



Home Office

# **Country Policy and Information Note**

## **Gambia: Female genital mutilation (FGM)**

**Version 1.0**

**December 2016**

# Preface

This note provides country of origin information (COI) and policy guidance to Home Office decision makers on handling particular types of protection and human rights claims. This includes whether claims are likely to justify the granting of asylum, humanitarian protection or discretionary leave and whether – in the event of a claim being refused – it is likely to be certifiable as ‘clearly unfounded’ under s94 of the Nationality, Immigration and Asylum Act 2002.

Decision makers must consider claims on an individual basis, taking into account the case specific facts and all relevant evidence, including: the policy guidance contained with this note; the available COI; any applicable caselaw; and the Home Office casework guidance in relation to relevant policies.

## Country Information

The COI within this note has been compiled from a wide range of external information sources (usually) published in English. Consideration has been given to the relevance, reliability, accuracy, objectivity, currency, transparency and traceability of the information and wherever possible attempts have been made to corroborate the information used across independent sources, to ensure accuracy. All sources cited have been referenced in footnotes. It has been researched and presented with reference to the [Common EU \[European Union\] Guidelines for Processing Country of Origin Information \(COI\)](#), dated April 2008, and the [European Asylum Support Office’s research guidelines, Country of Origin Information report methodology](#), dated July 2012.

## Feedback

Our goal is to continuously improve the guidance and information we provide. Therefore, if you would like to comment on this note, please email [the Country Policy and Information Team](#).

## Independent Advisory Group on Country Information

The Independent Advisory Group on Country Information (IAGCI) was set up in March 2009 by the Independent Chief Inspector of Borders and Immigration to make recommendations to him about the content of the Home Office’s COI material. The IAGCI welcomes feedback on the Home Office’s COI material. It is not the function of the IAGCI to endorse any Home Office material, procedures or policy. IAGCI may be contacted at:

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5th Floor, Globe House, 89 Eccleston Square, London, SW1V 1PN.

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Information about the IAGCI’s work and a list of the COI documents which have been reviewed by the IAGCI can be found on the Independent Chief Inspector’s website at <http://icinspector.independent.gov.uk/country-information-reviews/>

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# Policy guidance

Updated: 14 December 2016

## 1. Introduction

### 1.1 Basis of claim

- 1.1.1 Fear of persecution or serious harm by non-state agents either because:
- (a) the person will be subjected to female genital mutilation (FGM); or
  - (b) the person is the parent of a minor child who is opposed to the procedure in a place where there is a real risk of it being carried out.

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### 1.2 Points to note

- 1.2.1 The World Health Organisation defines FGM as ‘all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons’.
- 1.2.2 Sources use various terms to refer to FGM, including female circumcision, female genital circumcision or female genital cutting. It can be abbreviated as FGC or FGM/C. However, for the purposes of this note, the practice is referred to as FGM.
- 1.2.3 Decision makers must also consider the [Asylum Instruction on Gender Issues in Asylum Claims](#).

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## 2. Consideration of Issues

### 2.1 Credibility

- 2.1.1 For information on assessing credibility, see the [Asylum Instruction on Assessing Credibility and Refugee Status](#).
- 2.1.2 Decision makers must also check if there has been a previous application for a UK visa or another form of leave. Asylum applications matched to visas should be investigated prior to the asylum interview (see the [Asylum Instruction on Visa Matches, Asylum Claims from UK Visa Applicants](#)).
- 2.1.3 Decision makers should also consider the need to conduct language analysis testing (see the [Asylum Instruction on Language Analysis](#)).

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### 2.2 Particular social group

- 2.2.1 In the country guidance case of [K and others \(FGM\) Gambia CG \[2013\] UKUT 62 \(IAC\)](#) the parties agreed that FGM, in any form, is persecution for a Convention reason (particular social group) in Gambia not only of a girl child but also of the parents of a minor child where they are opposed to the procedure and where there is a real risk of its infliction (para 13).
- 2.2.2 Although women and girls fearing FGM (and also of the parents of a minor child where they are opposed to the procedure) form a PSG, this does not

mean that establishing such membership is sufficient to be recognised as a refugee. The question in each case is whether the particular person will face a real risk of persecution on account of their membership of such a group.

2.2.3 For further guidance on particular social groups see the [Asylum Instruction on Assessing Credibility and Refugee Status](#).

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## 2.3 Assessment of risk

2.3.1 A girl or woman will not be entitled to protection just because they have already undergone FGM. Assessment of risk must be future-facing, i.e. the likelihood that a person will be subjected to FGM (or further FGM) on return.

### i. Women and girls fearing FGM

2.3.2 In the country guidance case of [K and others \(FGM\) Gambia CG \[2013\] UKUT 62 \(IAC\)](#) the Upper Tribunal found that FGM has been practised upon about three quarters of the female population of Gambia historically and that there has been no significant change in its incidence (para 120). Incidence of FGM varies by ethnic group and in no ethnic group is the practice universal (para 121) and the evidence falls short of demonstrating that intact females in Gambia are, as such, at real risk of FGM. The assessment of risk of FGM is a fact sensitive exercise (para 122).

2.3.3 The Upper Tribunal in [K and others](#) found that there are significant variables which affect the risk:

- the practice of the kin group of birth;
- the ethnic background, taking into account high levels of intermarriage and of polygamy;
- the education of the individual said to be at risk;
- her age;
- whether she lived in an urban or rural area before coming to the UK;
- the kin group into which she has married (if married);
- and the practice of the kin group into which she has married (if married).

Also relevant is the prevalence of FGM amongst the extended family, as this may increase or reduce the relevant risk which may arise from the prevalence of the practice amongst members of the ethnic group in general (para 123).

2.3.4 In addition to the statistical information currently known about the prevalence of the practice within the ethnic group (para 124), the Upper Tribunal in [K and others](#) identified the following factors which are of general application (para 125):

- a. In the case of an unmarried woman, parental opposition reduces the risk. In the case of a married woman, opposition from the husband reduces the risk. If the husband has no other “wives”, the risk may be reduced further. However, it should be borne in mind that parental/spousal opposition may be insufficient to prevent the girl or woman from being subjected to FGM

where the extended family is one that practises it, although this will always be a question of fact.

- b. If the prevalence of the practice amongst the extended family is greater than the prevalence of the practice in the ethnic group in question, this will increase the risk. Conversely, if the prevalence of the practice amongst the extended family is less than the prevalence of the practice in the ethnic group in question, this will reduce the risk.
- c. If the woman is educated (whether she is single or married), the risk will reduce.
- d. If the individual lived in an urban area prior to coming to the United Kingdom, this will reduce the risk. Conversely, if the individual lived in a rural area prior to coming to the United Kingdom, this will increase the risk.
- e. The age of a woman does not affect the risk measurably; it is an issue upon marriage. Amongst the Fula, FGM has been carried out on babies as young as one week old. The average age at which FGM is carried out appears to be reducing and this may be due to concerns about the international pressure to stop the practice. Although there are statistics about the average age at which FGM is carried out on girls and women for particular ethnic groups, the evidence does not show that, in general, being above or below the relevant average age has a material effect on risk. It would therefore be unhelpful in most cases to focus on the age of the girl or woman and the average age at which FGM is carried out for the ethnic group of her father (if unmarried) or that of her husband (if married).

Thus, it is possible to arrive at a conclusion that the risk faced by an individual is less than, or more than, the rate of incidence of FGM in the ethnic group of the individual's father (if unmarried) or her husband (if married). The rate of incidence of FGM in an ethnic group must therefore be distinguished from the degree of likelihood of infliction on an individual against her will or against the will of her parents. Some individuals from ethnic groups with a high incidence may not be at risk, while some individuals from ethnic groups with a low incidence may be at risk (para 126).

2.3.5 See also [Prevalence by age](#), [Prevalence by ethnic groups](#) and [Prevalence by region](#).

ii. [Parents who resist/oppose FGM for their minor children](#)

2.3.6 FGM has traditionally been part of the rite of passage to womanhood among certain ethnic groups in Gambia. However, in recent times, physical cutting is progressively being disassociated from the traditional ritual. The practice is not so much linked to eligibility of marriage, but seen more as a mechanism to facilitate admission into social network and capital. Peer pressure plays a major role in its perpetuation under fear of societal exclusion if families do not do it (see [Prevalence by age](#)).

2.3.7 A person who is the parent of a minor child who is opposed to them undergoing FGM may face societal discrimination and ostracism for going against cultural or family traditions. Decision makers need to consider each

case on its facts. However, in general, this is unlikely to reach the threshold to constitute serious harm

- 2.3.8 For further guidance on assessing risk see the [Asylum Instruction on Assessing Credibility and Refugee Status](#).

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## 2.4 Protection

- 2.4.1 In December, 2015 the Women's (Amendment) Act was enacted making it an offence for any person to engage in FGM, or to be an accomplice of those engaging in FGM, punishable by a fine or imprisonment for 3 years or both. The Act also makes it an offence to fail to report that FGM is happening or about to happen. If the act results in death the person can face life imprisonment. There are reports that the authorities have brought charges under the new legislation against at least two people. FGM remains a deeply entrenched practice and concerns have been expressed that the criminalisation of FGM may force the practice underground, or into neighbouring countries where it is not criminalised (see [Legal position](#)).

- 2.4.2 The Home Office's view is that this change to the Gambian criminal law specifically banning FGM, and the evidence of it being implemented amounts to strong grounds supported by cogent evidence to depart from the finding in [K and others](#) that there is no effective state protection for those at risk of FGM (para 127).

- 2.4.3 In general effective state protection is likely to be available. Decision makers need to consider each case on its facts. The onus is on the person to show why they would not be able to seek and obtain effective state protection.

- 2.4.4 For further guidance on assessing the availability or not of state protection, see the [Asylum Instruction on Assessing Credibility and Refugee Status](#).

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## 2.5 Internal relocation

- 2.5.1 The Upper Tribunal in [K and others](#) found that as a general matter, a person at real risk of FGM in her home area is unlikely to be able to avail herself of internal relocation. Cogent reasons need to be given for a finding that the individual would be able to relocate safely, especially given the evidence that ethnic groups are thoroughly interspersed, the country is small and ethnic groups in different parts of the country are highly interconnected (para 128).

- 2.5.2 Decision makers must consider on the facts of the case whether internal relocation is reasonable, taking into account the person's circumstances and the likelihood and ability of the agent of persecution (i.e. the family or community members) to pursue the person.

- 2.5.3 For further guidance on internal relocation, see the [Asylum Instruction on Assessing Credibility and Refugee Status](#).

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## 2.6 Certification

- 2.6.1 Where a claim is refused, it is unlikely to be certifiable as 'clearly unfounded' under section 94 of the Nationality, Immigration and Asylum Act 2002.
- 2.6.2 For further guidance on certification, see the [Certification of Protection and Human Rights claims under section 94 of the Nationality, Immigration and Asylum Act 2002 \(clearly unfounded claims\)](#)

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## 3. Policy summary

- 3.1.1 The prevalence of FGM in Gambia is approximately 75% but varies by ethnic group. Despite this, caselaw has established that there is no general risk of FGM; each case must be considered on its facts. There are significant variations by region, religion, ethnicity, kin group of birth and marriage and education status which may increase, or reduce the risk, and these must be considered alongside the individual circumstances of the person concerned particularly family opposition to the practice.
- 3.1.2 In general effective state protection is likely to be available. A new law enacted in December 2015 specifically bans FGM, and there is evidence that this is being implemented and prosecutions brought by the authorities.
- 3.1.3 If a person is at real risk from non state agents in their home area, it is unlikely that they will be able to relocate to a part of the country where they would not be at risk, but each case must be considered on its facts.
- 3.1.4 Where a claim is refused, it is unlikely to be certifiable as 'clearly unfounded' under section 94 of the Nationality, Immigration and Asylum Act 2002.

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# Country Information

Updated: 25 November 2016

## 4. Types of FGM

4.1.1 The World Health Organisation defined female genital mutilation/cutting (FGM/C) thus:

‘Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

‘...Female genital mutilation is classified into 4 major types.

‘Type 1: Often referred to as clitoridectomy, this is the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals), and in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

‘Type 2: Often referred to as excision, this is the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva ).

‘Type 3: Often referred to as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy).

‘Type 4: This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.’<sup>1</sup>

4.1.2 The 28 Too Many Gambia Country Profile from March 2015 noted:

‘The type of FGM most widely practised corresponds to Types I and II, with 67.9% of women and 36.7% of daughters, indicating that they had ‘had flesh removed’.

‘...The MICS [Multiple Indicator Cluster Survey] 2010 findings of percentage of different types of FGM correspond with the results of a study undertaken by Kaplan *et al.* between December 2008 and March 2009. Their findings were based on gynaecological examinations of 871 women and girls who had undergone FGM and reported to medical clinics for gynaecological-related treatment. The study found the prevalence of Type I was 66.2%, with Type 2 recorded at 26.3% and Type III at 7.5% (Kaplan *et al.*, 2011).’<sup>2</sup>

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<sup>1</sup> World Health Organisation – Female genital mutilation fact sheet, updated February 2016  
<http://www.who.int/mediacentre/factsheets/fs241/en/> date accessed: 2 August 2016

<sup>2</sup> 28 Too Many – Gambia Country Profile, March 2015 p.29-30  
[http://www.28toomany.org/media/file/profile/Gambia\\_v5\\_high.pdf](http://www.28toomany.org/media/file/profile/Gambia_v5_high.pdf) date accessed: 19 October 2016

## 5. Status of women in Gambia

5.1.1 The US State Department 2015 Human Rights Practices Report, released April 2016, noted:

‘The constitution prohibits discrimination based on race, religion, gender, disability, language, or social status, and the government generally enforced these prohibitions. Nevertheless, discrimination against women remained a problem.

‘...The constitution and law provide for freedom of movement within the country, foreign travel, emigration, and repatriation, and the government generally respected these rights.’<sup>3</sup>

5.1.2 An International Journal of Women’s Health report from April 2016 noted:

‘As a manifestation of gender inequality, FGM/C is deeply entrenched in social, economic, and political structures and must be understood within a context marked by strong gender discrimination that seriously affects the rights of girls and women, and that influences a low Human Development Index position (155 out of 177). Despite being granted equal rights as men under the national constitution, women in The Gambia confront a discriminatory family code (customary and Sharia law regulating marriage, widow inheritance, polygamy, divorce, child custody, and women’s rights to inheritance), restrictions on resources and assets (discriminatory practices in access to land, financial services, and employment), and restrictions on physical integrity (FGM/C and domestic violence remaining widespread problems together with inaccessible and insufficient maternal health care services).’<sup>4</sup>

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## 6. Prevalence of FGM

### 6.1 Sources

6.1.1 Much of the statistical information on FGM in the country is obtained from both the Unicef Multiple Indicator Cluster Survey of 2010 <http://www.gbos.gov.gm/uploads/survey/UNICEFGambiaMICSIV.pdf>; and the Gambia Bureau of Statistics Gambia Demographic and Health Survey 2013 <http://dhsprogram.com/pubs/pdf/FR289/FR289.pdf> .

6.1.2 It should be noted that as reported by 28 Too Many:

‘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

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<sup>3</sup> The US State Department - 2015 Human Rights Practices Report, released April 2016, Sections 2.d and 6 <http://www.state.gov/drl/rls/hrrpt/humanrightsreport/index.htm?year=2015&dliid=252685> date accessed: 4 August 2016

<sup>4</sup> International Journal of Women’s Health – ‘Female genital mutilation/cutting: changes and trends in knowledge, attitudes, and practices among health care professionals in The Gambia’, 12 April 2016 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4835126/> date accessed: 4 August 2016

be unaware that they have been cut or the extent of the cutting, especially if it was carried out at a young age.

Data collected about daughters cannot be used to accurately estimate the prevalence of girls under the age of 15 (UNICEF, 2013)..<sup>5</sup>

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## 6.2 Prevalence by age

### 6.2.1 An International Journal of Women's Health Report from June 2013 noted:

'...In many societies, it is a rite of passage to womanhood, with strong ancestral and sociocultural roots. Rationalizations for the perpetuation of FGM/C include: preservation of ethnic and gender identity, femininity, female purity/virginity, and "family honor"; maintenance of cleanliness and health; and assurance of women's marriageability. In The Gambia, FGM/C is carried out in girls aged between birth (7 days) up to preadolescence, and usually before the first menstruation and marriage.

'...In the Gambia, the United Nations Children's Fund multiple indicator cluster survey in 2010 showed that the prevalence of FGM/C remains as high as 76.3% in women aged 15–49 years. A recent study by the present authors revealed that FGM/C was still practiced in all six regions in the Gambia and resulted in various forms of damage/injury in one out of three women and girls examined. All forms of FGM/C lead to...high numbers of complications, especially infection associated with hemorrhage.'<sup>6</sup>

### 6.2.2 An Orchid Project Gambia Country Profile from 2014 noted:

'FGC [female genital cutting] is known to have been performed on young girls before the birth of Islam or Christianity and subsequently cuts across cultural and religious lines. In the Gambia, the practice of FGC has traditionally been conducted in a context of secrecy and excision is considered to give girls the power to pass into womanhood.'<sup>7</sup>

### 6.2.3 A subsequent International Journal of Women's Health report from April 2016 noted:

'FGM/C has traditionally been part of the rite of passage to womanhood among certain ethnic groups in the country. In these cases, FGM/C is the physical phase of a socializing process that molds the attitudes and beliefs of girls and women, consolidating ethnic and gender identity and preparing them for eligibility of marriage. However, over the past generation, several changes have been occurring, and recent research outlines that the physical cutting is progressively being disassociated from the traditional ritual.

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<sup>5</sup> 28 Too Many – Gambia Country Profile, March 2015 p.10 and 25

[http://www.28toomany.org/media/file/profile/Gambia\\_v5\\_high.pdf](http://www.28toomany.org/media/file/profile/Gambia_v5_high.pdf) date accessed: 3 August 2016

<sup>6</sup> International Journal of Women's Health – 'Female genital mutilation/cutting in the Gambia: long-term health consequences and complications during delivery and for the newborn', 14 June 2013 [http://www.intact-network.net/intact/cp/files/1374265161\\_ijwh-5-323.pdf](http://www.intact-network.net/intact/cp/files/1374265161_ijwh-5-323.pdf) date accessed: 1 August 2016

<sup>7</sup> Orchid Project – Gambia Country Profile, 2014 <http://orchidproject.org/country/the-gambia/> date accessed: 1 August 2016

'For decades, the social convention theory at the core of international prevention campaigns has defined FGM/C as a self-enforcing social norm, identifying it as a customary rule of behavior that occurs under fear of exclusion and that families do it – even when it is known to inflict harm upon girls – because the perceived social benefits are deemed more important than its disadvantages. While some recent perspectives deny this model and find empirical support in individual and family reasons as forces perpetuating the practice, the original formulation of social convention theory has been further refined and reinterpreted. Along these lines, Shell-Duncan et al regard FGM/C in The Gambia as a peer convention that ensures a woman's status by controlling her body and sexuality through virginity preservation concerns. Therefore, the practice is not linked to marriageability, but seen as a mechanism to facilitate admission into social network and capital, with peer pressure playing a major role in its perpetuation.

'Despite the fact that FGM/C has no religious origin or justification, the practice is commonly perceived as an Islamic duty in The Gambia, constituting one of the main arguments invoked for its continuation.'<sup>8</sup>

6.2.4 A 2016 Unicef Gambia Country Profile noted that 'three in four girls and women of reproductive age have undergone FGM/C.' The total percentage of girls and women aged 15 to 49 years who have undergone FGM/C = 75%.<sup>9</sup>

6.2.5 The same Unicef report noted that

'... more than half of girls and women were subjected to FGM/C before age five. The total percentage of girls aged 0 to 14 years who have undergone FGM/C (as reported by their mothers) = 56%.

The same Unicef report noted that 'almost two of three girls and women in Gambia support the continuation of FGM/C.'

'There has been no significant change in the prevalence of FGM/C in Gambia.'<sup>10</sup>

6.2.6 The 28 Too Many Gambia Country Profile from March 2015 noted:

'The national prevalence of FGM in The Gambia for girls and women (aged 15-49 years) is 76.3% and 42.4% for daughters aged 0-14 (MICS, 2010). The adult rate is a two percentage point decrease from the 2005/2006 recorded prevalence of 78.6%. However, Mrs Fatou Kinteh, gender specialist at the United Nations Population Fund (UNFPA), reported in February 2015 that the DHS 2013 shows a further reduction to 74.9%...This

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<sup>8</sup> International Journal of Women's Health – 'Female genital mutilation/cutting: changes and trends in knowledge, attitudes, and practices among health care professionals in The Gambia', 12 April 2016 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4835126/> date accessed: 4 August 2016

<sup>9</sup> Unicef – Gambia Country Profile 2016, 17 August 2016 [https://data.unicef.org/wp-content/uploads/country\\_profiles/Gambia/FGMC\\_GMB.pdf](https://data.unicef.org/wp-content/uploads/country_profiles/Gambia/FGMC_GMB.pdf) date accessed: 4 November 2016

<sup>10</sup> Unicef – Gambia Country Profile 2016, 17 August 2016 [https://data.unicef.org/wp-content/uploads/country\\_profiles/Gambia/FGMC\\_GMB.pdf](https://data.unicef.org/wp-content/uploads/country_profiles/Gambia/FGMC_GMB.pdf) date accessed: 4 November 2016

new data was not publicly available at the publication of this report (March 2015).

‘Regionally, there is a slightly higher rate of FGM in rural areas (78.1% for women and 45.9% for daughters aged 0-14) than in urban areas (74.6% for women and 38.0% for daughters aged 0-14). There is substantial ethnic cross over within regions, making the FGM prevalence rates according to region and ethnicity complex. The rural eastern region of Basse has the highest prevalence rate of 99% for women and 71.5% among 0-14 year-olds. The lowest prevalence rate is in the urban coastal region of Banjul, where 56.3% of women have undergone FGM (this represents a rise of 11.5 percentage points over 5 years, which is not easily explained) and 24.4% of 0-14 year-olds. Banjul is the only region reported to have an increase in prevalence whereas the other Local Government Areas (LGAs) either decreased or stayed the same. With respect to FGM practices according to ethnicity, the Sarahule have the highest prevalence rate among women 97.8% and 76.3% among daughters aged 0-14, and Wolof the lowest at 12.4% for women and 3.7 % for daughters aged 0-14. In most ethnic groups there is above a 50% support rate for continuing the practice, though the number of daughters aged 0-14 reportedly cut is lower than this rate of support.’<sup>11</sup>

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### 6.3 Prevalence by region

6.3.1 An Obstetrics and Gynecology International Research Paper from June 2013 noted:

‘FGM/C prevalence rates per region/LGA [Local Government Area]

‘Region	Local government area	Prevalence
Great Banjul Area	Banjul	56.3%
	Kanifing	69.5%
West Coast Region	Brikama	84.5%
Lower River Region	Mansakonko	90.6%
North Bank Region	Kerewan	49.2%
Central River Region	Kuntaur	63.4%
	Janjanbureh	75.9%
Upper River Region	Basse	99.0%.’ <sup>12</sup>

6.3.2 The 28 Too Many Gambia Country Profile from March 2015 noted:

<sup>11</sup> 28 Too Many – Gambia Country Profile, March 2015 p.10

[http://www.28toomany.org/media/file/profile/Gambia\\_v5\\_high.pdf](http://www.28toomany.org/media/file/profile/Gambia_v5_high.pdf) date accessed: 3 August 2016

<sup>12</sup> Obstetrics and Gynecology International – ‘Female Genital Mutilation/Cutting: The Secret World of Women as Seen by Men’, 16 June 2013

[http://www.mgf.uab.cat/esp/scientific\\_publications/secret\\_world.pdf?iframe=true&width=100%&height=100%](http://www.mgf.uab.cat/esp/scientific_publications/secret_world.pdf?iframe=true&width=100%&height=100%) date accessed: 3 August 2016

‘Although FGM is widespread across The Gambia, there is significant variation between areas. There are eight LGAs across the country. Of these, Basse, the eastern-most and most rural region of the country, has the highest prevalence rate amongst 15-49 year-old women at 99.0% (only 1% of women had not been cut) and among 0-14 year-olds at 71.5% (MICS, 2010)...

‘Banjul, coastal, and the most urbanised area, has the lowest prevalence rate amongst both 15-49 year-old women (56.3%) and 0-14 year olds (24.4%).

‘Significantly fewer daughters have been reported to be cut than women and girls aged 15-49 across all areas of the country. There is also a slightly higher prevalence rate in rural areas (15-49 year-olds at 78.1%; 0-14 year-olds at 45.9%) than urban areas (15-49 year-olds at 74.6%; 0-14 year-olds at 38.0%) (MICS, 2010).

‘Understanding regional difference and rural/urban difference in FGM prevalence goes alongside understanding difference by ethnicity. LGAs in The Gambia are often inhabited by large clusters of particular ethnic groups. Given a significant variation in prevalence by ethnicity a correlation of high prevalence rates would be expected in LGAs with a high number of Mandinka. For example, in Mansakonko LGA Mandinka make up 62% of the population.

‘... data does not capture ethnicity by LGA...it should be noted that the Basse LGA is predominantly inhabited by the Sarahule, Mandinka and Fula ethnic groups (who all have high prevalence rates), whereas the coastal area (Banjul and Kanifing LGAs) are predominantly inhabited by Wolof (low prevalence) and Mandinka (high prevalence). There are also clusters of ethnic groups in high densities throughout the country.

‘...in Banjul there was an 11.5 percentage point increase in the number of reported cases.

The data cannot explain the rise in reported prevalence in Banjul, where the population has declined 10% in the intervening years...

‘...Also of note is that the reported prevalence rate remained at 99% in Basse, even though this area has been a major centre of anti-FGM initiatives.’<sup>13</sup>

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## 6.4 Prevalence by ethnic groups

- 6.4.1 An International Journal of Women’s Health report from April 2016 noted: ‘There is ample evidence that FGM/C is closely tied to ethnic affiliation, which seems to be the most decisive factor for its prevalence. With an ethnically diverse population, The Gambia is composed of different groups,

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<sup>13</sup> 28 Too Many – Gambia Country Profile, March 2015 p.25-27  
[http://www.28toomany.org/media/file/profile/Gambia\\_v5\\_high.pdf](http://www.28toomany.org/media/file/profile/Gambia_v5_high.pdf) date accessed: 3 August 2016

which are closely linked through generations of inter-ethnic marriage and by the unifying force of Islam, the major religion in the country.’<sup>14</sup>

6.4.2 An Obstetrics and Gynecology International Research Paper from June 2013 noted:

‘FGM/C prevalence rates per ethnic group

‘Ethnic group	Prevalence
Mandinka/Jahanka	96.7%
Wolof	12.4%
Djola/Karoninka	87.0%
Fula/Tukulor/Lorobo	87.3%
Serer	43.0%
Serahule	97.8%.’ <sup>15</sup>

6.4.3 The 28 Too Many Gambia Country Profile from March 2015 noted:

‘The Mandinka/Jahanke account for 36% of the population and form the largest ethnic group in The Gambia... They are also known as the Mandingos, Mande or Malinke and have their origins in Mali... The largest population of Mandinkas/Jahanke is in Brikama (36% of the national total) with the highest concentration in Mansakonko (62% of the country’s central region population)... Traditionally, Mandinkas are farmers and they follow Islam, which they reportedly brought to The Gambia... During the period of Jawara’s [Jammeh’s predecessor] government, the Mandinkas were prominent in politics.

‘...FGM is widely practised by the Mandinka with a 96.7% prevalence rate amongst women aged 15-49. Some Mandinka practice ‘sealing’ analogous to Type III to ensure their daughter’s virginity at marriage, with 5.9% of women and 4.8% of daughters were reported sewn closed. Most Mandinka girls go through an initiation ritual called ‘nyaakaa’ between the ages of four and ten, which involves FGM. In this ritual, girls are transformed from ‘solima’ (uninitiated girls) to girls who know the ritual’s secrets, which will prepare them for marriage and motherhood later in life. During the several-week seclusion period girls learn the values of respect, obedience, endurance and privacy/discretion, as well as practical skills, songs, dances, proverbs and secrets of womanhood.’<sup>16</sup>

6.4.4 The same 28 Too Many report noted:

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<sup>14</sup> International Journal of Women’s Health – ‘Female genital mutilation/cutting: changes and trends in knowledge, attitudes, and practices among health care professionals in The Gambia’, 12 April 2016 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4835126/> date accessed: 4 August 2016

<sup>15</sup> Obstetrics and Gynecology International – ‘Female Genital Mutilation/Cutting: The Secret World of Women as Seen by Men’, 16 June 2013 [http://www.mgf.uab.cat/esp/scientific\\_publications/secret\\_world.pdf?iframe=true&width=100%&height=100%](http://www.mgf.uab.cat/esp/scientific_publications/secret_world.pdf?iframe=true&width=100%&height=100%) date accessed: 3 August 2016

<sup>16</sup> 28 Too Many – Gambia Country Profile, March 2015 p.21 [http://www.28toomany.org/media/file/profile/Gambia\\_v5\\_high.pdf](http://www.28toomany.org/media/file/profile/Gambia_v5_high.pdf) date accessed: 4 August 2016

'The Fula are traditionally pastoralists, originating from the Upper Senegal River region and forming the second largest ethnic group in The Gambia... There are a number of sub-groups among the Fula based on area of origin before entering Gambian land; some of these groups traditionally practice FGM and others do not.

'Both the Census and the MICS 2010 group all Fula groups together with the Tukolor/Lorobo, though the groups are closely related, yet distinct. Combined, they account for 22% of the population with the highest proportions residing in Brikama (near the coast) and Basse (in the east).

'...the Fula people – also known as Fulanis, Fulbe and Puel.

'...Fulas were reportedly among the first to embrace Islam... with the Tukolor reportedly known for their religious zeal and for adopting Islam earlier than the Fula. The Fula and Tukolor have been linked with efforts to convert others to Islam.

'...FGM is widely practised by Fula communities across The Gambia, with 87.3% of women aged 15-49 reportedly cut. Some Fula practise 'sealing' analogous to Type III to ensure their daughter's virginity at marriage; 11% of women and 6% of daughters were reported sewn closed.'<sup>17</sup>

#### 6.4.5 The same 28 Too Many report noted:

'The Wolof (also known as Jollof/Jolof) account for 15% of the population and constitute the third largest ethnic group... Wolof is also the predominant ethnic group in Senegal and is widespread across the Senegambia region... Islam is the predominant religion of the Wolof.

'...The FGM prevalence rate amongst women aged 15-49 is 12.4% - representing the lowest of the ethnic groups.'<sup>18</sup>

#### 6.4.6 The same 28 Too Many report noted:

'The Jola/Karoninka groups constitute 11% of the population. They are located along the southern border of The Gambia with Senegal, with the vast majority (97%) residing in Brikama/Kanifing.

There are close connections between the Jola and the Diola in the Casamance region of Senegal, which is politically significant given that President Jammeh is Jola... The Jola are reported to have largely rejected Islam for traditional beliefs or preferred Christian conversion... However, under the Presidency of Jammeh, Islam has been emphasised.

'FGM is prevalent amongst the Jola/Karoninka ethnic group, with a recorded 87% of women aged 15-49 having undergone the practice.'<sup>19</sup>

#### 6.4.7 The same 28 Too Many report noted:

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<sup>17</sup> 28 Too Many – Gambia Country Profile, March 2015 p.20  
[http://www.28toomany.org/media/file/profile/Gambia\\_v5\\_high.pdf](http://www.28toomany.org/media/file/profile/Gambia_v5_high.pdf) date accessed: 4 August 2016

<sup>18</sup> 28 Too Many – Gambia Country Profile, March 2015 p.23-24  
[http://www.28toomany.org/media/file/profile/Gambia\\_v5\\_high.pdf](http://www.28toomany.org/media/file/profile/Gambia_v5_high.pdf) date accessed: 4 August 2016

<sup>19</sup> 28 Too Many – Gambia Country Profile, March 2015 p.20-21  
[http://www.28toomany.org/media/file/profile/Gambia\\_v5\\_high.pdf](http://www.28toomany.org/media/file/profile/Gambia_v5_high.pdf) date accessed: 4 August 2016



'The Sarahule (also spelled Serahule, Sarahuleh) comprise 8% of the population, with over two thirds (67.8%) residing in Basse. Kantora has the highest concentration of Sarahule, accounting for 59% of the district population. The Sarahule are exclusively Muslim and their origin is unclear.

'FGM is widely practised by the Sarahule, with the highest recorded rates of FGM in The Gambia for women aged 15-49 (97.8%). FGM is usually performed in the first weeks of life without ceremony and is viewed as a religious practice. The Sarahule have the highest rate of the practice referred to as 'sealing' analogous to Type III to ensure their daughter's virginity at marriage; 19% of both women and daughters were reportedly sewn closed.'<sup>20</sup>

#### 6.4.8 The same 28 Too Many report noted:

'The Serere (also known as the Serrer or the Serer) are a minority, accounting for 3% of the population (Census, 2003). Traditionally concentrated along the coastal regions, they are one of the oldest migrant groups in The Gambia...While many Serere have adopted Islam some are Christian.

'FGM is practised by the Serere although evidence from comparative studies in Senegal indicates that it may be an adopted practice in The Gambia...The prevalence rate is 43% among women aged 15-49.'<sup>21</sup>

#### 6.4.9 The same 28 Too Many report noted:

'...of the five main ethnic groups the Wolof has the lowest prevalence rate of reported FGM among 15-49 year-olds (12.4%) and 0-14 year-olds (3.7%). Sarahule have the highest prevalence rate among 15-49 year-olds (97.8%) and among 0-14 year-olds (76.3%).

The Fula ethnic group comprises a number of sub-groups. Among these groups the following practise FGM: Torankas, Peuls, Futas, Tukuleurs, Jawarinkas, Lorobebs, Ngalunkas and Daliankos. The Hobobebs and the Jama do not practise FGM. In the Serere ethnic group the Njefenjefe do not practise FGM although the Niumikas do. Also, among the Jola, the Foni practise FGM, whereas the Jola Casa do not...Many reports claim that the Wolof do not practise FGM apart from in instances of marrying into a practising group. The Daffeh report, however, looks at the variations of FGM according to ethnic sub-group and ancestral geographic origin. This report argues that some sub-groups of the Wolof have a strong tradition of FGM...'<sup>22</sup>

#### 6.4.10 An International Journal of Women's Health Report from June 2013 noted:

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<sup>20</sup> 28 Too Many – Gambia Country Profile, March 2015 p.22-23  
[http://www.28toomany.org/media/file/profile/Gambia\\_v5\\_high.pdf](http://www.28toomany.org/media/file/profile/Gambia_v5_high.pdf) date accessed: 4 August 2016

<sup>21</sup> 28 Too Many – Gambia Country Profile, March 2015 p.23  
[http://www.28toomany.org/media/file/profile/Gambia\\_v5\\_high.pdf](http://www.28toomany.org/media/file/profile/Gambia_v5_high.pdf) date accessed: 4 August 2016

<sup>22</sup> 28 Too Many – Gambia Country Profile, March 2015 p.28  
[http://www.28toomany.org/media/file/profile/Gambia\\_v5\\_high.pdf](http://www.28toomany.org/media/file/profile/Gambia_v5_high.pdf) date accessed: 4 August 2016

'...Data were collected from 588 female patients examined for antenatal care or delivery in hospitals and health centers of the Western Health Region, The Gambia. The information collected, both through a questionnaire and medical examination, included sociodemographic factors, the presence or not of FGM/C, the types of FGM/C practiced, the long-term health consequences of FGM/C, complications during delivery and for the newborn. Odds ratios, their 95% confidence intervals, and P values were calculated

'With regard to ethnicity, it was found that FGM/C prevalence rates were 17.5% among Wolof and 46.2% among Serer, whereas Mandinka, Fula, Sarahole and Djola ethnic groups practice FGM/C extensively, with prevalences in the range of 94.3%–96.7%.'<sup>23</sup>

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## 7. Legal position

7.1.1 A February 2016 Foroyaa Newspaper report noted:

'On 28/12/2015 lawmakers passed a Bill banning FGM/C and criminalizing the practice.

'The Amendment to the 2010 Women's Act states that a person who engages in Female Circumcision commits an offence and if found guilty of the act shall face imprisonment for 3 years or fine of D50,000 [approx £900] or both.

'Where Female Circumcision causes death, the penalty is life imprisonment.

'Accomplices of those engaged in the act will face up to 3 years imprisonment or D50,000 [approx £900] fine or both; a person who knows that FGM is happening or about to happen and fails to report it is subject to a fine of D10,000 [approx £180].'<sup>24</sup>

[The Numbeo.com website (updated in January 2016) referred to an average net monthly wage in the country of D2,366 (equivalent to approximately £45 using xe.com currency converter) [https://www.numbeo.com/cost-of-living/country\\_result.jsp?country=Gambia](https://www.numbeo.com/cost-of-living/country_result.jsp?country=Gambia) .]

7.1.2 An AfricLaw report from January 2016 noted:

'From the coastal village of Brufut, on the chilly night of 24 November 2015, President Jammeh declared a ban on FGM stating that it was a cultural and not a religious practice... This was swiftly followed by the passing of the Women's (Amendment) Bill 2015 by the National Assembly on 2 December 2015 to prohibit female circumcision. The amendment addresses one of the key deficiencies of the Women's Act 2010 which was the absence of a

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<sup>23</sup> International Journal of Women's Health – 'Female genital mutilation/cutting in the Gambia: long-term health consequences and complications during delivery and for the newborn', 14 June 2013 [http://www.intact-network.net/intact/cp/files/1374265161\\_ijwh-5-323.pdf](http://www.intact-network.net/intact/cp/files/1374265161_ijwh-5-323.pdf) date accessed: 1 August 2016

<sup>24</sup> Foroyaa Newspaper – 'Gambia: Understanding the Legal implementation of the Law on FGM/C for the Population', 8 February 2016 <https://www.foroyaa.gm/archives/9295> date accessed: 2 August 2016

provision on eliminating harmful traditional practices. The Amendment Act added sections 32A and 32B in the Women's Act. With the enactment, The Gambia joined a number of African countries in adopting legislation as a reform strategy for ending FGM.

'...The Act uses the term 'circumcision' instead of 'mutilation'. However, in defining circumcision, it lists female genital mutilation. Section 32A makes it an offence for any person to engage in female circumcision and whoever contravenes it is liable on conviction to an imprisonment for a term of three years or a fine of fifty thousand dalasis (approximately \$1250) or both. The Act also stipulates a life sentence in prison when the circumcision results in death.

'The Act also addresses those who commission the procedure in section 32B(1). It states that 'a person who requests, incites or promotes female circumcision by providing tools or by any other means commits an offence and is liable on conviction to imprisonment for a term of three years or a fine of fifty thousand Dalasis or both.' In addition, a fine of ten thousand dalasis (approximately \$250) as provided in section 32B(2) of the Act is levied against anyone knowing about the practice and failing to report.

'However, there is a major lacuna in the Act, in so far as it makes no provision for cross-border circumcision addressing both circumcisers who perform the procedure outside the country as well as girls forced to undergo the procedure in countries with weaker FGM laws. Girls living nearer the borders are more vulnerable as they can be forced to move. A good example of a country addressing cross-border circumcision is Ghana which reviewed its laws to prosecute all perpetrators including those who perform it outside the country.

'The Gambia has been known to enact laws that address specific issues such as the 2013 Domestic Violence Act and the Sexual Offences Act. It is thus surprising that an anti-FGM law was not enacted but rather was subsumed in the Women's Act 2010. Generally, the enforcement of the Women's Act is weak. To ensure Sections 32A and 32B do not become 'scarecrows', there would be the need to put in place detailed plan for implementation, enforcement and monitoring as well as establishment of enforcement mechanisms such as an Anti-FGM Prosecution Unit and the Anti-FGM Board. The existence of such 'tools' may bring about accountability in terms of reporting, investigating and prosecuting FGM cases.'<sup>25</sup>

- 7.1.3 Huffington Post reported in August 2015 that 'advocates say that the legislation could just drive families to continue performing the practice discreetly if the government doesn't take further action, according to Reuters. "It is a positive first step, but I think many people feel that it won't

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<sup>25</sup> AfricLaw – 'Banning female circumcision in The Gambia through legislative change: The next steps', 19 January 2016 <https://africlaw.com/2016/01/19/banning-female-circumcision-in-the-gambia-through-legislative-change-the-next-steps/> date accessed: 2 August 2016

change much,” Hazel Barrett, a British expert on FGM and professor at Coventry University, told Reuters.’<sup>26</sup>

- 7.1.4 An article in the Point (Banjul) from March 2016 noted: ‘Barely two months after the government pronounced the ban on Female Genital Mutilation (FGM) in the country, two suspects were yesterday indicted and remanded in custody for allegedly practising FGM.’<sup>27</sup>
- 7.1.5 Reporting on the political environment in The Gambia 28 Too Many reported in its country profile that ‘The capacity of institutions to enforce legislation is challenging, and the ‘culture of silence’ surrounding gender-based violence, sexuality and FGM limits individuals’ capacity to report cases and be considered ‘legitimate’ (Touray, 2006). Systems for reporting, especially outside the Greater Banjul area, are weak with monitoring and regulatory guidelines non-existent (UNDP/Women’s Bureau, 2014). There is a socio-cultural perception that gender-based violence is legitimate.’<sup>28</sup>
- 7.1.6 A September 2016 smbc news report noted:
- ‘The United Nations Population Fund is supporting The Gambia’s Women’s Bureau in its anti-FGM advocacy program for stakeholders in regions across the country. The program was jumpstarted last week in the central Gambia.
- ‘The Gambia in November last year banned female genital cutting with penalties of up to life in prison but anti-FGM campaigners while welcoming the new law said the practice is so deeply rooted it may go underground. The [sic] sounded the call for increased advocacy about the new law and about the practice itself.
- ‘At least two women have so far being charged by Gambian authorities after a young girl in the Kiang region. State prosecutors are asking for a life sentence.
- ‘The United Nation said the ban begins a pivotal era in the life of Gambian women.
- ‘A UNFPA and Unicef program allowed for the sensitization and training of traditional and religious leaders, men, women, children, policy makers, law enforcement agents and circumcisers on the health and human rights effects of FGM.
- ‘Many young girls have joined the campaign and the use of social media has become instrumental.’<sup>29</sup>

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<sup>26</sup> Huffington Post, Gambia’s Ban On Female Genital Mutilation Isn’t Enough To Stop It: Experts, 12 August 2015 [http://www.huffingtonpost.com/entry/gambias-ban-on-female-genital-mutilation-isnt-enough-to-stop-practice-experts-say\\_us\\_5665d7cce4b072e9d1c6ebea](http://www.huffingtonpost.com/entry/gambias-ban-on-female-genital-mutilation-isnt-enough-to-stop-practice-experts-say_us_5665d7cce4b072e9d1c6ebea) date accessed 9 November 2016

<sup>27</sup> The Point (Banjul) – ‘Gambia: Two Remanded for Practising Female Genital Mutilation’, 11 March 2016 <http://allafrica.com/stories/201603111422.html> date accessed: 2 August 2016

<sup>28</sup> 28 Too Many – Gambia Country Profile, March 2015 p.70 [http://www.28toomany.org/media/file/profile/Gambia\\_v5\\_high.pdf](http://www.28toomany.org/media/file/profile/Gambia_v5_high.pdf) date accessed: 19 October 2016

<sup>29</sup> Smbc news – ‘UN supporting anti-FGM law sensitization programme in The Gambia’, 6 September 2016 <https://gambia.smbcgo.com/un-supporting-anti-fgm-law-sensitization-in-the-gambia/> date

7.1.7 A Daily Observer article from May 2016 noted:

‘Haddy Mboge-Barrow, Coordinator, Network Against Gender Based Violence (NGBV), has stressed that as advocates of Female Genital Mutilation and Cutting (FGM/C) they still have a big job to do.

“We have an unfinished work on the law because it is only talking about within The Gambia, but we need to ensure that it covers outside The Gambia. [For Gambian] children who go through FGM outside The Gambia, the perpetrators can be prosecuted,” she said.

‘...“We are all aware that there is a law on FGM but the law in itself doesn’t finish our work; in fact we have more work to do than ever,” she stressed.

“This is because before the law people may report the complication but now that there is law people would not want to report complications and they would catch them very young so that people would not be aware that the children are mutilated.”

‘...“We want them to stop not because they have been forced to stop, rather they should stop because they are convinced that it is not beneficial; that is the only way it could be history in the country.”’<sup>30</sup>

7.1.8 In October 2016 Foroyaa reported cited UNICEF Country Representative, Mrs. Sara Beysolow Nyanti as stating that

‘In many countries ... despite the existence of legal mechanisms to oversee FGM/C, challenges and limitations in implementation persist, and are primarily due to a lack of resources, skilled personnel, appropriate documentation, as well as weak organizational capacity.’<sup>31</sup>

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## 8. Support

8.1.1 The 28 Too Many Gambia Country Profile noted:

‘There are now a number of organisations – both national and international – working in the area of FGM or on issues that have a direct/indirect association. Organisations with an explicit mandate to address FGM include the Association for Promoting Girls’ and Women’s Advancement (APGWA), BAFROW [The Foundation for Research on Women’s Health, Productivity and the Environment], GAMCOTRAP [The Gambia Committee on Traditional Practices Affecting the Health of Women and Children], Tostan and Wassu Gambia Kafo, as well as ActionAid and Activista and Future In Our Hands (FIOH). UNICEF and UNFPA provide significant funding through the Joint Programme.

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accessed: 29 September 2016

<sup>30</sup> Daily Observer – ‘We Have Unfinished Work on FGM/C Law’, 6 May 2016 <http://observer.gm/we-have-unfinished-work-on-fgmc-law/> date accessed: 2 August 2016

<sup>31</sup> Foroyaa newspaper, FGM/C VIOLATES BASIC HUMAN RIGHTS – Says UNICEF Resident Representative, 23 October 2016 <http://www.foroyaa.gm/archives/12477> date accessed 9 November 2016

'Others work more discretely on issues broadly linked to FGM, such as women's rights, women's reproductive health, health service delivery, legal education, and 'empowerment' efforts through income generation and awareness-raising. These include Concern Universal, ChildFund, Avisu and the Child Protection Alliance.

'...Although distinct in their approaches, four of the five main organisations working specifically on FGM utilise community engagement strategies, promoting dialogue and discussion among community members (APGWA, Tostan, BAFROW, GAMCOTRAP). These approaches are a combination of health-based, rights-based approaches, with BAFROW and APGWA also advocating alternative rites of passage. The fifth, Wassu Gambia Kafo, aims to increase knowledge and build the country's evidence-base through systematic research into the health consequences of FGM.

'There are numerous infrastructure challenges to the work of campaigners. Lack of passable roads in rural areas, lack of electricity in rural communities, giving no access to computers/internet and incomplete coverage of mobile phones make communication and coordination difficult.'<sup>32</sup>

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<sup>32</sup> 28 Too Many – Gambia Country Profile, March 2015 p.57-58 and 69  
[http://www.28toomany.org/media/file/profile/Gambia\\_v5\\_high.pdf](http://www.28toomany.org/media/file/profile/Gambia_v5_high.pdf) date accessed: 4 August 2016

# Version Control and Contacts

## Contacts

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## Clearance

Below is information on when this note was cleared:

- version **1.0**
- valid from **15 December 2016**

## Changes from last version of this guidance

First version in CPIN format.

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