). Often, a combination of strategies is used and these are outlined below:

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

Table 9: Strategies used by organisations to promote the abandonment of FGM



Fig. 27: Symbolic Burning of Cutting Instruments at a FGC Declaration Ceremony, Goudiry Village 2015 (with permission © Tostan Senegal).

INTERNATIONAL ORGANISATIONS

ACTION AID

Strategies: H / HTP / E / R / SG
www.actionaid.org

For the last ten years Action Aid has been working in Senegal on a wide range of education, health and farming projects. As part of its strategy to work with communities across Africa to stop FGM, Action Aid has undertaken community awareness and training programmes in Senegal to highlight the harmful effects of the practice. This work has included local religious leaders, where Imams are trained to understand issues like child marriage and FGM so that they can reinforce that FGM is not a religious requirement. Action Aid also provides direct support to women and girls who have escaped FGM, and trains women to form Women's Watch Groups to report cases of FGM.

THE ASSOCIATION OF EUROPEAN PARLIAMENTARIANS WITH AFRICA (AWEPA)

Strategies: HR / E / HTP / M / CDP
www.awepa.org

AWEPA has been implementing parliamentary capacity building programmes in Africa for almost 30 years with a strong focus on human rights and gender equality. Since 2011 it has been working in collaboration on the UNJP. Through its network of parliamentarians across Africa and Europe, and its experience of working on the issue of FGM, it focuses on both FGM legislation and the monitoring of its implementation and also works at a community level on education and sensitisation programmes.

In 2013, a national parliamentary workshop and various sensitisation activities led to the establishment of a 'Task Force on FGM/C' ('Comité de Pilotage') in the Parliament of Senegal, chaired by the President of the Health and Social Affairs Committee, while a declaration ('Déclaration de Saly') was adopted in which MPs recognised their key role as parliamentarians in the work to abandon FGM.

From this AWEPA undertook a number of targeted activities in Senegal, including elected delegates visiting regions in the north and south-east to instigate debates on the abandonment of FGM. The discussions were welcomed, with local communities requesting that the representatives continue to work on the topic. Follow up work addressed the issues of monitoring and evaluation, a strategy for field visits and ensured significant media coverage through radio, TV news and written articles. In April 2014, a consultation mission resulted in a detailed action plan made by the Task Force on FGM/C to continue progress. One of the first activities was a high level workshop on FGM for Senegal National Assembly Committee Chairs in December 2014. It brought together 57 participants, including the Vice-President of the National Assembly, Chairs of different Committees, other MPs, experts, UNFPA representatives and members of the Comité de pilotage to discuss FGM/C. AWEPA reports that all these activities have resulted in increased awareness amongst MPs in Senegal, a sharing of expertise and experience, increased interaction between all parties and strengthened links between MPs and local leaders on the subject.



Fig. 28: AWEPA banner (with permission © AWEPA)

ENVIRONMENTAL DEVELOPMENT ACTION IN THE THIRD WORLD (ENDA)

Strategies: HR / E / H / M
 endatiersmonde.org

ENDA was established by the African Institute for Economic Development and Planning in 1972. Based in Senegal, it is active in fourteen countries and has programmes involved with youth education, health promotion, democracy and governance and sustainable development. Work carried out in West Africa is undertaken under the subsidiary 'ENDA Graf Sahel'. In addition, 'ENDA Health', works on community health initiatives throughout West Africa, including Senegal. Priority areas include human rights and health, capacity building and support for CBOs, malaria and HIV/AIDS.

ENDA has been working to end FGM since the 1990s, with activities such as organising a workshop on the harmful nature of the practice in 1993 and producing a report examining the incidence of FGM in Senegal in 1998. More recently, in 2010-11, with the support of the International Development Research Centre, ENDA led a research project on FGM that looked at how modern communication tools, such as mobile phones, the Internet, and community radio, can be enlisted in the work to eradicate FGM in francophone West Africa.

GROUPE POUR L'ABOLITION DES MUTILATIONS SEXUELLES (GAMS)

Strategies: HTP / H / L / E / SG
 gams.be

GAMS is an NGO established in Belgium in 1996 that works to end FGM by organising awareness raising activities and training, as well as advocacy at both national and international level (including work alongside the IAC). GAMS also aims to support women and girls who have had FGM through services such as health, counselling and legal aid.

In Senegal, GAMS has built up its work to abandon FGM in four villages in the region of

Vélingara in Kolda (the villages of Sinthiourou Samba Foula, Mankacounda, Saré Bassy and Saré Dialo). Funding has been received from Japanese and Belgian NGOs for this work, which includes improving literacy and alternative income generating activities and GAMS continues to seek funding to continue these activities.

THE GRANDMOTHER PROJECT (GMP)

Strategies: CDP / E / H / HTP / SG / MB
 www.grandmotherproject.org

GMP is an INGO working mainly in West Africa that recognises the influential role that grandmothers have within their families and communities and uses them as leaders for change and development. GMP's project in Senegal is called Girls' Holistic Development, which is about improving all aspects of their lives including support for girls to pursue their education, supporting intergenerational community forums to promote positive cultural values and to discuss HTPs such as FGM and child marriage. Grandmothers are supported to play a central role in these discussions and problem-solving activities between all age groups, both male and female. They aim to identify and perpetuate the 'good' traditions (such as songs, dances and storytelling) and eliminate the 'bad' traditions (such as child marriage, teen pregnancy and FGM). GMP has also facilitated programmes between schools and communities to break down some of the misunderstandings about modern education and successfully introduced curricula on traditional values into local schools with the active support of the ministry of education. Part of the educational innovations includes pamphlets like the one shown in the picture which are used in schools.

GMP reports that where this work has been done in villages around Vélingara in the Casamance region, the knowledge and confidence of grandmothers has increased, they have become more open to change and they have been empowered to become catalysts for change in their communities and tackle issues such as FGM.

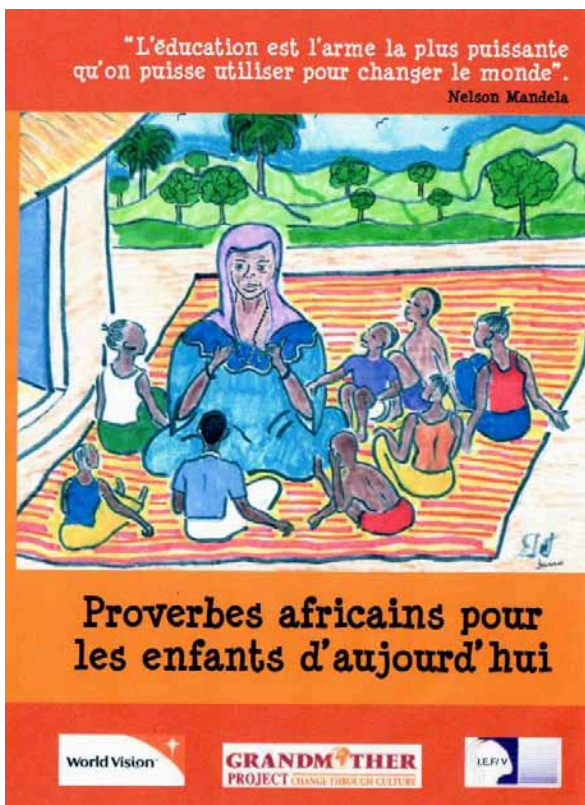


Fig. 29: African Proverbs for today's children. A partner project with World Vision in Vélingara, Tambacounda (© Grandmother Project Facebook Page)

INTER-AFRICAN COMMITTEE ON TRADITIONAL PRACTICES (IAC)

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

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

IAC programmes throughout Africa include training for professionals, women's and men's groups, peer educators and legal bodies. It undertakes information and sensitisation

campaigns, targeting different groups such as religious leaders and traditional rulers, and provides training and credit to ex-circumcisers, utilising them as agents for change. COSEPRAT is the IAC national committee member for Senegal.

ORCHID PROJECT

Strategies: HR / CDP / E / HTP
orchidproject.org

The Orchid Project is a UK-based NGO founded in 2010 to raise awareness, advocate and partner with other organisations to help end FGM. Working with partners at grassroots level, such as Tostan in Senegal, the Orchid Project supports activities based on a social norms/human rights approach.

The Orchid Project is partnering with Tostan on a 'Social Mobilisation' project taking place in the regions of Kolda and Sédhiou (southern Senegal) and the Fouta (northern Senegal). The programme supports social mobilisation agents and teams of volunteers who have already abandoned FGM through Tostan's CEP work, to spread the message of abandonment and encourage others to join them. For instance, they provide funding for transport costs and purchase motorcycles for Tostan staff to move between villages. These individuals and groups then share their knowledge with non-participating, inter-marrying groups and to date this has led to 72 communities choosing to abandon FGM and reinforced the decision to abandon in many more.



Fig. 30: Medina Yoro Foulah Kolda- FGM Abandonment Declaration (with permission © Alicia Field Orchid Project)

The Orchid Project also supports the work of Sister Fa, a Senegalese hip hop singer who undertakes educational tours, taking the message to abandon FGM to communities through her music. In co-operation with the Orchid Project, Tostan and World Vision, Sister Fa tours Senegal every year with her ‘Education sans Excision’ (‘Education without Cutting’) project, raising awareness of the dangers of FGM in schools.

PLAN INTERNATIONAL – SENEGAL

Strategies: HTP / E / HR
plan-international.org

The four key aims of Plan International in Senegal are: quality learning for children and youth; child protection; a safe and healthy environment and social and economic leadership for youth and women. Plan Senegal works both at the national level and locally with families and communities to protect children, especially girls, from gender-based violence. In communities where HTPs such as FGM are widespread, Plan Senegal reinforces and supports ongoing local efforts to reduce the practices.

SAVE THE CHILDREN – SENEGAL

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

Save the Children works in 120 countries across the world, with a strong focus on child rights. Its programmes range from child protection to food security and education, with projects focusing on a variety of issues and approaches, from grassroots aid to high-level policy change. Save the Children has been operating in Senegal since 2002 and Senegal is one of the countries where it works to end FGM.

Strategies used by Save the Children to end FGM include meeting ethnic groups living in the areas

between Senegal and neighbouring countries to discuss FGM. Save the Children works alongside community and traditional leaders to develop appropriate interventions and reinforce advocacy work in the country.

TOSTAN

Strategies: HR / CDP / H / MB / SG
www.tostan.org

The origins of Tostan and its work to empower communities date back to the 1970s in Senegal. The first village whose people collectively decided to abandon FGM through Tostan’s Community Empowerment Programme (CEP) did so in July 1997. Tostan works in partnership with a wide range of organisations, including the Government of Senegal and the UNFPA-UNICEF Joint Programme (UNJP). It engages in outreach activities, and organises events to promote wider discussion and dialogue around FGM (Tostan uses the term FGC, or ‘the practice’), early/forced marriage and human rights more broadly.

Since 2005, Tostan report that thousands of villages have joined the movement for the abandonment of FGM in Senegal, and in 2014 there were 175 communities actively engaged in the CEP across ten regions including Kolda, Kaolack, Sedhiou, Matam, Saint Louis, Bakel and Thies. The CEP, which has been commended by the Government as a ‘model of best practise’, is a non-formal education programme running over a three-year period with classes led by a trained, local facilitator. A ‘cluster’ of communities from the same ethnic background begin the CEP at the same time. Classes are divided into two phases – the Kobi (meaning ‘to plough the soil’), covering sessions on democracy, human rights, problem solving and health, and the Aawde (meaning ‘to plant the seed’), covering sessions on literacy, numeracy and management. During and after the CEP has been completed communities are supported through a community-led microcredit scheme.



Fig. 31: Facilitator and Participants at a CEP session, Kaolack Region (with permission © Tostan Senegal)

Facilitators (fluent in the local language) use oral traditions and visual tools to guide the sessions, which are designed to encourage reflection on social norms such as FGM and early forced marriage. FGM is addressed within a human rights framework but spoken about specifically during the Kobi sessions on health and hygiene. The CEP also uses a model of organised diffusion, which encourages participants to reach out to communities and individuals not involved to share ideas, learning and new information. Community Management Committees (CMCs) are set up and trained in the management skills necessary to implement development projects. In 2006, Tostan set up the Empowered Communities Network (ECN) in Senegal to help communities partner with other organisations. Tostan has also been involved with the Zero Fistula Project and the organisation of repair surgery camps providing consultations, repair surgery and support for local women in the regions of Kolda-Sedhiou and Tambacounda-Kedougou in Southern Senegal.

UNICEF / UNFPA

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

Senegal was one of the first 15 countries forming part of the UNFPA-UNICEF Joint Programme (UNJP) on FGM from its inception in 2008. At the national level, the UNJP has contributed to the development of the second ‘National Action

Plan in Senegal to accelerate the abandonment of FGM/C’ (2010-2015), and the establishment of the National Technical Committee in charge of monitoring and coordination. At the local level, the UNJP has been part of the movement led by Tostan and the implementation of its Community Empowerment Programme (CEP). UNICEF also supports a wide range of grassroots NGOs working on different strategies towards the abandonment of FGM. It has, for example, supported the engagement of religious (in particular Muslim) leaders in the movement to abandon FGM, and the involvement of local media and the production of information materials on FGM in local languages.

WORLD VISION

Strategies: CDP / E / H / HTP
www.worldvision.org

World Vision has been working in Senegal since the drought crisis of 1983-84. As part of its work to address FGM, it uses various strategies throughout several African countries including raising awareness in communities, advocacy, Alternative Rights of Passage (ARPs) and education and training for ex-circumcisers.

In Senegal, specifically, World Vision has worked with partners, including GMP, on the Girl’s Holistic Development Project (GHD). This project is proving successful in uniting grandmothers with their granddaughters as a way of changing attitudes, highlighting the dangers of FGM and uniting the community against the practice. World Vision also campaigns against FGM through the global campaign ‘Action 2015’.

NATIONAL AND LOCAL ORGANISATIONS

ASSOCIATION POUR LA PROMOTION DE LA FEMME SÉNÉGALaise (APROFES)

Strategies: HR / H / E / HTP / SG

Since 1987 APROFES has been working to raise awareness of women’s rights in Senegal. Its projects aim to increase the social, political

and economic role played by women through improving access to resources including health services, participation in decision-making, increasing economic independence and reducing violence against women. APROFES works both at the national level through its coalition work and at the local level with women leaders, entrepreneurs and women's groups to run awareness raising campaigns and provide counselling, support and legal assistance to victims of Gender Based Violence (GBV). Partners in Senegal include Réseau Siggil Jigéen and Crossroads International.

COLLECTIF DES FEMMES POUR LA DÉFENSE DE L'ENFANT ET DE LA FAMILLE (COFDEF)

Strategies: H / HTP / HR / L

Since its formation in 1993 COFDEF has focused on three key issues that affect women throughout Senegal: the enforcement of healthcare and reproductive rights; HIV/AIDS; and the exclusion of women from political power and decision making. COFDEF undertakes awareness raising and training programmes throughout communities, stressing the importance of including and seeking the approval of religious leaders from the outset. Its work includes campaigning for an end to HTPs, including FGM. At a national level COFDEF has also been involved with the movement to enforce the gender parity law in Senegal.

CONSEIL SÉNÉGALAIS DES FEMMES (COSEF)

Strategies: HR / E

Women's rights, in the context of human rights, underpin the work of COSEF. Since 1995, COSEF has undertaken education, consultation and monitoring and evaluation work on women's issues throughout Senegal. These issues include: access to politics; the relationship with men in society; promotion and development of gender issues; and defining strategies to preserve the physical integrity and dignity of all women. COSEF aims to create a framework for information sharing, study, research, training and consultation on all

issues affecting women in Senegal. Activities have included participation in the World Conference on Women (Beijing 1995), being a founding member of the Committee against Violence towards Women and supporting other organisations engaged in similar issues.

COMITÉ SÉNÉGALAIS SUR LES PRATIQUES TRADITIONNELLES (COSEPRAT)

Strategies: HTP / EX / H

Based in Dakar, COSEPRAT is the national committee member of the IAC. It aims to raise awareness of HTPs, including FGM, and contributes internationally through attendance at conferences and summits and at a national level by holding seminars, training medical staff and Traditional Birth Attendants (TBAs) and initiating alternative sources of income for excisors.



Fig. 32: A musical display at an event organised on 6 February 2015 to mark Zero Tolerance Day (with permission ©COSEPRAT)

COSEPRAT organised activities for International Day of Zero Tolerance to FGM in February 2015 and has completed a sensitisation project with UNICEF Senegal in the Guédiawaye suburb of Dakar. COSEPRAT reports that activities are limited due to a lack of funding.

GROUPE DE RECHERCHE SUR LES FEMMES ET LES LOIS AU SÉNÉGAL (GREFELS)

Strategies: HR / H / SG / M

Founded in 1994, GREFELS (the Research Group on Women and Laws in Senegal) stems from the work of the international solidarity network Women Living Under Muslim Laws (WLUML). Through research and training at both the national and local level, GREFELS promotes and supports women's rights in Senegal, tackling issues including sexual and reproductive rights of women, trafficking and sexual exploitation of women and girls and GBV (including forced marriage, domestic violence and FGM).

As part of the 'Violence is Not Our Culture' campaign, GREFELS is creating a network of support and advocacy for young women and girls to eliminate the practice of FGM. A number of approaches are used, including:

- Integration of new media and technology through workshops – using blogs to manage communication around child protection and the use of online alerts so girls can inform the authorities if they are in danger of being sent away by families to undergo FGM
- Discussions on community radio stations in local languages to raise awareness of the dangers of FGM and encourage dialogue among medical professionals and religious leaders who oppose the practice

RÉSEAU SIGGIL JIGÉEN (RSJ)

Strategies: HR / H / E / HTP
siggiljigeeen.org

Established in 1995, Réseau Siggil Jigéen (RSJ) aims to promote and protect women's rights in Senegal through a network of 16 member organisations that are directly involved in the day-to-day lives of Senegalese women, including ADFES, APROFES and COFDEF. Member activism areas include: health, reproductive rights and family planning, education and literacy, training and micro-finance schemes. The work to abandon HTPs, including child marriage and FGM, is supported by RSJ through its partnership with COSEPRAT.

CHALLENGES FACED BY ANTI-FGM

INITIATIVES

There are numerous infrastructure challenges to the work of campaigners. Lack of passable roads in rural areas, lack of electricity in rural communities, which gives no access to computers/internet, makes communication and coordination difficult. Other more direct challenges to initiatives are:

- Providing continued support to communities that have started the abandonment process
- Lack of sustainable funding for projects that work with communities over prolonged periods of time
- Lack of support for abandoning FGM among some religious leaders, even though it is illegal
- Care for women who have already undergone FGM, which is linked to poor healthcare infrastructure
- Non-enforcement of the law against FGM and little provision in the law or society for women who want to protect their children from FGM
- Lack of medical studies in country on the problems caused by FGM, or gynaecological observation to support the self-reported numbers of FGM prevalence
- More thought into surveys gathering data on FGM prevalence and abandonment, given the pressures of the known illegality of the procedure making the legitimacy of 'truthful reporting' questionable and pushing the practice underground



Fig. 33: Villagers in the rural area of Keur Simbara (© Jessie Boucher)

CONCLUSIONS

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

ADOPTING CULTURALLY RELEVANT PROGRAMMES

Communities in which FGM is found in Senegal have different specifics around the practice and also express differing reasons for FGM. Programmes to tackle FGM need to be aware of these differences and deploy strategies to address the issues within each community and to build support to stop FGM. The GMP's Girls' Holistic Development recognises and uses the influential role of elder women to act as champions for change, and Tostan work with and empower communities. Both these programmes encourage and support change from within communities through their CEP.

SUSTAINABLE FUNDING

Programmes and research studies concerned with the elimination of FGM require sustainable funding in order to be effective. Continued publicity of current FGM practices at a global level, particularly through the UN and WHO, is crucial for ensuring that NGOs and charities are given support and resources long term. Prioritising charitable aid and grant funding is inherently challenging, and programmes for ending FGM are given less attention than those related to the health and poverty crises.

FGM AND THE MILLENNIUM DEVELOPMENT GOALS

Considering FGM within the larger framework of the MDGs conveys the significant negative impact FGM makes on humanity. Preventing FGM is connected to promoting the eradication of extreme poverty and hunger, the promotion of universal primary education, gender equality,

reducing child mortality, improving maternal health and combating HIV/AIDS.

Relating FGM to wider social crises is important when creating grant proposals and communicating anti-FGM initiatives to a wider audience because it highlights the need for funding anti-FGM programmes and research for broader social change. There has been a momentum for change, with the UN global ban on FGM in December 2012 and the UN Commission on the Status of Women (UNCSW) 57th session focused on violence against women and girls, including FGM. We hope that this momentum is continued and that violence against women, and FGM, are reflected in the post-MDGs agenda and at the Beijing +20 platform to be held in September 2015.

FGM AND EDUCATION

Education is a central issue in the elimination of FGM. The lack of basic education is a root cause for perpetuating social stigmas surrounding FGM as they relate to health, sexuality and women's rights. FGM hinders girls' ability to obtain basic education and prevents them from pursuing higher education and employment opportunities. This lack of education directly relates to issues surrounding child marriage. We recommend that organisations continue to provide programming related to education for boy and girls, and that the Government makes efforts to comprehensively report on education conditions.

FGM, MEDICAL CARE AND HEALTH EDUCATION

More resources and education are needed across the health systems in Senegal and there needs to be better access to healthcare, especially in rural areas. With regard to FGM, health providers need to be better trained on the complications surrounding FGM and provided with resources to support girls and women who have undergone FGM, addressing both the physical and psychological issues.

FGM, ADVOCACY AND LOBBYING

National advocacy and lobbying is essential to ensure that the Government supports anti-FGM programmes and initiatives and that progress towards the elimination of FGM in Senegal is maintained. Support is also required from international partners and donors for the development of Senegal's health and education sectors as well as supporting local initiatives that tackle FGM.

FGM AND THE LAW

Although FGM was criminalised in Senegal in 1999, law enforcement is weak and education and training is required for all those responsible for upholding the law. Consideration should also be given to measures to protect those at risk or seeking to protect their children from FGM.

FGM IN THE MEDIA

Media has proven to be a useful tool against FGM and in advocating for women's rights. 28 Too Many supports the work that has been done with media on FGM and encourages these projects to continue. Diverse forms of media should be used (including formal and informal media) to promote awareness of FGM and advocate for women's rights at a grassroots level.

FGM AND FAITH-BASED ORGANISATIONS

With over 80% of the population in Africa attending a faith building at least once a week, religious narratives are essential for personal understanding, family and society. Faith-based organisations are a major agent of change, and their international, regional, national and local presence and structures offer platforms for teaching, education, support and health provision regarding issues such as FGM. In Senegal, a significant number of those who practise FGM believe it to be a religious requirement. Therefore it is essential that religious leaders speak out against the practice and encourage its abandonment.

COMMUNICATION AND COLLABORATIVE PROJECTS

There are a number of successful anti-FGM programmes currently operating in Senegal, with the majority of the progress beginning at the grassroots level.

We recommend continued effort to communicate their work more publicly and encourage collaborative projects. A coalition against FGM will be a stronger voice in terms of lobbying and will be more effective in obtaining sustainable funding and achieving programme success, and efforts in Senegal are headed in this direction.

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

FURTHER RESEARCH

- More complete data and complementary methodologies on what is working and changing in FGM programming would be beneficial.
- Consistency in both the order of questions in surveys and the age cohort of daughters asked about would allow for analysis of trends between data sets.
- Determine how to collect reliable data on an illegal practice, which needs to be addressed at global and grass roots levels.
- Given the significant work being done to end FGM in Senegal, there is a lack of medical reports on the impact of FGM and how the situation may be changing. This needs to be addressed.
- Further research on the involvement and impact of religious leaders in the work to end FGM could be beneficial to programming.

- Monitoring girls' enrolment and attendance at school, and discouraging early marriage in favour of completing education, could be influential in changing beliefs and the practice of FGM. Similarly, educating boys on the harm of FGM is important, as is encouraging them to marry uncut girls.
- Investigate the use of social media and mobile phone technology as a strategy to advocate and educate around the issue of FGM, and to support girls at risk and survivors of FGM.

APPENDIX I - LIST OF INTERNATIONAL AND NATIONAL ORGANISATIONS CONTRIBUTING TO DEVELOPMENT GOALS AND WOMEN'S AND CHILDREN'S RIGHTS IN SENEGAL

<p>Action Aid</p> <p>The African Movement of Working Children and Youth (AMWCY)</p> <p>African Network for the Prevention and Protection against Child Abuse and Neglect (ANPPCAN)</p> <p>Amnesty International</p> <p>Association of European Parliamentarians with Africa (AWEPA)</p> <p>Association des Femmes Juristes du Sénégal</p> <p>Association pour le Développement des femmes et de l'enfant au Sénégal (ADFES)</p> <p>Association Pour La Promotion De La Femme Sénégalaise (APROFES)</p> <p>Association Sénégalaise pour le Bien-être Familial (ASBEF)</p> <p>Association Sénégalaise Pour La Promotion De La Famille (ASPF)</p> <p>Association Sénégalaise de Protection et de Promotion des Droits de l'Enfant et de la Femme (ASPRODEF)</p> <p>Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa (CARMMA)</p> <p>Centre Africain pour l'Education aux Droits Humains et a la Paix</p> <p>Child Fund International</p> <p>Children of the World</p> <p>Christian Aid</p> <p>Christian Children's Fund</p> <p>Coalition Nationale de Associations et ONG en Faveur de l'Enfance au Sénégal (CONAFE)</p> <p>Collectif Des Femmes Pour La Défense De La Famille (COFDEF)</p> <p>Comite D'Etudes Sur Les Femmes, La Famille et L'Environnement En Afrique (CEFFEVA)</p> <p>Comité Sénégalais sur les Pratiques Traditionnelles (COSEPRAT)</p>	<p>Conseil Sénégalais Des Femmes (COSEF)</p> <p>Child Rights International Network (CRIN)</p> <p>Crossroads International</p> <p>Defence for Children International (DCI) – Senegal</p> <p>Economic Community Of West African States (ECOWAS)</p> <p>ENDA Graf Sahel</p> <p>Environmental Development Action in the Third World (ENDA)</p> <p>Forum for Women Educationalists (FAWE)</p> <p>Global Fund for Children</p> <p>Grandmother Project (GMP)</p> <p>Groupe pour l'Abolition des Mutilations Sexuelles (GAMS)</p> <p>Groupe pour l'Etude et l'Enseignement de la Population (GEEP)</p> <p>Groupe de Recherche sur les Femmes et les Lois au Sénégal (GREFELS)</p> <p>(I)NTACT International Action Against FGM</p> <p>Inter-African Committee on Traditional Practices (IAC) – Senegal</p> <p>Médicos del Mundo</p> <p>Orchid Project</p> <p>Organisation pour la Formation et l'Appui au Développement (OFAD NAFOORE)</p> <p>Open Society Initiative for West Africa (OSIWA)</p> <p>Plan International – Senegal</p> <p>Rencontre Africaine pour la Défense des Droits de l'Homme (RADDHO)</p> <p>Réseau Africain pour le Développement Intégré (RADI)</p> <p>Réseau Siggil Jigéen (RSJ)</p> <p>Save the Children – Senegal</p>	<p>Sister Fa</p> <p>SOS Children's Villages</p> <p>Tostan</p> <p>Union des Coalitions Ouest Africaines pour l'Enfance (UCOA)</p> <p>UN Women</p> <p>United Nations Children's Fund (UNICEF)</p> <p>United Nations Development Programme (UNDP)</p> <p>United Nations Population Fund (UNFPA)</p> <p>USAID</p> <p>Women Living Under Muslim Laws (WLUML)</p> <p>World Health Organisation (WHO)</p> <p>World Vision</p>
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