

A close-up portrait of a young woman with dark skin and braided hair. She is looking directly at the camera with a slight smile. The background is blurred.

COUNTRY PROFILE:  
**FGM IN THE GAMBIA**

MARCH 2015

 **28 TOO MANY**  
FGM...  
let's end it.



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## PREFACE

It is my great pleasure to write the Preface for this report on the current state of FGM in The Gambia. I have been undertaking research in The Gambia for over 35 years and during that time I have developed a real and deep admiration and respect for the women of the country. The women of The Gambia perform the challenging roles of wives and mothers, food producers, income earners and are the stalwarts of their families and communities, this is despite the fact that a majority of them have been subjected to FGM. FGM in The Gambia is still legal and is often mistakenly justified on religious grounds. In reality it is a cruel practice that is a violation of human rights and adversely affects the mental and physical health and well-being of hundreds of thousands of girls and women. A number of organisations have worked for many years to end FGM in The Gambia, but poor prevalence data has made it difficult to evaluate the success of such campaigns. This report will provide up to date baseline data on FGM in The Gambia by, for example, rural/urban residence, administrative region as well as ethnicity. This will enable researchers, policy makers and activists to measure the success of interventions and target those communities that appear to be resistant to change. I hope this report will provide the stimulus to end FGM in The Gambia within a generation. For the sake of future generations of Gambian girls and women, I sincerely hope so.



Professor Hazel Barrett  
Executive Director  
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## FOREWORD

As we marked the International Day of Zero Tolerance to FGM last month with a European Learning Forum and Summit in London, events at the UN, and events hosted by the Inter-African Committee and across Africa, I was encouraged at how the movement to end FGM is gathering pace. Initiatives such as The Girl Generation (a global campaign funded by the UK Department for International Development (DFID) to support the African-led movement to end FGM) are helping to ensure that the girls of today will be the first generation whose daughters will not be cut.

There are positive stories coming out of The Gambia which give me hope that The Gambia will reach the point where FGM will no longer be practised. Late last year in The Gambia the first Youth Summit was held, after which Amie Bojang-Sissoko said *'At one point I felt we were losing our activism, but now I feel it has been reenergised'*. Another individual, Aja Babung Sidibeh, became an FGM practitioner after her parents died. Since then, she has 'dropped the knife' and taken up the fight against FGM. Sidibeh explained, *'What I know today, if I had known that before, I would never have circumcised any woman'*. She concluded, *'We have caused lots of suffering to our women. That's why I told you that what I know today, if my grandparents knew that, they would not have circumcised anyone. Ignorance was the problem.'*

Encouraging stories from The Gambia are set against a global scene where in excess of 125 million women and girls alive today have experienced FGM in Africa and the Middle East, and 30 million more will be affected by 2025 – one girl being cut every ten seconds. While FGM is practised primarily in 28 African countries clustered from West Africa to Egypt and the Horn, it is also found in parts of Asia and across the world among diaspora groups who bring traditions with them on migration.

FGM has no health benefits yet has serious, immediate and long-term physical and psychological health consequences, which can be

severe, including post-traumatic stress disorder, depression, anxiety and reduced desire or sexual satisfaction. Babies born to women who have experienced FGM suffer higher rates of neonatal death, and mothers can experience obstetric complications and fistula. In The Gambia, there is strong in-country evidence of medical complications caused directly by FGM.

Globally, reasons for FGM are highly varied between ethnic groups and communities; it is a deeply embedded social practice associated with adulthood, marriageability, purity and sexual control.

FGM is traditionally carried out by older community women, in unhygienic conditions in isolated settings, but there is a worrying trend towards medicalisation in The Gambia. Although this is currently a small proportion of those having FGM, it is advocated by the pro-FGM lobby and supported by some healthcare professionals who already carry out FGM.

This Country Report on FGM in The Gambia shows the 2010 national prevalence for girls and women aged 15-49 years is 76.3%. This is a two percentage point decrease from the 2005/6 figure. Extracts from the forthcoming 2013 DHS report show a further drop to 74.9%. Rates for girls 0-14 years are lower, but they may still have FGM later in life.

There is a slightly higher rate of FGM in rural areas (78.1% women; 45.9% daughters) than in urban areas (74.6% women; 38% daughters). The regional pattern is complex, but it is highest in Basse (99% women, 71.5% daughters) and lowest in Banjul (56.3% women – increased 11.5% in last 5 years; 24.4% daughters).

Types of FGM are mostly 'flesh removed' (Types I & II) for 67.9% women; 36.7% daughters, although 5-7% of women and girls have 'sewn closed' (Type III). There is a worrying trend to practicing on young infants, where it is generally carried out on those under 10 years. There is also a fall in

'FGM status', suggesting women are claiming to be uncut. A participant interviewed by an NGO programme regarding practising FGM claimed 'we take their money; say what they want and do what we have always done'. If this is the case it casts doubts on the accuracy of daughter data.

There is a strong link between FGM and Islam, a powerful pro-FGM religious lobby. This is exacerbated by ambivalent Government attitudes towards supporting FGM, although the female Vice President supports anti-FGM work.

Underlying culture in The Gambia trains girls to suffer abuse in silence, using FGM as a marker of a subservient girl, which is called 'knowing the eye'. The power of insult and prejudicial behaviour to make uncut women comply with the practice also keep the practice in existence.

More positively, at the recent Youth Summit, 100 young activists were taught by a leading Islamic scholar, Hama Jaiteh, that FGM is not an Islamic practice and were encouraged to spread the word in their communities. They were told that Islam was being used to '*shield an evil intention [that is] harmful to a person's development*'. Young women stood up and urged others not to be afraid to challenge practices such as FGM. This summit has been followed in January 2015 with the launch of a media campaign, supported by The Girl Generation. The aim of the campaign is to raise awareness of the effects of FGM and influence those with authority to help end FGM.

Since first visiting Africa in 2001, I have visited twelve African countries, Malaysia, Pakistan, the Middle East, Dubai, USA, Canada and Australia and New Zealand, where there are migrant communities who practise FGM. Having listened to the stories of over two thousand survivors, not one girl was pleased she was cut. All have physical or mental trauma from FGM and many, including those from The Gambia, have begun themselves to campaign for FGM to end.

After our in-country work carried out by our research team, I was personally delighted to meet Isatou Touray of the Inter-African Committee (IAC) and GAMCOTRAP in 2014, and hear how they are working nationally and internationally to help advance the work towards FGM ending. The 'Dropping the Knife' case study below gives further hope. While we highlight in this report areas that need addressing, we also recognise the work of CSOs and NGOs on areas such as alternative rites of passage (ARPs); working with 'men against FGM', among other initiatives, as progress.

We look forward to seeing further progress and talking with activists in my forthcoming visit to The Gambia later this year.

**Ann-Marie Wilson**

**28 Too Many Executive Director**

## Dropping the Knife Ceremony

The Gambia Committee on Traditional Practices affecting the health of Women and Children (GAMCOTRAP) is a Non-Governmental Organisation (NGO) that has been engaging with issues on the health and rights of Gambian women –including female genital mutilation (FGM) – for many years. Since 2007, GAMCOTRAP have been running ‘Dropping the Knife’ ceremonies, which are designed to target clusters of communities to change their attitudes and mind-sets on harmful traditional practices (HTP), including FGM. Their first event took place at the Independence Stadium in Bakau, where 18 practitioners publicly vowed to stop practising FGM. Following this, GAMCOTRAP held an event in 2009 in Basse, where 60 practitioners declared abandonment. In 2011, a further 20 communities in the Lower River Region publicly denounced their practice at a ceremony in Soma. In 2012, 25 practitioners, along with their communities, declared that they will no longer perform FGM. GAMCOTRAP continued to encourage positive change in 2013 with a ceremony held in Wassu in the northern Central River Region, where a further 30 practitioners vowed to ‘drop the knife’. Reports indicate that 564 communities in the Upper, Central and Lower River Regions have participated in ‘Dropping the Knife’ ceremonies (Global Fund for Women website). With a steady track record of hosting abandonment ceremonies throughout The Gambia, GAMCOTRAP’s culturally-sensitive programmes are key campaigns for facilitating shifts towards positive change.



Fig. 1: A GAMCOTRAP ‘Dropping the Knife’ ceremony (©GAMCOTRAP)

*‘When people are informed and empowered they demand their rights and take informed decisions guided by knowledge and belief that the best interest of the child, [and the] health and wellbeing of women is paramount’.*

-Dr Isatou Touray, Executive Director of GAMCOTRAP

Unless otherwise stated, the information is sourced from *Panapress*, 2013.



## 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 strategies 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 abandoned in The Gambia, 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 The Gambia ([www.28toomany.org/countries/TheGambia/](http://www.28toomany.org/countries/TheGambia/)).

## ACKNOWLEDGEMENTS

28 Too Many is extremely grateful to all the FGM practising communities, local 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 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 have enabled this Country Profile to be produced. For more information, please contact us on [info@28toomany.org](mailto:info@28toomany.org).

## THE TEAM

**Katherine Allen** is Lead Editor and researcher for 28 Too Many. She is also a DPhil (PhD) student in the history of medicine at the University of Oxford.

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**Philippa Sivan** is Research Coordinator for 28 Too Many. Prior to this she worked for seven years with Oxfam.



**Dr Ann-Marie Wilson** founded 28 Too Many and is the Executive Director and has written various papers on FGM.

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: The Gambia People, photograph by Willem van Leuven sr. cc. ©

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

AEO	Alternative Employment Opportunity
AFPRC	Armed Forces Provisional Ruling Council
AIDS	Acquired Immunodeficiency Syndrome
APRC	Alliance for Patriotic Reorientation and Construction
ARP	Alternative Rites of Passage
CBO	Community Based Organisation
CEDAW	Convention on the Elimination of Discrimination against Women
CEP	Community Empowerment Programme
CHW	Community Health Worker
CORDEG	The Committee for the Restoration of Democracy in The Gambia
CRC	Convention on the Rights of the Child
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
ECOWAS	The Economic Community of West African States
EFA	Education for All
ERP	Economic Recovery Programme
FBO	Faith-Based Organisation
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender Based Violence

GDP	Gross Domestic Product
GII	The Gender Inequality Index
GMD	Gambian Dalasi (local currency)
GRTS	Gambia Radio and Television Station
HCP	Health Care Professionals
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HTP	Harmful Traditional Practice
IAC	Inter-African Committee
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organisation
INGO	International Non-Governmental Organisation
LGA	Local Government Area
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MoBSE	Ministry of Basic and Secondary Education
MOHSW	Ministry of Health and Social Welfare
NGO	Non-Governmental Organisation
NPOA	National Plan of Action
OBGYN	Obstetrician and Gynaecologist
OECD	The Organisation for Economic Co-operation and Development
PPP	People's Progressive Party
RVTH	Royal Victoria Teaching Hospital
SEGRA	Serholt Early Grade Reading Ability
SIGI	Social Institutions and Gender Index
SMA	Social Mobilisation Agent
TB	Tuberculosis
TBA	Traditional Birth Attendant
U5	Under 5 age group
UDHR	Universal Declaration on Human Rights
UDP	United Democratic Party
UK	United Kingdom
UN	United Nations
UNCRC	UN Convention on the Rights of the Child
UNCSW	UN Commission on the Status of Women
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
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 The Gambia, 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.

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% (*The Standard*, 2015). This 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.

The types of FGM performed were reported in the Multiple Indicator Cluster Survey (MICS) as 'flesh removed' (Types I and II), 'nicked' (Type IV) and 'sewn closed' (Type III) or undetermined. For the 'flesh removed' category, 67.9% of women and 36.7% of daughters aged 0-14 were recorded. Only 0.1% of women were recorded as having the 'nicked' type (and 0.0% for daughters). 6.8% of women and 5.3% of daughters aged 0-14 were recorded to have the 'sewn closed' type of FGM. The age at which FGM is performed is not documented by the MICS, though studies suggest that there is a trend towards practising on infants and on girls aged 1-10. There is also a worrying consistent fall in the reporting of FGM status within the MICS reports, suggesting that the data might be flawed and/or women are choosing to claim they are not cut. Data is lacking on FGM practitioners, though it is suggested that practitioners 'inherit' the occupation. Medicalised FGM is condemned in The Gambia; however, studies found that some health practitioners have performed FGM on girls because they perceived it as being 'safer'.

FGM is not illegal in The Gambia, though efforts are being made to pass legislation. This includes the preparation of a draft Bill on FGM. The Government's position on ending FGM remains unclear. It has tight restrictions on NGO policies, restrictions on discussing FGM in the media and a history

of active resistance to anti-FGM activities. Simultaneously, the Government has made efforts to promote FGM education (including as part of the national health curriculum) and is working with the United Nations Joint Programme (UNJP). There are many organisations working in The Gambia to encourage the abandonment of FGM using a variety of strategies. A comprehensive overview of these organisations is included in this report.

We propose measures relating to:

- Adopting culturally relevant programmes. In The Gambia change must come from within the country and at a community level to best suit the cultural specificities of a region.
- Sustainable funding. This is an issue across the development (NGO) sector and a major challenge in The Gambia is organisations competing for funding (among other resources), rather than working collaboratively and networking.
- 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. Access to secondary education needs to be extended across the country, in particular to support girls' attendance.
- Improving access to health facilities and management of health complications of FGM. Improvement is needed to ensure that residents have access to quality care that meets the standards of the National Health Policy and the Reproductive Health Policy.
- Increased advocacy and lobbying. Efforts have been made to create legislation and we support the continuing work to pass the draft Bill on FGM into law and to situate FGM explicitly under the Children's Act.
- Fostering the further development of effective media campaigns
- Encouraging FBOs to act as agents of change and to be proactive in ending FGM. Dialogue with religious leaders in The Gambia is crucial given the religious pro-FGM lobby.
- Further research. Understanding better the reasons for the abandonment of FGM will help to contextualise data and will enable more effective programming. Further research is also needed to provide medical statistics on the negative consequences of FGM, which will better equip the Government to formulate policies and implement legislation criminalising FGM (FGM Network, 2009). There is a hope that when the Demographic Health Survey (DHS) 2013 report is published in full it will shed more light on the motivation for FGM, specifics of the practice by age, for example, among other variables, and detail both men's and women's responses.

## 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 three 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 5<sup>th</sup> 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,

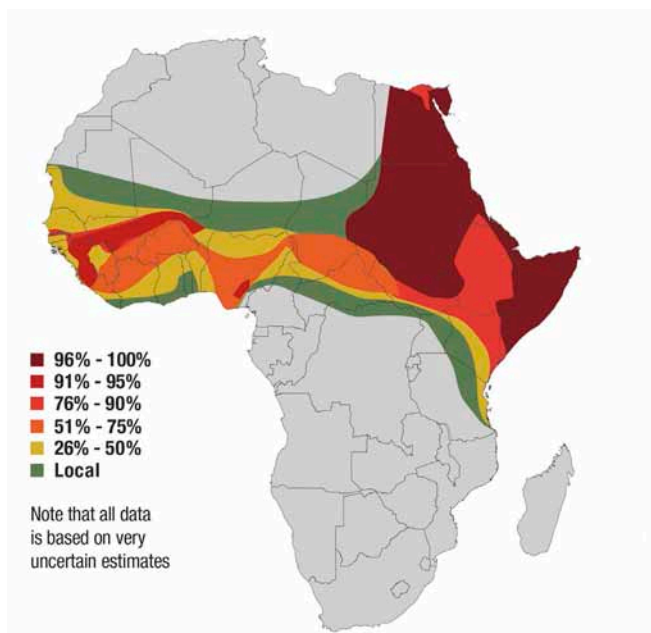
or some early attempt at population control' (Lightfoot-Klein, 1983).

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 amongst 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 (Afril News)**

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

<b>Type I</b>	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
<b>Type II</b>	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.
<b>Type III</b>	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).
<b>Type IV</b>	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation.

In the case of The Gambia, the MICS (2010) survey does not follow the WHO classifications. Rather they follow the categories of ‘flesh removed’, ‘nicked’ and ‘sewn closed’. 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.

FGM is sometimes a rite of passage into the journey of 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 in some cultures. 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 new born 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 Millennium Development Goals (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, 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 The Gambia and highlights a number of indicators which are indicative of the country context and development status. The Gambia is ranked 172 out of 187 countries and territories in the Human Development Index (HDI). The Gambia's Human Development value has increased from 0.3 in 1980 to 0.441 in 2013, indicating progress has been made in the indicators (life expectancy at birth, mean years in schoolings and GNI per capita).

#### POPULATION

1,928,930 (Country Meters, 18 February 2015 est.)

Median age: 20.02 years (2014 est.)

Growth rate: 2.23% (2014 est.)

#### HUMAN DEVELOPMENT INDEX

Rank: 172nd out of 187 in 2014 (UNDP, 2014)

#### HEALTH

Life expectancy at birth (years): 58.6 (UNICEF, 2012 via World Factbook)

Infant mortality rate (per 1,000 live births): 34 (UNFP, 2014 via World Factbook)

Child mortality rate (under 5 year olds) (per 1,000): 54 (UNFP, 2014 via World Factbook)

Maternal mortality rate: 433 deaths/100,000 live births (GDHS, 2013 via World Factbook); country comparison to the world (out of 194 ranked countries): 29

Fertility rate, total (births per woman): 3.85 (2014 est.)

HIV/AIDS – adult (aged 15-49) prevalence rate: 1.2% (UNAIDS, 2013 est.)

HIV/AIDS – people living with HIV/AIDS: 12,600 (UNAIDS, 2013 est.);

HIV/AIDS – deaths: 500 (2012 est.)

**LITERACY (PERCENTAGE OF THOSE WHO CAN READ AND WRITE)**

Adult (15+) population: 52%. Female: 43.1%; Male: 61.4% (2012 est.) (World Bank)

Youth (15-24 years): 69.4% Female: 65.5%; Male: 73.4% (2012 est.) (World Bank)

**GROSS DOMESTIC PRODUCT (GDP) (IN US DOLLARS)**

GDP (official exchange rate): \$896 million (2013 est.)

GDP per capita (purchase power parity): \$2,000 (2013 est.)

GDP (real growth rate): 6.4% (2013 est.)

**URBANISATION**

Urban population: 57.3% of total population (2011 est.)

Rate of urbanisation: 3.63% annual rate of change (2011-2015 est.)

**ETHNIC GROUPS**

Mandinka (42%), Fula (18%), Wolof (16%), Jola (10%), Sarahule (9%), other (4%), non-African (1%) (2003 Census)

**RELIGIONS**

Muslim (90%), Christian (8%), indigenous beliefs (2%) (2003 Census)

**LANGUAGES**

English (official), Mandinka, Wolof, Fula and other indigenous vernaculars

Unless otherwise stated, all citations are from the World Factbook.

**MILLENNIUM DEVELOPMENT GOALS**

The eradication of FGM is pertinent to six of the United Nations' (UN) eight Millennium Development Goals (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 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 The Gambia 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 all forms of gender-based violence in The Gambia.

## POLITICAL BACKGROUND

### HISTORICAL

The current political borders of The Gambia have existed since 1889. The country is the smallest by area in mainland Africa and is surrounded by Senegal along its northern, eastern and southern borders, with the Atlantic Ocean forming the western border. The area has been subject to different rule and to invasion by peoples from Africa, the Arab world and Europe. Until the end of the 16<sup>th</sup> century the Ghanaian, Malian and Shongai empires periodically ruled The Gambia before it was claimed by the Portuguese and Baltic Germans (The Gambia Rising, undated).

In the 17<sup>th</sup> century, the Portuguese sold their trading rights on the River Gambia to Britain and, following struggles for political and commercial supremacy, France formally ceded possession of The Gambia to Britain in 1783. The British primarily used The Gambia to accommodate and transport slaves to the West and the Americas. Over time, Britain's dominance extended, and in 1889 an agreement was formed with France (colonisers of neighbouring Senegal) to establish the current boundaries. The Gambia became an official British colony triggering resistance, especially among religious leaders from coastal regions.

In 1954, the Legislative Council gave the Executive a non-colonial majority and The Gambia became a self-governing territory in 1962, an independent country on 18 February 1965, and a republic in 1970. At independence, Dawda Jawara of the People's Progressive Party (PPP) was appointed Prime Minister (and then President), and held office until 1994.

Colonialism left little in terms of infrastructure. Jawara's inheritance of an undeveloped economy meant there was a reliance on trade and foreign aid. Economic difficulties in the 1970s and early 1980s prompted dissatisfaction amongst civilian groups and an attempted coup took place in 1981. In response, Jawara sought to re-assert democratic practice and in 1982 the PPP won the

presidential elections in a majority vote (72%). From 1985, the country underwent the Economic Recovery Programme (ERP), which led to initial revival followed by devastating corruption and economic stagnation.

Unless otherwise indicated, information is from Touray, 2000.

## CURRENT POLITICAL CONDITIONS

Jawara was succeeded by the incumbent president, Yahya A.J.J. Jammeh, in 1994 following a military coup. Jammeh led the Armed Forces Provisional Ruling Council (AFPRC), which became his political party the Alliance for Patriotic Reorientation and Construction (APRC), and he has won three elections (2001, 2006 and 2011). The main political opposition party is the United Democratic Party (UDP). The APRC initiated a constitutional review and the new constitution was approved in 1997. Although the APRC made commitments to return to civilian government, including forming the Independent Electoral Commission and constituting a multi-party system, up until 2001 major political parties (including the PPP) were prohibited from taking part in elections. The 2011 elections saw 83% of the population turn out to vote and the APRC won by a 72% majority. The Economic Community of West African States (ECOWAS) criticised the process, claiming that the APRC coerced individuals to vote. The era of Jammeh's rule has been marked by relative stability and steady economic growth. Despite this, the civil and political context has been challenging and expression of political opposition repressed (BBC, 2011).

In October 2013, The Gambia withdrew from the Commonwealth, which Jammeh described as a 'neo-colonial institution' (BBC, 2013). International donors have reduced bilateral aid to the country largely on account of human rights concerns, with Britain stopping direct aid altogether in 2011 (Freeman, 2013). Amnesty International has raised concerns over the arrests of journalists, human rights defenders and lawyers, as well as

government attempts to shut down independent media stations (Amnesty International, 2012). In December 2014, the United States of America (US) confirmed it would drop The Gambia from a trade agreement allowing duty-free trade (the African Growth and Opportunity Act), reportedly as a result of The Gambia's moves to introduce severe new laws against homosexuality, with life imprisonment as punishment (Lavers, 2014).

There was a failed coup (categorised as a 'terrorist attack' by the Government) on 30 December 2014. Gunmen, reportedly led by former chief of the presidential guard, Lamin Sanneh, attacked the Presidential Palace while President Jammeh was overseas.

## ANTHROPOLOGICAL BACKGROUND

Although The Gambia only occupies a total land area of 11,295 sq. km there is significant ethnic diversity and dynamism. The Gambia's anthropological background is best understood within the context of the wider Senegambia Major's regional make-up and history, which incorporates Guinea, Guinea-Bissau, Senegal, The Gambia, Mauritania and parts of Mali (Saine, 2012). The Gambia has over twenty distinct ethnic groups, which can be divided into five majority groups (Mandinka, Fula, Wolof, Jola and Sarahule) along with numerous sub-groups.

The different ethnic groups can also be grouped broadly into two main linguistic categories – the

Mande-speaking (Bambara, Mandinka, Jahanke and Sarahule) and the remaining groups speaking Northern Atlantic languages (Juffermans and McGlynn, 2009). The Gambia is also home to a population of 'non-Gambians', including a significant number of refugees from Senegal (especially the Casamance region), Liberia and Sierra Leone, as well as some non-Africans. Despite distinctions between different ethnicities and a rich variety of cultural practices there are also significant linkages and shared traditions. Groups across The Gambia are brought together through inter-marriage, co-existence and cooperation (Saine, 2012) and the inter-ethnic linkages extend across the Senegalese border.

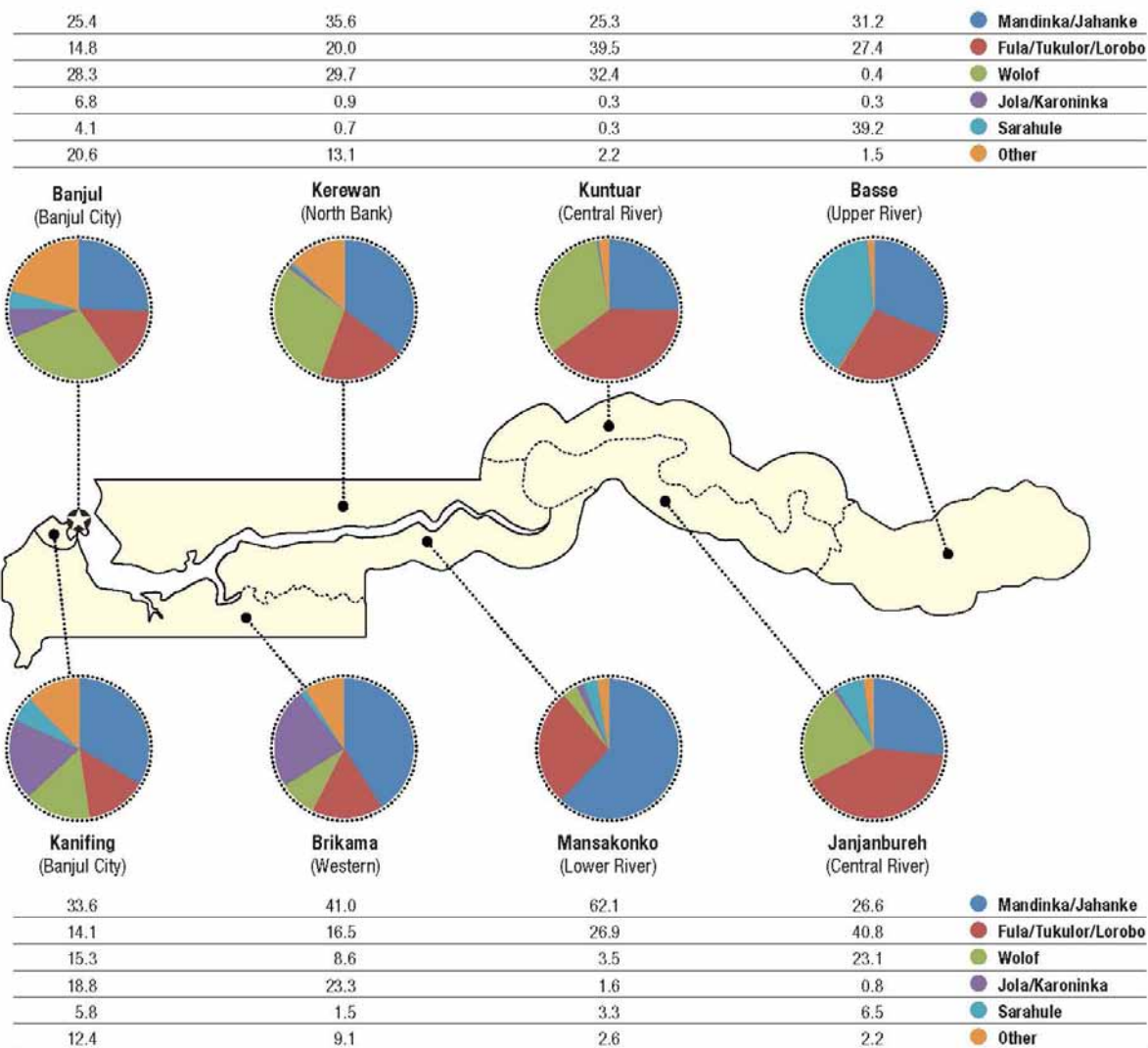


Fig. 4: Ethnic groups in The Gambia (percent distribution by Local Government Area (LGA)). The names in parentheses below District names are alternative/previously-used District names (© 28 Too Many).

Figures drawn from the 2003 Population and Housing Census (2013 disaggregated data not yet publicly available) indicate that the Mandinka/Jahanke form the dominant group (36%) followed by the Fula/Tukulor (22%), the Wolof (14%), the Jola/Karoninka (11%) and the Sarahule (8%), with the Serere, Creole/Aku, Manjago, BAMBARENG and other groups totaling 9%. Figure 4 shows the distribution of these ethnic groups by proportion. While no region is exclusively occupied by one particular ethnic group there is a distinct pattern of distribution which groups the Wolof along the north bank and coastal region, the Sarahule to the east of the country, the Jola in the south west, the Fula in the central region, and the Mandinka in concentrated pockets throughout the country.

## ETHNIC TENSIONS

The Gambia has been held as a model of ethnic tolerance and harmony. The country's integrated society has been attributed to the relatively peaceful colonial period and the absence of highly precious resources, which often trigger power struggles and external interference. Although the majority of the population identifies itself as Muslim there is a significant Christian population (10%), as well as incorporation and blending of African belief systems (Saine, 2012). Religion has not been the source of tension and is largely considered a unifying force.

Within politics, President Jammeh is Jola (a minority ethnic group) while Jawara was Mandinka (the majority ethnic group). Senegal has expressed concern that Jammeh's connections with the Diola (a sub-group of the Jola) in the Casamance region of Southern Senegal will exacerbate the separatist movement of the Casamance, with the possibility that it will join The Gambia (Levinson, 1998; Minority Rights Group International, 2008). Ethnic tensions were given as one of the factors for the coup in 1994, with the APRC wanting to maintain The Gambia's autonomy and avoid being linked too closely with Wolof-majority Senegal. There is growing belief that Jolas and Jola communities in The Gambia receive preferential treatment.

## Joking relationships

An important aspect of Gambian culture and its system of conflict management is the institutionalised joking relationships that form 'customary ties' (Davidheiser, 2006). These joking relationships exist between different ethnic groups, communities, family members, and regions, and are usually derived from historic events where tension once existed. Jokes simultaneously strengthen friendships and build understanding of a shared heritage.

Joking relationships have been instrumental in resolving longstanding conflicts. Community elders have reported concern that joking relationships will not be maintained by the younger generations.

## ETHNIC GROUPS

This section profiles the main ethnic groups in The Gambia (with groupings as per the 2003 Census). The practice of FGM is broadly detailed along with gender indicators signifying women and girls' position within each ethnic group.

### AKU/CREOLE (AKU MARABOU)

The Aku, also known as the Creole, is a minority ethnic group being 1% of the population (Census, 2003), descending from African slaves (mainly of Yoruba ethnicity) who established residency in Banjul. The Aku are primarily Christian, although the term Aku Marabou is used to distinguish those who follow Islam (Drammeh, 2014). The Aku also have European heritage through intermarriage and are reported to follow 'Western' lifestyles. Their language is derived from the Krio language in Sierra Leone, which has its roots in English.

FGM is practised by the Aku at a prevalence rate of 25%, with the number of respondents reporting that one daughter had been cut standing at 18.7%. The Aku demonstrate the lowest tolerance to gender-based violence among the ethnic groups surveyed, with 27.7% stating that it is justifiable for a husband to beat his wife. The Aku have the highest rates of girls' enrolment in primary education at 98.4% and low rates of early marriage with 1.2% of girls under 15 reportedly married (MICS, 2010).



## BAMBARA

The Bambara are a minority ethnic sub-group of the Mande, or Mandinka, constituting 1% of the population (Census, 2003). Traditionally, the Bambara adhere to Islam though continue to observe traditional rituals. Bambara refers to captive Africans who originated in the upper Senegal-Niger region and were transported to the Senegambia region. The structure of Bambara households and society is patriarchal and patrilineal, and like the Mandinka, is hierarchical and based on internal caste divisions (including griots).

There is a high prevalence rate of FGM amongst the Bambara-headed households (92.1% of women aged 15-49). Furthermore, 84.9% of Bambara headed households regarded wife-beating as justifiable. 6% of women indicated they were married before the age of 15, with 65.1% of all married women (aged 15-49) from Bambara-headed households reporting that their husband was more than ten years older. Over a third (33.9%) of women were in polygamous marriages (MICS, 2010).

## FULA, TUKOLOR/LOROBO

The Fula are traditionally pastoralists, originating from the Upper Senegal River region and forming the second largest ethnic group in The Gambia (Minority Rights Group International, 2008). 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 origin of the Fula people – also known as Fulanis, Fulbe and Puel – is debated, with Fula 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. Fulas were reportedly among the first to embrace Islam (Access Gambia, undated), with the Tukolor reportedly known for their religious zeal and for adopting Islam earlier than the Fula (Burke, 2002). The Fula and Tukolor have been linked with efforts to convert others to Islam (Access Gambia, undated; Burke, 2002).



Fig. 5: Fula girls (© Tostan, Photograph by Lilli Loveday)

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. Other gender indicators demonstrate that the Fula group has the highest rate of early marriage with 15.6% of girls under the age of 15 reportedly married. Additionally, a high number of marriages (50.8%) involve marriage to somebody 10 years or more older and 81.1% of Fula respondents believe that a man is justified to beat his wife (MICS, 2010).

## JOLA/KARONINKA

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 (Minority Rights Group International, 2008). The Jola have no class system and political organisation is typically at village level (Minority Rights Group International, 2008), with reports that sub-group identities are highly fragmented and distinctive. The Jola are reported to have largely rejected Islam for traditional beliefs or preferred Christian conversion. During the Soninke-Marabout wars they resisted efforts to abandon their traditional beliefs in favour of Islam (Burke, 2002; Access Gambia, undated). 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. The majority of women aged 15-49 in Jola-headed households recorded being married to somebody between 5-9 years older, with 37.9% in polygamous marriages. 6.3% of girls under the age of 15 are reportedly married, with 66% of respondents indicating that wife-beating is acceptable. The primary school adjusted net attendance rate for Jola/Karoninka girls is 71.9% (MICS, 2010).

### MANDINKA/JAHANKE

The Mandinka/Jahanke account for 36% of the population and form the largest ethnic group in The Gambia (Census, 2003). They are also known as the Mandingos, Mande or Malinke and have their origins in Mali, reportedly spreading throughout West Africa between the 13<sup>th</sup> – 16<sup>th</sup> centuries and becoming established in The Gambia by the 15<sup>th</sup> century (Access Gambia, undated). 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) (Census, 2003). Traditionally, Mandinkas are farmers and they follow Islam, which they reportedly brought to The Gambia (Burke, 2002). During the period of Jawara's government, the Mandinkas were prominent in politics (Access Gambia, undated).

The Mandinka/Jahanke 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, clerics, while nobles are members of the royal household or potential holders of power. The artisan group comprises of griots (see box below), 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. Politically, Mandinkas are governed at the family level and at state level by the Chief, known as the *Mansa* (Access Gambia, undated).

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.



**Fig. 6: Girls chasing bubbles in a Mandinka community (Photograph by Lilli Loveday©)**

## Endurance and Silence: FGM Initiation and Womanhood Training

The essential aspects of learning involved in the Mandinka initiation (*nyaakaa*) are the virtues of female behaviour. Respect (*horomo*), secrecy (*suturo*) and endurance (*sabati*) are collectively understood as 'knowing the eye' and are closely interlinked (Skramstad, 2008). The first and last values are taught through the pain of the initiation ritual, though training for pain endurance starts before initiation when young girls' hair is plaited /braided (a painful process that they are taught to suffer in silence).

The pain of FGM during initiation is additional to the physical pain inflicted on the girls during the seclusion period. Such pain is a result of punishments for transgressions or tests of endurance intended to create discipline. Physical punishment is considered socially acceptable in Gambian society, which also includes wife beating. There is a positive correlation between women's acceptance of physical violence in the home and higher prevalence of FGM as can be seen in the ethnic group data in this anthropological section. The infliction of pain also forms subordination and instils acceptance of the social hierarchy under which these girls and women are expected to live. Enduring pain is considered a female virtue. Skramstad has noted that *'if unpleasant and painful experiences and feelings cannot be ignored, they should ideally be born in silence without complaints. Married women who are disappointed or angry with their husbands should simply bear and conceal their dissatisfaction. They should by no means reveal their husband's weakness in public, according to the ideal of suturo....a number of experiences never should be expressed or represented'* (Skramstad, 2008).

Several studies on FGM in The Gambia have noted the earlier age of cutting and the increase of cutting without ritual. What used to be a group ritual to change *solima* into initiated girls (as part of the journey to womanhood) is now performed on infants and hence young girls are not experiencing the cultural learning process of the ritual. This shift in the rituals associated with FGM raises the question of whether FGM now acts as a sign that a girl was brought up in a household that would have instilled 'the eye' through proper training during childhood, rather than the training during FGM. Shell-Duncan *et al.* (2011) propose that FGM signals to other women that the cut girl 'is worthy of inclusion in their social network'. If so, then it is possible that FGM will be abandoned for some less harmful marker of a traditionally-educated girl.

There are high rates of perceived acceptability of gender-based violence, with 75% of Mandinka respondents indicating that wife-beating is acceptable. Additionally, there are high rates of polygamous marriage, with 38.8% of women aged 15-49 in a Mandinka-headed household reportedly in polygamous marriages and 44.9% of women in a marriage with somebody 10 or more years older. The rate of marriage for girls under 15 years old is 7.7%, and the adjusted net attendance rate in primary education for girls is low in comparison to other groups, at 66.3% (MICS, 2010).

### MANJAGO

The Manjago is a minority ethnic group in The Gambia, accounting for 2% of the population (Census, 2003). The origins of the Manjago are believed to be in Guinea Bissau and they are mainly Christian.

The prevalence of FGM in Manjago-headed households is 18.1% amongst women aged 15-49.

41.8% reported finding wife-beating justifiable. 100% of women reported being married to somebody more than ten years older than them, while rates of polygamy were lowest (except for in the non-Gambian category) among Manjago-headed households at 16.6%. Marriage under the age of 15 is relatively low compared to other ethnic groups, at 5% and the adjusted net enrolment ratio in primary education for girls is high at 93.1% (MICS, 2010).

### SARAHULE (SONINKE)

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. Some research suggests that they migrated to The Gambia following the break-up of the ancient Shongai Empire in the late 15<sup>th</sup> century. Other reports place their origins as being the descendants of the original empire of Ghana (Burke, 2002).





**Fig. 7: Sarahule woman listens to testimonies by CEP participants at the first Sarahule Interzonal meeting near Basse (©Tostan, Photograph by Lilli Loveday).**

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. The Sarahule also represent the ethnic group with the second highest rate of recorded marriage amongst girls under the age of 15 (10.6%) and the highest rate of recorded polygamy amongst women aged 15-49 (53.3%). 90.5% of respondents indicated that they believed wife-beating was acceptable (MICS, 2010). The Sarahule have a net adjusted attendance rate in primary education for girls of 57.5%.

### **SERERE**

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. They share origins with the Diola in Senegal and are believed to have migrated from northern Senegal. There is evidence of intermarriage with Mandinka and Wolofs (Burke, 2002). While many Serere have adopted Islam some are Christian.

The Serere are reported to have been reluctant to adopt Islam with many forced to flee from their homeland to The Gambia following the Soninke-Marabout wars. Socially, the Serere are organised into five class groups – the ruling noble class, soldiers, commoners (the Jambur), artisans and slaves. Similar to the Mandinkas intermarriage between class groups is prohibited. Griots form part of the artisan class and often gain significant wealth despite their lower class status (Access Gambia, undated).

FGM is practised by the Serere although evidence from comparative studies in Senegal indicates that it may be an adopted practice in The Gambia (Kaplan, 1998). The prevalence rate is 43% among women aged 15-49. There are high rates of marriage to older partners among women in Serere headed households, with a recorded 87.3% reporting marriage to somebody 10 or more years older. The net adjusted attendance rate in primary education for Serere girls is relatively high at 80.4%. The number of women in Serere-headed households stating that wife beating is acceptable for one reason or another is 57% (MICS, 2010).

### **WOLOF**

The Wolof (also known as Jollof/Jolof) account for 15% of the population and constitute the third largest ethnic group (Census, 2003). Wolof is also the predominant ethnic group in Senegal and is widespread across the Senegambia region. The Wolof language is widely adopted by residents living along the coast and is considered to be a popular language among youth, though some complain of the ‘Wolofisation’ of the culture (Burke, 2002). 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 amongst women aged 15-49 is 12.4% - representing the lowest of the ethnic groups. The rate of marriage of girls under the age of 15 is 7.6%, and 44.2% of women aged 15-49 in Wolof-headed households are in polygamous marriages. Furthermore, 72.6% of women responded that it was permissible for a man to beat his wife and the number of women married to someone 10 or more years older is high at 62.8%. The adjusted net attendance rate in primary school for girls from Wolof-headed households is 55.3% (MICS, 2010).

### Griots- Communicating Traditions

A griot (also known as a *Jali*) is a unique designation specific to the West African region for a traditional communicator and found in The Gambia among the Mandinka, Bambara and Serere. Their role is to remember history and keep it alive through storytelling, advice-giving and knowledge-sharing and it is open to men and women.

Griots are considered an integral part of Gambian culture, playing an important role at cultural events including weddings, naming ceremonies, and singing at FGM ceremonies (Access Gambia, undated).

These traditional communicators have worked with health personnel to provide information about FGM at health clinics through dramas and songs in local languages. GAMCOTRAP has trained griots on FGM, including education related to health and religion. Following the training, the traditional communicators developed rhythms and songs about FGM's harmful impacts, which they disseminated through local radios stations. The communicators were also trained on the Maputo Protocol and the CEDAW convention and their songs were used to begin workshops.

## OVERVIEW OF FGM IN THE GAMBIA

This section gives a broad picture of the state of FGM in The Gambia. 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 at eradication.

### NATIONAL STATISTICS RELATING TO FGM

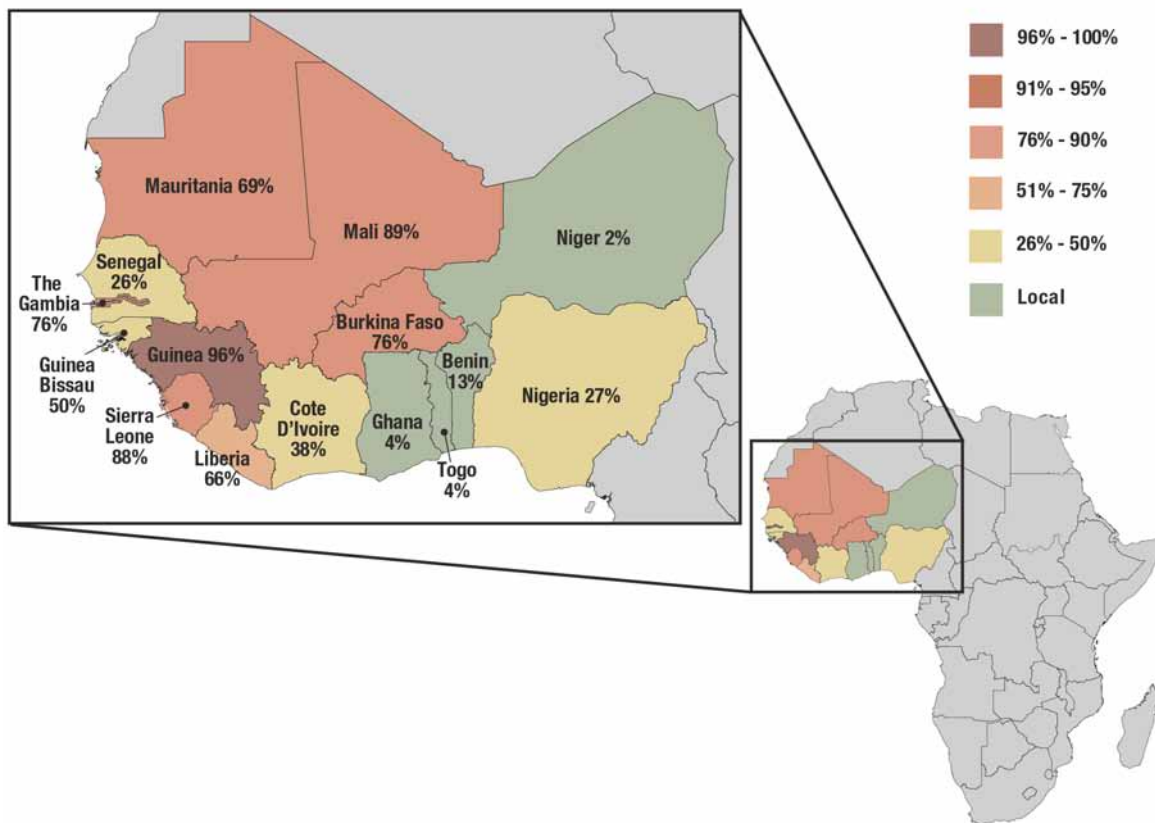
The estimated national prevalence of FGM in girls and women (aged 15-49 years) is 76.3% (MICS, 2010). It has also been reported that the DHS 2013 full survey shows a reduction in FGM prevalence from 78% to 74.9% (*The Standard*, 2015). The Gambia is classified as a Group 2 country, according to the United Nations Children's Fund (UNICEF) classification, with moderately high FGM prevalence (51-80%).

Statistics on the prevalence of FGM in developing countries are compiled through large-scale household surveys – the DHS and MICS. For The Gambia, the most recent and publicly available set of data on FGM (at the time of publication) was the MICS 2010. More up-to-date data is forthcoming, given that in 2013 a DHS was completed with questions related to FGM included in the survey.

The preliminary results of this have been made available, but do not include the FGM-specific information.

The MICS 2010 in The Gambia asked women aged between 15-49 years old to:

1. Report their own FGM status and type of cutting
2. The FGM status of their daughters aged 0-14 and type of cutting
3. Indicate their attitude regarding continuation/or not of the practice



**Fig: 8: Prevalence of FGM in West Africa (UNICEF, 2013)**

### 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.

Data collected about daughters cannot be used to accurately estimate the prevalence of girls under the age of 15 (UNICEF, 2013). MICS asked the FGM status of all daughters under 15 years. 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. These figures however (unless they are adjusted) do not take into account the fact that these girls may still be vulnerable to FGM after the age of 15 years old.

A MICS was also completed in 2005/2006, with both the 2010 and 2005/2006 MICS surveys following the same methodological approach for data collection about women and girls aged 15-49 but not the same questions in both surveys about

daughters. This provides a point of comparison for observing trends in FGM practise and prevalence among women and girls aged 15-49 only.

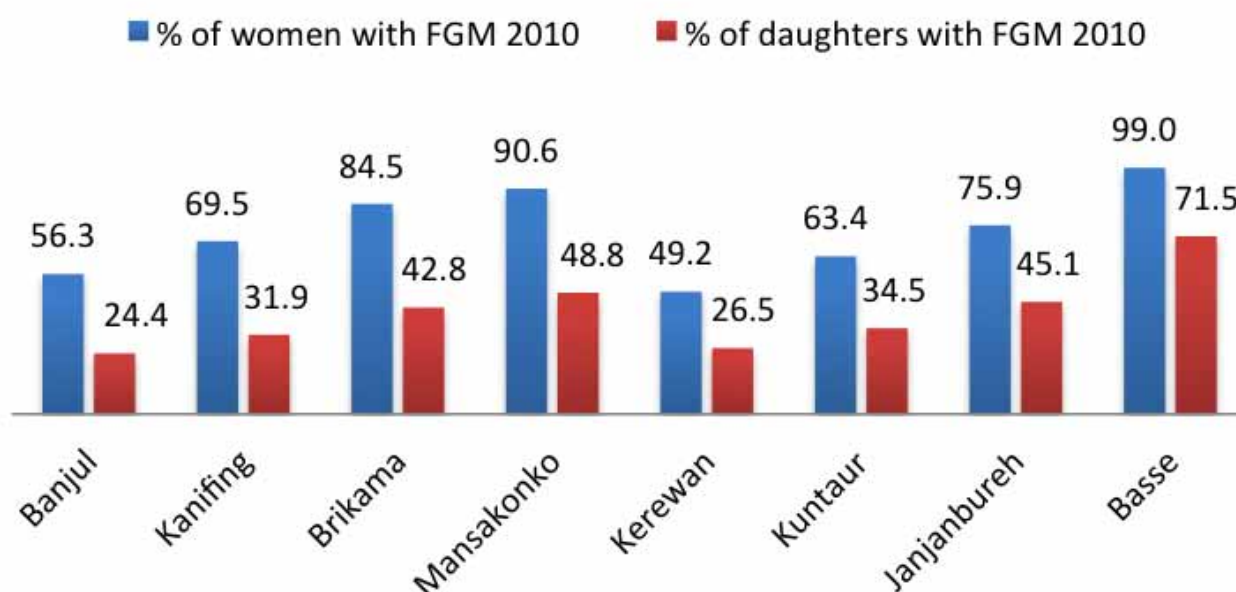
In 2005/2006, the national prevalence had been 78.3%, indicating that there has been a two percentage point fall in FGM prevalence over a period of five years.

### PREVALENCE OF FGM IN THE GAMBIA BY PLACE OF RESIDENCE

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%).

### Prevalence of FGM among women and girls aged 15-49 and daughters 0-14 years old according to LGA of residence



**Fig. 9: Prevalence of FGM among women and girls aged 15-49 and daughters 0-14 years old according to LGA of residence (MICS, 2010)**

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.

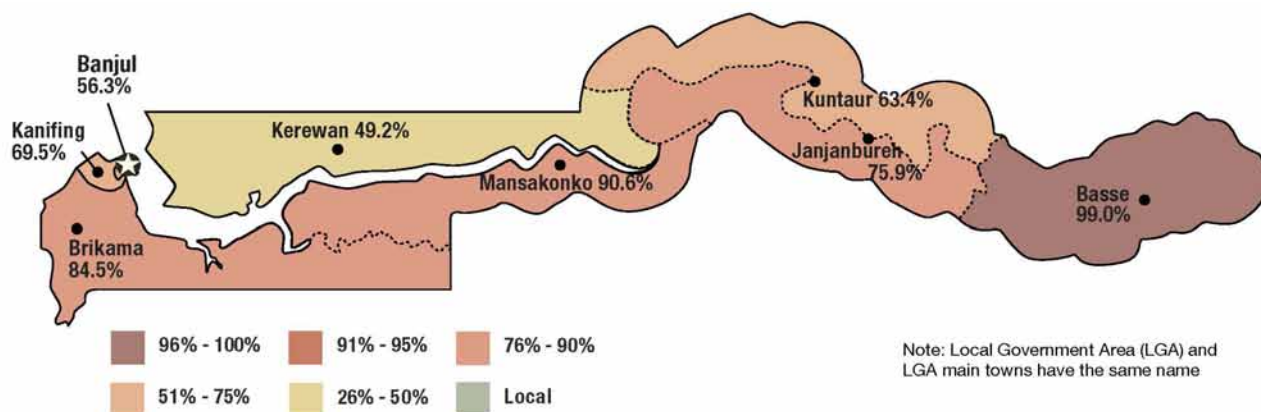
Although MICS data does not capture ethnicity by LGA (the 2003 Census does), it should be noted that the Basse LGA is predominantly inhabited by the Sarahule, Mandinka and Fula ethnic groups (who all have high prevalence rates), whereas the coastal area (Banjul and Kanifing

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 (see figure 4 on page 19).

Data (not shown in figure 9) for women aged 15-49 illustrates a percentage point reduction in prevalence across nearly all LGAs between the two MICS data sets 2005/2006 and 2010. However, in Banjul there was an 11.5 percentage point increase in the number of reported cases.

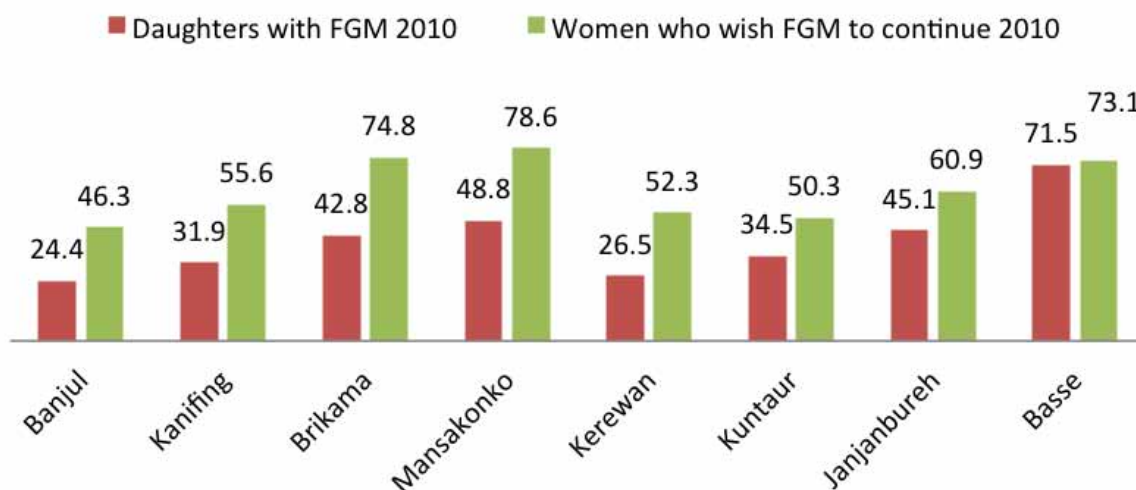
The data cannot explain the rise in reported prevalence in Banjul, where the population has declined 10% in the intervening years (Census, 2003). This data from Banjul, with high coverage of anti-FGM messages and programmes, needs further research. The out-migration experienced by Banjul could possibly be along ethnic lines, with non-practising communities leaving, but this cannot be verified with current data.





**Fig. 10: Prevalence of FGM (percentage) by Local Government Area (LGA) in The Gambia**

**Percent distribution of FGM prevalence in daughters aged 0-14 in 2010, showing also the percentage of women in 2010 who wish to see FGM continue by LGA of residence**



**Fig. 11: Percent distribution of FGM prevalence in daughters aged 0-14 in 2010, showing also the percentage of women in 2010 who wish to see FGM continue by LGA residence (MICS, 2010)**

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. This comparison cannot be made for daughters as in 2005 the MICS measured the percentage of women with at least one daughter with FGM and in 2010 they asked about all daughters 0-14 with FGM.

Figure 11 highlights a large discrepancy between the numbers of daughters reported as cut and the higher rate of the mother's wish for FGM to continue. There is above 50% support for

continuing the practice in every LGA except Banjul (46.3%).

The strongest support for continuation is found in Mansakonko (78.6%), though only 48.8% of daughters are reported to have undergone FGM, followed by Brikama with 74.8% support but only 42.8% of girls cut. Basse, meanwhile, has 73.1% recorded support and 71.5% of daughters who had undergone FGM. A proportion of this may be due to the fact that the girls have not yet reached the age at which FGM is performed at the time of the survey.

### PREVALENCE OF FGM BY ETHNICITY

According to the MICS (2010), 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%). MICS 2005/2006 uses different classifications of ethnic groups limiting the possibility of measuring difference between the two data sets.

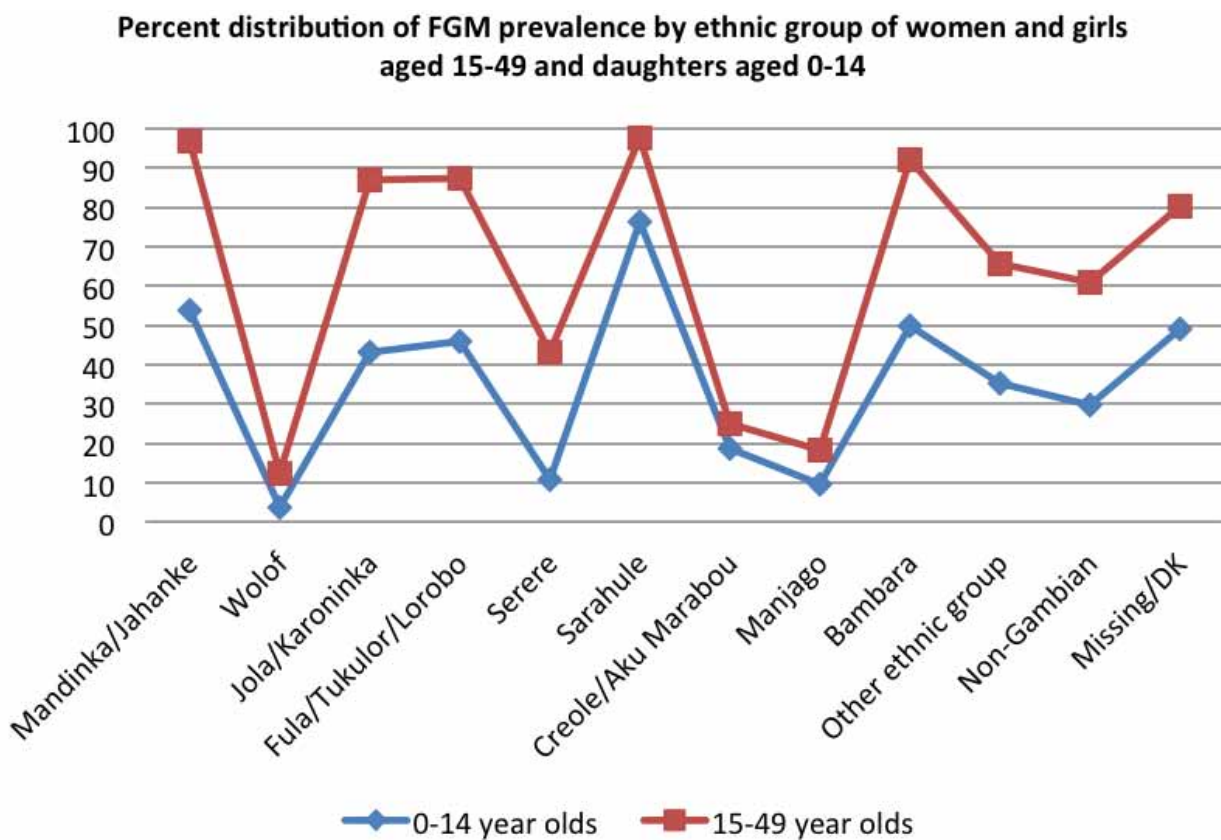
The Fula ethnic group comprises a number of sub-groups. Among these groups the following practise FGM: Torankas, Peuls, Futas, Tukuleurs, Jawarinkas, Lorobebs, Ngalunkas and Daliankos. The Hobobebs and the Jama do not practise FGM. In the Serere ethnic group the Njefenjefe do not practise FGM although the Niumikas do. Also, among the Jola, the Foni practise FGM, whereas the Jola Casa do not (UNICEF, 2002). 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 (Daffeh *et al.*, 1999 in Hernlund, 2009).

### PREVALENCE OF FGM IN THE GAMBIA

#### BY AGE

Age at which FGM is performed is not collected by MICS. There are reports of recorded differences amongst ethnic groups. The Fula and Sarahule are reported to practise FGM at a younger age than other ethnic groups. There is also a reported trend towards practising FGM on infant girls (IRIN news, 2009; Shell-Duncan *et al.*, 2010).



**Fig. 12: Percent distribution of FGM prevalence among women and girls aged 15-49 and daughters aged 0-14 by ethnicity of household head (MICS, 2010)**

Later reports put the age between 4 and 10, but in practise FGM can occur anytime between ages 1 and 10 (Skramstad, 2008). In a concordance analysis between FGM performed on mothers and on their daughters, in more than 75% of pairings the mother had been cut at a significantly older age than her daughters (Shell-Duncan *et al.*, 2010).

Table 1 shows a consistent fall in the reporting of FGM status as the cohorts are followed across the years (see arrows). Without under-reporting, one would expect the percentage to remain the same as the cohort aged between the data. The only exception is the oldest cohort in 2010, where the figures rose in the five years from 77.7% at 40-44 years to 79% at ages 45-49 (a rise of 1.3 percentage points may be within the margin of error). There is no explanation for the falls which are on average over 3 percentage points.

It may be a response to anti-FGM programmes making it less comfortable to express true FGM status. The data, though, does highlight a small difference in the rates between the oldest and youngest cohorts, 79% and 77.1% respectively.

Table 1 shows under-reporting across the ages in the two data sets. There is therefore concern that the daughters' data in Table 2 is similarly flawed.

Age of girls and women	2005/6	2010
15-19	79.9	77.1
20-24	78.2	76.8
25-29	77.2	77.5
30-34	78.4	74.6
35-39	79.5	73.1
40-44	77.7	75.3
45-49	74.2	79

**Table 1: Prevalence of FGM by age from two data points (MICS 2005/6 and 2010)**

## TYPE OF FGM AND PRACTITIONERS

The MICS does not use the WHO classifications for FGM (Types I-IV). Women who responded that they had been cut were asked to classify the type of FGM they had undergone by the following categories (which correspond to Type I-IV categories):

- Had flesh removed (corresponding to Types I and II)
- Were nicked (corresponding to Type IV)
- Were sewn closed (corresponding to Type III)

The Gambia has a form of sealing the vagina analogous to Type III. This type does not use stitching, but rather a seal formed by clots of blood or herbal powder leaving only a small opening, about the diameter of a matchstick, for urination and menstruation. This procedure involves the removal of the clitoris and the labia minora, followed by sealing of the vaginal opening. The legs are forced to stay tightly together during the period of convalescence (about 40 days) allowing the vaginal tissue to fuse (US Dept. of State, 2001). It is unclear from the MICS (2010) or Kaplan data (2011) (see below) whether the category is 'sewn closed' or observed as Type III, in other words the vagina is sealed closed without stitching. This practice is commonly known in Mandinka as *notoro*, and is mostly carried out by some Mandinka, Sarahule and Fula ethnic groups (GAMCOTRAP, undated).

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 figures for sewn closed were not considerably different between women (6.8%) and daughters (5.3%).



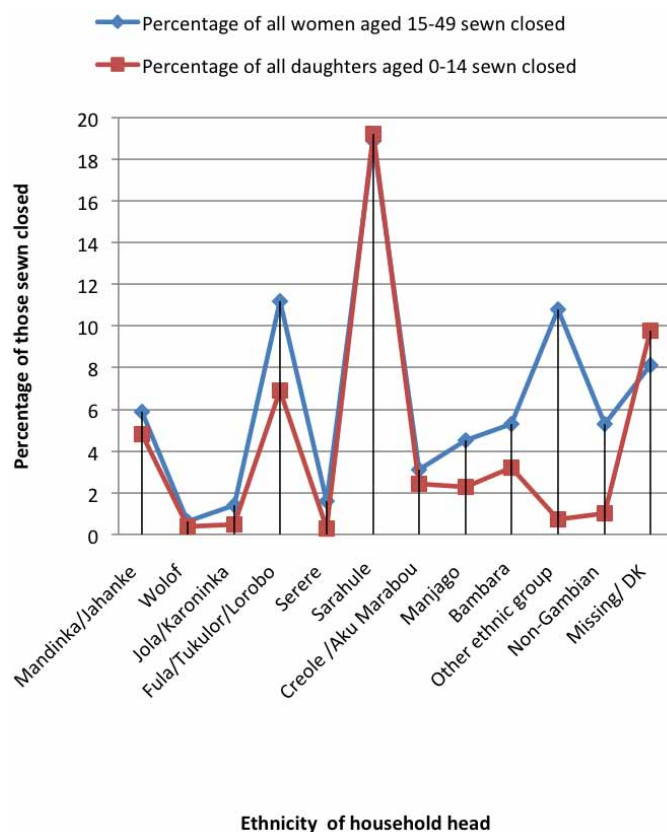
Type of FGM performed	Percentage of all women aged 15-49	Percentage of all daughters aged 0-14
Had flesh removed	67.9	36.7
Were nicked	0.1	0
Were sewn closed	6.8	5.3
Form of FGM not determined	1.6	0.5
No FGM	23.7	57.6

**Table 2. Percentage of women and girls 15-49 and daughters 0-14 with FGM and the types of FGM performed (MICS, 2010)**

The MICS 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).

Figure 13 compares the rate of infibulations between women and girls aged 15-49 and mothers' reported infibulations of daughters disaggregated by ethnicity of the household head. The figure for daughters may not be a final figure as they may still have been at risk of undergoing FGM. However, MICS data shows 6% of girls aged 0-4 had been infibulated. This figure rises by 1.4 percentage points to 7.4% among 5-9 year-olds and 8.1% of 10-14 year-olds, showing that the majority of girls at risk of being sewn closed had been by the age of 4 (if the age of practise has not changed).

The highest rate of sealing is found among the Sarahule and is unchanged between mothers and daughters at around 19%. The practice shows a change among the category 'other ethnic groups' with women reporting 10% as sealed closed but only 0.7% of daughters. Three groups report the practice prevalence at below 1% for daughters.



**Fig. 13: Percentage of women and daughters 'sewn closed' in ethnic groups according to the household head's ethnicity (Kaplan *et al.*, 2011).**

### PRACTITIONERS OF FGM

The MICS (2010) does not capture data on practitioners of FGM. However, there is indication that FGM practitioners in The Gambia 'inherit' the tradition and that there is a strong expectation that those born into the role will fulfil their duties (Global Voices, 2014). Interventions teaching traditional FGM practitioners of the practice's associated risks have influenced attitudinal shifts and facilitated their abandonment of the role.

The Gambia Medical Association condemns the medicalisation of FGM. In a study by Kaplan *et al.* (2013b), it was found that 7.6% of both male and female Health Care Professionals (HCPs) surveyed reported that they had performed FGM on girls, and 42.9% indicated that they supported medicalisation of the practice based on perceptions that this is 'safer'.

This idea of FGM being safer if done by health workers has been taken up by the pro-FGM lobby in The Gambia as a counter to those interventions advocating the negative health impacts of FGM. Though it may help to improve the early problems of FGM, long term it does not alter the negative health (including psychological) and reproductive issues faced by women and remains a breach of their human rights.

*'Nobody can do it here, except the ngangsimba'*

*'There is a female dispenser who actually circumcised girls and I went there and told them "Look, this is a customary practice" (...) female circumcision should be secretive. It is exclusively the area of the ngangsimbas'* – Elder Mandinka Man (in Shell Duncan et al., 2010)

*Ngangsimba* is a Mandinka word referring to the female head of the women's community in Mandinka villages. *Ngangsimbas* hold significant authority and there have been instances where they have limited discussion in communities around FGM (Loveday, 2010). *Ngangsinbas* are responsible for performing FGM. All respondents in a study undertaken by Shell-Duncan et al. (2010) asserted that it would be unacceptable to perform FGM in a medical setting, even though they expressed desire for the risks of FGM to be minimised.

## THE ECONOMICS OF FGM IN THE GAMBIA

There are at least four ways to address the economic implications of FGM: the cost to the family; the livelihood of the practitioner; the cost to the state in healthcare and lost human potential. The cost to the family includes the fee for the FGM procedure, any accompanying celebrations, plus healthcare costs if the girl suffers any adverse effects from FGM. Across wealth quintiles the highest rates of FGM are recorded in the third and fourth richest wealth quintile (80.9% and 82.6%), with the richest quintile demonstrating the lowest prevalence rate of 69.8% (MICS, 2010).

A study undertaken in The Gambia to assess the health consequences of FGM highlighted that there is a significant economic cost related to the practice (Kaplan *et al.*, 2011). 34.3% - or 1 in 3- of all cases recorded requiring medical follow-up (see healthcare section).

Though health services are supposed to be provided for by the state, medications and supplies are often unavailable within public health facilities and must be purchased by families from private pharmacies. With 48.4% of The Gambian population recorded in 2010 as living below the poverty line, this has a major impact on access to care. Moreover, rates of FGM are highest amongst rural communities where access to medical care is limited. Here, the economic cost of treatment is compounded by the fact that travel to health facilities is challenging and costly.

There are associated burdens on the state, both in terms of additional costs in healthcare provisions and loss of human potential through death or ill health of some FGM survivors. Although Gambia-specific data on healthcare expenditure associated with FGM-related medical complications is lacking, a study undertaken by WHO indicates that, on average, FGM accounts for 0.1%-1% of healthcare spending on women aged 15-45 (Bishai *et al.*, 2010).

Reports indicate that cutters receive between GMD 50 and GMD 200 per child along with other gifts (Afri Consult Group, 2010). One cutter interviewed by the BBC stated, *'I get £2 per child cut plus a bag of rice and clothing'* (Lloyd-Roberts, 2013), with the accompanying prestige and social status also highlighted. Anecdotal reports indicate that cutters provided with alternative sources of income have been enabled to earn an income from another source (Lloyd-Roberts, 2013). This information needs to be read with a caution that cutters have also been known to declare abandonment of the knife but continue in secret. Furthermore, while there is an economic element to undertaking the practice, attributing value to the economic argument as being fundamental to the continuation of FGM in The Gambia needs to be carefully approached.

Evidence indicates that while cutters gain some incentives from undertaking FGM that may be used to supplement family income, it is often not the primary source of income and does not constitute the main driver of its continuation. The economic factors arising from inequity between men and women are considered to be more significant (Koroma, 2002). This has implications for interventions against FGM and is discussed in the interventions section below.

## SOCIOLOGICAL BACKGROUND

### ROLE OF WOMEN

Women typically occupy a lower status than men, with women's roles and gender norms guided by a principle of male dominance. Interactions between men and women are defined by a strong pattern of patriarchy which exists across the different ethnic groups, and *'it is generally accepted by a majority of both men and women that the status of women is inferior to that of men'* (CEDAW, 2003).



**Fig. 14: Women selling produce grown at a women's vegetable garden to generate income (Photograph by Lilli Loveday©)**

The Gambia was ranked 76th out of 86 in the 2012 Organisation for Economic Co-operation and Development's (OECD) Social Institutions and Gender Index (SIGI), with a SIGI value of 0.39 (SIGI, 2014). This score represents a further decline from the 2009 SIGI ranking, which placed The Gambia 69th out of 102 countries, with a SIGI value of 0.19. 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). The Gambia's GII value of 0.624 ranks it 137<sup>th</sup> out of 149 countries in 2013 (Human Development Report, 2014).

*'There cannot be any meaningful development without the full and active participation of all of [The Gambia's] citizenry, particularly women and girls'*

**-Vice President Dr Aja Isatou Njie Saidy**

(54<sup>th</sup> Session on the Commission on the Status of Women, 2010)

To help improve gender equality in The Gambia the Government created the Gender Policy 2010-2020, and this was supported by the enactment of the Women's Act in 2010 which is designed to address the shortcomings of the Constitution regarding gendered discrimination. These mechanisms have been further substantiated by the Sexual Offences Bill 2013 and the Domestic Violence Bill 2013. The Women's Act is a progressive document and the first of its kind across Africa, representing a positive and sincere commitment at the institutional level to women's rights (Women's Bureau/UNDP, 2014).

**PHYSICAL INTEGRITY**

Women's physical integrity is protected by various legal enactments, including the Constitution and the Women's Act, which expressly prohibit violence against women, including all forms of physical, sexual, psychological and economic harm. The Criminal Code prohibits rape and recognises rape and assault within marriage as grounds for divorce.

The Domestic Violence Act 2013 and the Sexual Offences Act 2013 make specific provision to provide protection for victims of domestic violence, clarifying that victim 'consent' is not justifiable as a defence. This acknowledges that there is widespread 'acceptance' of gender-based violence with a 'culture of silence' surrounding domestic abuse providing, in part, the legitimacy for acts of violence to be perpetuated and go unreported (Faal and Njie, 2013).

The MICS 2010 indicates that 75% of women believe it is justifiable for a husband or partner to

hit or beat them, with significant regional, as well as urban/rural, variation. The majority of women who approved their partner's violence felt it was justifiable on the grounds of refusing to have sex with him (59.6%), going out without informing him (53%), neglecting the children (52.4%), arguing with him (33%) and burning the food (13.6%). There is a higher 'acceptance' of domestic violence amongst rural women (86.7%) compared to urban women (63.1%), with the lowest rates of 'acceptance' recorded in Banjul (45.5%) and the highest in Basse (94.5%). There are also variations based on the ethnicity of household heads detailed in the Anthropology section.

In 2012, a National Steering Committee on Gender Based Violence, supported by UNICEF/ United Nations Population Fund (UNFPA), was formed, leading to the development of the National Plan of Action (NPOA) on gender-based violence for 2013-2017. Recognising the strength of attitudes which surround gender-based violence, the NPOA aims to 'reduce the number of women who accept Gender Based Violence from 75% to 30%' and to make violence an 'abnormal', opposed to a 'normal', phenomenon. Other, non-state actors, have an important role to play in supporting efforts, including in the establishment of a 'One Stop Centre' for victims of gender-based violence and awareness-raising on utilising the law (Women's Bureau/UNDP, 2014).

**RESOURCES AND ENTITLEMENTS**

Women's resources and entitlements are limited by observance of Customary and Islamic religious law called Shari'a Law which does not give women equal rights to both access and control of resources. Under Customary Law and tradition land is typically owned by men and women are 'loaned' the land for cultivation by male members of society (including their husbands, family members and the wider members of the community) (SIGI, 2014).

Limited land ownership affects women's ability to access financial services, including accessing



credit and loans. Women's economic status in The Gambia has been defined by a system of dependence on men, which is intensified in rural regions by limited access to education and poor literacy (CEDAW, 2003). Economic inclusion is further restricted by cultural perceptions of women's accepted occupations and around 80% of women are engaged in the agricultural sector (FAO, 2009, quoted on SIGI website).



**Fig. 15: Given women's limited land tenure for commercial production, bananas are typically cultivated by men, and sold by women (Photograph by Lilli Loveday©)**

### CIVIL LIBERTIES

At the level of policy and legislation women's civil liberties are guaranteed, including their full participation in politics. There are no legal restrictions on their freedom of movement, and they have the right to choose their own domicile. In practise, these liberties are restricted by underlying customs and norms, and Shari'a Law.

Once married, women are expected to adopt a position of subservience to their husbands (Haddad, 1998). Women are customarily (and religiously) expected to transfer to their husband's

family home. Upon divorce, especially as most marriages are not legally registered in civil law, women are not afforded any rights to property and are expected to return to their family home. Under Shari'a women are unable to initiate divorce, unless their husband agrees or unless they go through Shari'a courts. Polygamy is permissible under Shari'a law and it is recorded that 40.7% of women in The Gambia are in polygamous marriages, with 46.5% of women married before the age of 18 (MICS, 2010).

Female representation across the national Parliament is low at only 9.4% (MoFEA, 2014). Of the 53 members of the National Assembly, five are female (with four elected and one nominated deputy). Reports indicate that at community level only five of 1,873 village heads are women and there are no female regional government representatives. Male dominance and discriminatory gender/social norms are stated as being the reason for poor female political representation (Jammeh, 2014b).

## HEALTHCARE SYSTEM

The healthcare system is comprised of public and private sector facilities, as well as traditional medicine networks. The National Health Policy recognises traditional medicine as complementary to the 'modern' or 'orthodox' health system (see text box below). The 2008 physician density in The Gambia was estimated at 0.11 physicians to every 1000 people, which is low compared to developed nations (World Factbook). It is estimated that there is a 73% shortfall in workforce ability to respond to medical need (UNFPA, 2014). The health service has relied heavily on overseas medical personnel, notably from Cuba and Taiwan.

The establishment of the American International University West Africa (based in Fajara) in 2011, which runs health service courses, should contribute to the sustainability of the medical workforce (AIUWA, undated). The Government has also provided shorter, less in-depth training to auxiliary workers in order to increase the skill-base and ease the burden on nurses and midwives. Furthermore, Traditional Birth Attendants (TBAs) and Community Health Workers (CHWs) have been trained as part of community-based health programmes (Cham *et al.*, 2005). At the village level, the majority of care is delivered by CHWs and TBAs. As of 2014 The Gambia has the following healthcare workforce figures: 79 midwives, 180 auxiliary midwives, 97 nurse-midwives, 200 nurses, 132 nurses or nurse-midwives, 29 physicians, and 11 obstetricians and gynaecologists (OBGYNs) (UNFPA, 2014).

Healthcare is currently subsidised and medicine should be provided free of charge. The Government aims to provide free maternal, child and emergency care, though this is not realised. Public healthcare is cheaper than private facilities and traditional healers (Cham *et al.*, 2005). The unstable availability of medicines/supplies means that prescriptions cannot always be supplied by public pharmacies and are often sourced through private facilities.

## Traditional Medicine

Traditional medicine constitutes a significant element of The Gambia's national healthcare system. It is part of the country's culture and has spiritual significance drawn from Islam (Peterson, undated). Practitioners inherit the ability to provide traditional healing from family heritage and, unlike modern medicine which is often symptom-focused, traditional medicine aims to treat the causes of an illness. These causes are often believed to be occult in origin.

Traditional medicine is often the preferred choice of healthcare in some rural areas (Cham *et al.*, 2005). This is despite evidence suggesting that it is more expensive than public and private healthcare, with the average cost of a visit being US\$4 compared to public services at US\$0.50. Traditional practitioners may be more accessible in rural, isolated regions and usually offer payment-in-kind or payment-over-time options, which are more convenient for poor households (Cham *et al.*, 2005).

Traditional practitioners and medicinal products are required by law to be formally registered at the Traditional Medicine Unit in the MOHSW, Banjul (Ceesay, 2015).

## HEALTH AND THE MILLENNIUM

### DEVELOPMENT GOALS

#### GOAL 4: REDUCE CHILD MORTALITY

The Gambia's MDG target for reductions to the infant mortality rate was 42/1000 live births by 2015, and for Under 5 (U5) mortality was 67.5 per 1000 live births by 2015. The 2014 MDG Status Update Report for The Gambia indicates that the country has met the MDG targets for both infant and child mortality indicators.

#### GOAL 5: IMPROVE MATERNAL HEALTH

The Gambia's MDG target is to reduce maternal mortality by three quarters between 1990 and 2015, representing a reduction from 730/100,000 live births to 263/100,000 by 2015 (National Health Policy). Maternal mortality rates remain high in The Gambia. The most recent DHS statistics indicate that the rate in 2013 was 433/100,000 live births (MoFEA, 2014). The section on Women's Health and Infant Mortality below discusses factors related to the high maternal mortality rate.



**Fig. 16: Woman and child in the town of Farafenni (Mishimoto cc. Farafenni, Gambia)**

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

The Gambia's MDG target for Human Immunodeficiency Virus (HIV) prevalence amongst 15-24 years olds is to reduce rates to between 0.3 and 0.9%. Despite HIV prevalence remaining relatively stable The Gambia is not on target to reach the indicator for HIV prevalence. The recent 2013 DHS survey indicates a national HIV prevalence rate of 1.9% (representing a slight increase from 1.83% in 2012), with a rate of 1% amongst 15-24 year olds (DHS in MoFEA, 2014).

Malaria is a leading cause of morbidity and mortality in The Gambia, and a major cause of U5 mortality. Though progress has been made, the targets for malaria and TB will not be met (MoFEA, 2014).

**WOMEN'S HEALTH AND INFANT**

**MORTALITY**

**WOMEN'S HEALTH**

Despite observed progress towards achieving MDG 5, the maternal mortality rate remains high in The Gambia at 433/100,000 live births (MoFEA, 2014). Maternal health indicators reflect challenges regarding the provision of health services as well as access to services and care-seeking behaviours. While the most common life-threatening emergencies for women are pregnancy-related complications, anaemia and malaria are also major indirect causes (Cole-Ceesay *et al.*, 2010). The Government is committed to providing free maternal (and infant) healthcare and emergency care, yet substantial barriers remain (DHS National Reproductive Health Policy 2007-2014).



**Fig. 17: Fula woman nursing her baby at a community meeting in the URR (©Tostan, photograph by Lilli Lovelady)**



### FGM TREATMENT

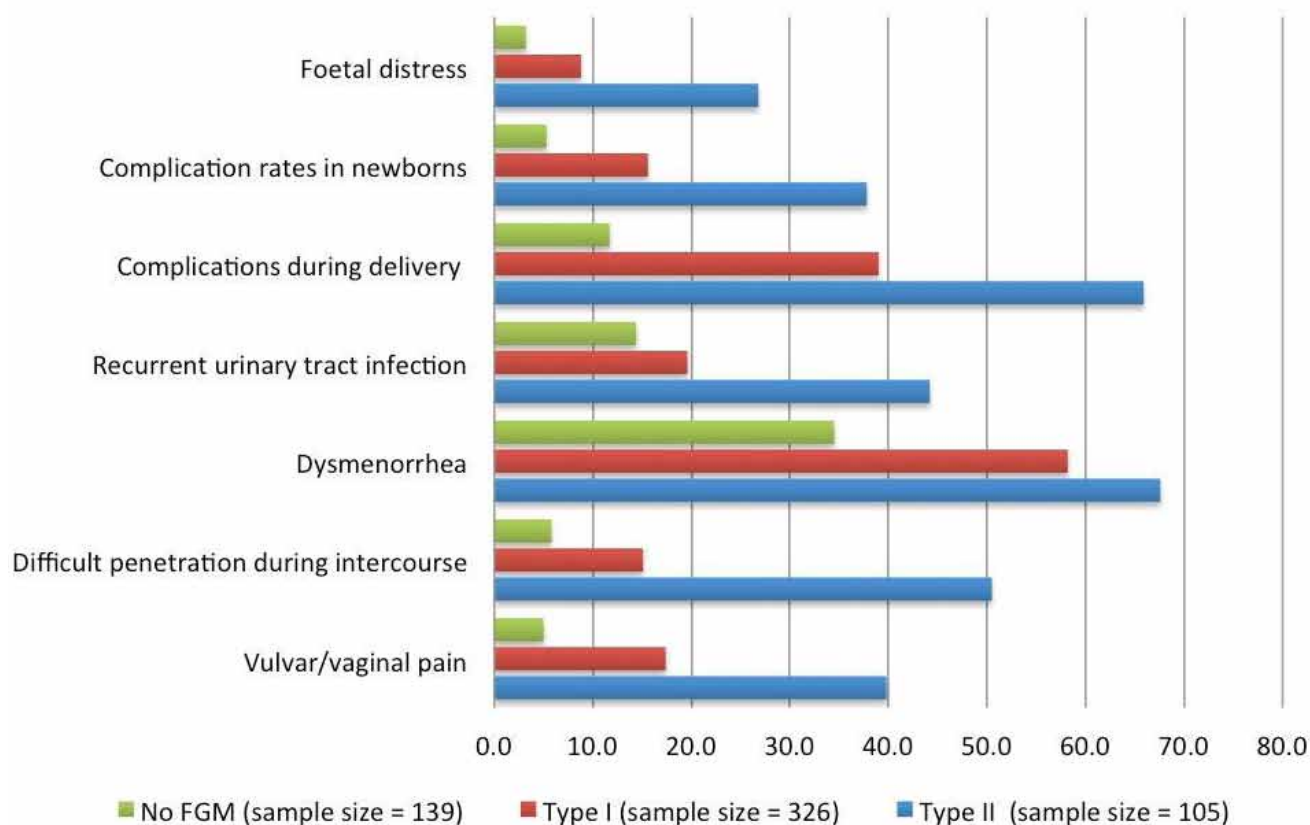
The Ministry of Health included FGM in the national health curriculum for nurses in 2010 and, in 2012, it developed a tool to collect data on the practice (and associated complications) of FGM. A 2013 study highlighted that only 40.9% of HCPs reported having treated or examined a girl with FGM (Kaplan *et al.*, 2013b). This is indicative that many HCPs may not either recognise the physical presentation of FGM and/or connect the practice of FGM with its associated health implications.

A number of studies provide insight regarding treatment sought and required for FGM-related health consequences. They indicate that, while health complications linked to FGM are widespread, there is a disconnect (both amongst women in

seeking healthcare and health practitioners in providing treatment) between observance of gynaecological, obstetric and sexual intercourse-related complications and understanding FGM to be the cause. A study undertaken by Singateh in 1985 highlights that communities equated immediate death resulting from FGM with errors in the family's ritual preparation, or with something shameful about the girl, rather than with the act of FGM itself (Singateh, 1985 quoted in Morison, 2001).

A study published in 2013 by Kaplan *et al.* indicates that of 588 women attending health facilities for delivery or ante-natal check-ups that were surveyed and examined, there were higher rates of complications reported in women who

**Comparison of health and birth complication for mothers and newborns according to Type of FGM**



**Fig. 18: Health and birth complications experienced by mothers and newborns according to type of FGM (Kaplan *et al.*, 2013)**

had undergone FGM than those who had not. Figure 18 shows that complications were found in all categories for women with no FGM, but rose with FGM and the severity of the type of FGM in all categories. Complications in delivery, for example, (including perineal tear, prolonged labour and stillbirths) rose from 11.7% among women with no FGM, to 39% of women with Type I to 65.9% of women suffering complications during birth with Type II FGM (Kaplan *et al.*, 2013).

An earlier study conducted by Kaplan *et al.* (2011) also highlights a number of cases with observed complications related to FGM. Over a period of four months a total of 871 women and girls who spontaneously reported at participating medical centres requiring gynaecological examination were found to have undergone FGM.

A total of 299 (34.3%) of the 871 cases presented health complications related to FGM. Of these, complications arising from recent FGM (within ten days of being cut) included infections (96 cases), haemorrhage (40 cases) and anaemia (42 cases). The highest percentages for immediate complications were observed in patients who had undergone Type II FGM. Scarring was also recorded, with a total of 189 women presenting with scarring, the highest percentage of cases being women with Type II FGM (88.7%) (Kaplan *et al.*, 2011).

### REPRODUCTIVE HEALTHCARE

Only 27% of the estimated full pregnancy-related healthcare need is met by the available workforce against the required number of visits (family planning, routine check-ups, birth attendances and routine follow-ups) for the total number of pregnancies (UNFPA, 2014).

Socio-cultural factors regarding women's decision-making authority, and issues surrounding the cultural inappropriateness of discussing pregnancy (for fear that it will 'bring bad luck'), are likely to be contributing factors to maternal morbidity and mortality. This may contribute to delayed reporting of complications or failure to

seek appropriate, timely care, further exacerbated by poor referral systems.

There is a serious, unmet need for emergency obstetric care and a need to strengthen provision of 24/7 emergency services. While the Health Policy mandates that financial constraints should not limit emergency care, testimonials highlight that in cases where the family did not have cash available they were told to return home and raise additional funds. Patient perceptions of positive emergency obstetric care are indicative of the systemic challenges, with a view that even if the child dies, but the mother survives, the case has been 'successful' (Cham *et al.*, 2009).

*'We are told that maternity fees are not more than GMD100. We go to the hospital with only that amount. In reality there is nothing in the hospital... You are asked to buy blood, medicines and other things. If you don't have money your patient will die. I spend GMD 2,200. I spent all that I have and even borrowed to meet the total cost.'*

Patient quote in Cham *et al.*, 2009

### REPRODUCTIVE HEALTH COMPLICATIONS

There are many reproductive health complications surrounding FGM. FGM increases the likelihood of infection during sexual intercourse in a number of ways:

1. Scar tissue can tear during penetration, leading to open surfaces where an infection (for example HIV) can pass directly into the blood.
2. The associated risk of haemorrhage can increase a woman's exposure to contaminated blood in the case of requiring a blood transfusion (WHO, undated). Haemorrhage is a known birth complication for women who have had FGM of all types due to the inelasticity of the scar tissue, which leads to tearing during delivery and potentially excessive loss of blood. 26% of maternal deaths in sub-Saharan Africa are due to haemorrhage.

Blood transfusion services in The Gambia are limited, though they have been extended to Bansang, Sulayman Junking General Hospital, the Armed Forces Provisional Ruling Council Hospital in Farafenni as well as some major health centres.

Storage of blood is problematic with limited facilities and poor electricity supply, although fridges have been provided to major health centres including RVTH (WHO, 2008b). There are reports of hospital staff charging for blood even though this is forbidden.

Fistula is a condition caused by long and obstructed labour, which has been linked to FGM as the inelasticity of scar tissue may block progress in the final stages of labour. Prolonged pressure from the baby getting stuck in the birth canal damages the tissues between the vagina and the urethra and/or the rectum resulting in incontinence. Obstructed or prolonged labour is more common in young mothers due to underdevelopment and 80% of those affected by fistula worldwide are under 15.

As well as being physically devastating, fistulas lead to social exclusion; sufferers are mocked and ostracised due to the smell and leakage. There are only two facilities providing a fistula repair service, (one in Banjul and a second run by BAFROW at their Well Woman clinic in Mandinaba), and these services give women the courage to be treated and encourage others to seek support (Sesay *et al.*, 2010).

### PLACE OF DELIVERY

An increasing proportion of babies are delivered at a health facility, though home births remain common, and there is variation between urban and rural areas. As a national average, 40.8% of babies are delivered in a public health centre, 5.9% at a private centre, 43.2% at home and 0.2% 'other' (MICS, 2010). DHS 2013 preliminary findings highlight that in Banjul 88.7% of babies are delivered by a skilled HCP, compared to Basse, where only 30.9% are attended by a skilled HCP.



**Fig. 19: UNICEF-trained TBA in the community of Kolibantang, URR (a Tostan intervention community) (©Tostan, photograph by Lilli Loveday)**

Delivery attended by a skilled person is a major factor in reducing mortality rates. Many babies are delivered by traditional birth attendants (TBAs), especially in more rural regions where health facilities are limited. Often TBAs lack training to deal appropriately with complicated births (Cole-Ceesay *et al.*, 2010). In The Gambia TBAs are culturally 'accepted', with reports indicating that some women only feel comfortable with them (Nyanzi *et al.*, 2007).

TBAs often have limited medical knowledge and impart cultural misconceptions about contraception, being described as '*gatekeepers of the sacred traditional norms and values of their societies*' (Nyanzi, 2008). Equipping TBAs with appropriate skills and knowledge is critical to ensuring safe delivery. UNICEF, in collaboration with the Ministry of Health, has promoted training of TBAs and the provision of essential equipment

to assist with emergencies (including resuscitation masks, a mobile phone for emergencies, gauzes and gloves) (Ceasay, 2010; UNICEF, undated).

### INFANT MORTALITY

The Gambia's infant mortality rate is 34/1000 live births, representing attainment of MDG 4 (MoFEA, 2014). There have been country-wide immunisation programmes which have contributed to the reduction of infant mortality. Research in The Gambia highlights that there are serious health implications not only for delivery, but also for the health of the newborn child in cases where the mother has undergone FGM.

FGM is a contributing factor to the infant mortality rate. Rates of stillbirth were higher among women with Type I or II FGM (3.8%) compared to no FGM (0%). A number of neonatal complications were recorded including foetal distress in 13.9% of deliveries to a mother with FGM (compared to 3.2% of cases in 'no FGM') and caput (swelling) of the foetal head recorded in 20.6% of FGM cases (compared to 1.1% in non FGM) (Kaplan, 2013).

In a multi-country survey the WHO (2006) demonstrated that death rates among newborns are higher in mothers who have had FGM. 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.

## EDUCATION

The formal education system has nine years of basic education, followed by three years of senior secondary education and then tertiary education. Basic education is a constitutional right for every child in The Gambia. Primary level is free for boys and girls from grades 1-6. It continues to be free or at a reduced rate for girls from grades 7-9 (though other costs still apply – uniform, equipment and transport). This payment difference is in order to realise the Education for All (EFA) gender parity goals.

Secondary education is principally provided by the private sector, however, grant-aided schools are assisted by Government and there are a number of international secondary schools (DoSBSE, 2006; Njie, 2013). Free secondary level schooling has been promised by the Government in 2014 for both boys and girls. It is not yet a reality. The Government has set a goal that by 2020 school fees for both boys and girls would be removed across all levels of education (Jallow, 2014).

There are a growing number of public sector tertiary institutions, with a number of private institutions offering post-secondary training (DoSBSE, 2006). Costs associated with schooling remain a significant challenge for many families. Infrastructure in rural regions also makes access to schools problematic, especially during the three-month rainy season which makes many roads impassable. A number of interventions have sought to overcome this, including organisations such as Jole Riders, which provide bikes to school children.

Despite a high Gross Enrolment Rate in basic education (92%) in 2014 (UNICEF (EMIS)), the quality of provision and rate of retention is low, with 41.8% of those enrolling in secondary education completing the lower secondary level.





**Fig. 20: A classroom block at the Lower Basic School in Gunjur (Photograph by Lilli Loveday©)**

The 2012 literacy rates remain low at 52% for adults and 60.4% for youth (Table 3). Following The Gambia’s withdrawal from the Commonwealth in October 2013, there were reports of a planned policy change which would shift the country’s language from English to a local (unspecified) language (*Telegraph*, 2014). This would have major implications in schools, which currently teach in English.

Age	Literacy rate % (2012)		
	Total	Female	Male
Youth - 15 24 years	69.4%	65.5%	73.4%
Adult - 15+	52.0%	43.1%	61.4%

**Table 3: Literacy rates by age and gender (World Bank, World Development Indicators, 2012)**

### MADRASSA EDUCATION

Islamic/Arabic Schools, known as Madrassas, are a formal education delivery system in The Gambia, teaching in Arabic and with an emphasis on Islamic content and practice. Children often attend Madrassas prior to joining the basic education, while others attend Madrassas exclusively.

For some, Madrassas play a valuable role in shaping the moral and spiritual development of children, while the formal (Western-modelled) education system is viewed as ‘an instrument of cultural domination’ (UNESCO, undated).

Despite a tradition of male-dominance in the Madrassa system, girls’ education opportunities have reportedly been opened up by Madrassas. The General Secretariat for Islamic/Arabic Education has challenged the misconception that Muslim girls should not go to school, by advocating for female participation in education (Women’s Bureau/UNDP, 2014).

### GENDER PARITY IN EDUCATION

The Gambia has noted considerable progress towards achieving gender parity in enrolment across the education system, with ratios (1 means equal) of girls to boys at primary: 1.01, secondary: 0.96 and tertiary: 0.84 (Ministry of Finance and Economic Affairs, 2014). However, female retention rates beyond secondary level are significantly lower than males.

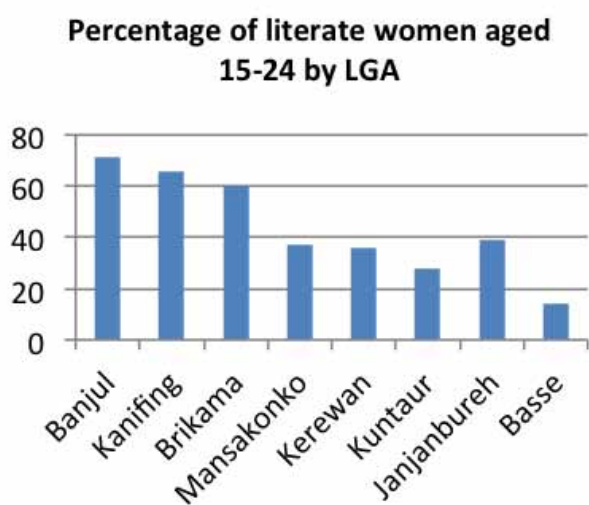
There have been improvements in enrolment ratios in tertiary education (from 0.44 in 1990, to 0.84 in 2014), but challenges persist including a socio-cultural preference for furthering male education and negative gender stereotypes limiting both females’ choices in subject areas and access to higher-level training (Women’s Bureau/UNDP, 2014). A programme has recently been launched by UNICEF called ‘TUSME’ to promote gender equality in education by enabling students to overcome challenges in their academic and social development (UNICEF Gambia, 2013).

Girls’ withdrawal from schools due to early marriage or pregnancy is prohibited, and policy requires pregnant girls to be permitted to return to school after they have delivered (Women’s Bureau/UNDP, 2014). Nevertheless, early marriage (and accompanying household responsibilities), teenage pregnancy and poverty are significant factors contributing to lower rates of female enrolment (Women’s Bureau/UNDP, 2014; Ceesay, 2014). Social shame linked with pregnancy outside marriage may limit girls’ ability to return to school (Gambiabeat, 2013).



There is significant regional difference in education, with girls in rural regions the most disadvantaged. Although advances have been made and females constitute a greater proportion of the literate population, female literacy rates remain low. Figure 21 shows that in Basse, female literacy among women aged 15-24 is the lowest across the country at 13.8%, with the highest rates observed in Banjul (71.4%). The most recent MICS survey found that only 14.1% of women who indicated that their highest level of education was primary school were, in fact, able to read a short sample statement about everyday life given to them to ascertain literacy.

The number of schools located within 3-5kms of communities has increased, leading to reduced security and safety barriers limiting girls' access. However, in some districts (especially in eastern areas) there were still no secondary schools as reported in May 2014 (Women's Bureau/UNDP report, 2014).



**Fig.21: Percentage of literate women aged 15-24 by LGA (MICS, 2010)**

## EDUCATION AND THE MILLENNIUM

### DEVELOPMENT GOALS

#### GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

The Gambia's target is to reduce the proportion of people with an income of less than \$1/day to a level of 15%. Despite significant progress, recent data indicates that in 2010 39.6% of the population were living on less than \$1/day and 48.4% were living on less than \$1.25 (MoFEA, 2014).

#### GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

The Gambia is making significant progress towards the achievement of the second MDG and it is likely that some targets will be met.

#### GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

The goal for gender equality and women's empowerment is measured by three indicators:

1. Attainment of equal access to education at both primary and secondary levels
2. The share of women in non-agricultural paid employment
3. The number of seats held by women in national Parliament. Against the targets

The Gambia achieved equal enrolment at primary level in 2013 (with a ratio of 1.01) (although this does not take into consideration levels of learning attained) (MoFEA, 2014). At secondary and tertiary levels there remains inequality between male and female enrolment rates (MoFEA, 2014). In 2014, the number of women in national Parliament was 9.4% (MoFEA, 2014) against a target of 33% and the number of women in non-agricultural paid work was 20.82% in 2011 (MoFEA, 2013 referencing Africa Gender Index). There is still progress to be made to achieve greater equality and empowerment in Gambian society. This is highly relevant given that FGM is

a manifestation of deeply entrenched gender inequality and constitutes an extreme form of discrimination against women.

## EDUCATION AND FGM

Some studies suggest that for FGM *'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.

Educated girls are better able to resist family and peer pressure and engage with information about the harm of FGM and their rights (UNICEF, 2008). Table 4 shows that The Gambia, unlike other countries in the region, has seen a small increase in the wish for both FGM to continue and the prevalence of FGM among daughters of mothers with a primary education, higher than both no education and secondary +. The increase is small enough that it may fall within the margin of error. What is made clear though is the effect of secondary + education on both measures.

Level of education of the mother	Percentage that want FGM to continue	Percentage of daughters with FGM
None	66.8	43.0
Primary	68.4	45.8
Secondary +	58.5	35.9

**Table 4: The effects on attitude to FGM and prevalence of FGM among daughters by mother's education level (MICS, 2010)**

Since 2011 there have been efforts to include FGM in the curriculum at schools. GAMCOTRAP has built a collaborative partnership with the Ministry of Basic and Secondary Education (MoBSE) to introduce teaching on FGM in the context of rights as one of the life skills components of the formal syllabus. Training was held for teachers in 2011 to discuss the potential problems of FGM and propose inclusion in the syllabus. Following

the event Senior Education Officer, Mrs Awa Saho Jallow of the curriculum department, commented: *'FGM is not only a cultural or traditional practice but also an academic one, which [sic] should devise ways and means of dispatching such information'*. She stressed the importance of providing accurate information on the practice and potential impacts of FGM to children (Sallah, 2012).

As of 2014 MoBSE had reportedly drafted a curriculum and schools had been identified to pilot the syllabus (Women's Bureau/UNDP, 2014).



**Fig. 22: A woman talks about what she learned through Tostan Gambia's CEP (© Tostan)**

## RELIGION

The Gambia is a secular state and its Constitution guarantees freedom of religious expression. The majority of The Gambia's population is Muslim (90%), with approximately 8% Christian and 2% practising indigenous religious beliefs. Of the Muslim population, the majority follow the Sunni denomination and are predominantly Malikite Sufis. The Christian community is predominantly Roman Catholic, although there are several Protestant groups; there is also a small Hindu population and members of the Bahi'a faith (from South Asia). An Inter-Faith Group for Dialogue and Peace exists, with representatives of Muslim, Christian and Bahi'a communities meeting to discuss religious matters.

Intermarriage between Muslims and Christians is common. In matters of marriage, inheritance and divorce, the Constitution recognises Shari'a Law for the Muslim populations, and in cases of intermarriage between Muslim males with non-Muslim females. The practice of Islam and Christianity is often blended with traditional beliefs. One manifestation of this blend is the wearing of *jujus* or *grigris* – protective charms linked with traditional beliefs – that contain written passages from the Qur'an (Mwakikagile, 2010).

Under the Presidency of Jammeh, there has been a shift away from secular Government policies towards a 'Muslim-oriented' policy of state intervention. The Ministry of Religious Affairs has been established (with the President appointed as Minister), and the Supreme Islamic Council has been rejuvenated. Moreover, Qur'anic verses have been inscribed on public buildings and mosques have been built in state institutions. The reformist approach of the current regime has been linked to the Government's efforts to substantiate political legitimacy, as well as serving as a response to their perception of rising immorality (linked primarily to tourism), and in a bid to reinforce the peaceful nature of Islam in response to rising global terrorism (Janson, 2014).



**Fig. 23: A woman breaks from work at the market to kneel for Friday prayers, in observance of the Islamic Holy Day (Photograph by Lilli Loveday©)**

Reports on religious freedom indicate some instances where minority religious groups have been targeted. Ten members of the Ndigal community were arrested and detained in October 2013 for observing Eid al-Adha on a different day than that declared by the Supreme Islamic Council. The Ministry of Basic and Secondary Education also reportedly closed two private schools after they refused to teach Islamic education (US Dept. of State, 2013). There are public calls for religious acceptance, with the country's peaceful status being attributed to its tolerance of different religions (The Daily Observer, 2014).

## RELIGION AND FGM

With an Islamic-majority population, and where religion is thought to be a significant reason for practising FGM, understanding the connection between religion and FGM in The Gambia is crucial. FGM predates the major religions and is not exclusive to one faith. FGM has been justified under Islam, yet many Gambian Muslims do not practise FGM and many agree it is not in the Qur'an.



As the Bible does not mention FGM, Christians in The Gambia who practise FGM do so because of a cultural custom or as a result of marriage to Muslim men. 64.2 % of Muslim men wish to see FGM continue, as do 18.2% of Christians. Figure 24 shows that just over 40% of Muslim men surveyed in the Kaplan *et al.* (2013) study viewed FGM as mandatory to Islam, while 18.8% of Christian men believed FGM is an Islamic mandate.

The large proportion of men from FGM-practising ethnic groups who view FGM as equivalent to male circumcision shows that there is a need to provide education for males on the biological implications of FGM and its health consequences.

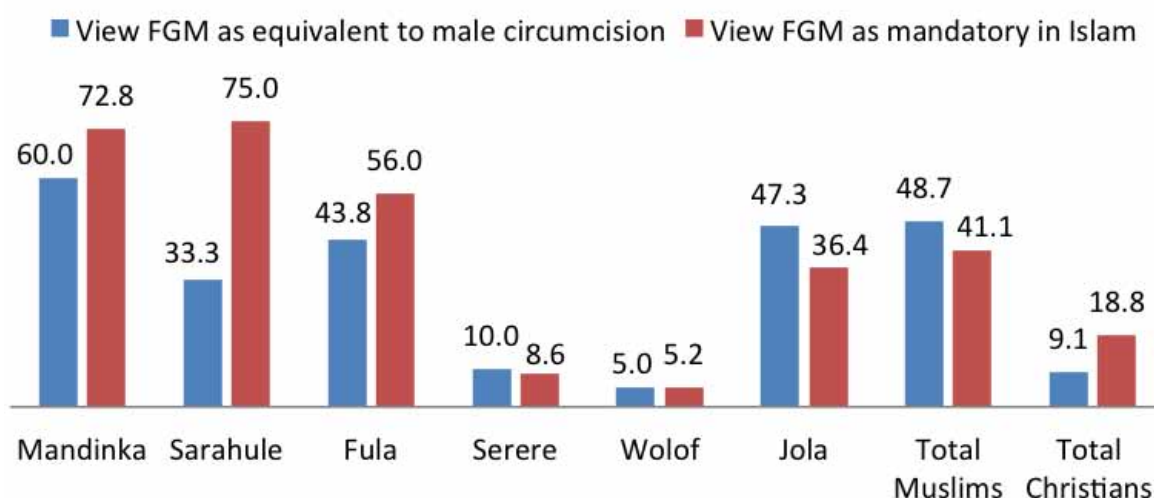
At a Youth Summit held in Banjul in October 2014, Islamic scholar Hama Jaiteh emphasised the importance of addressing the religious arguments justifying FGM. Jaiteh advocated a reassessment of the Qur’anic texts, stating: *‘There is no valid hadith they can bring to support their claims (...). Let everybody go back and read, conduct research. Islam is Islam, it is here to preserve the interests and rights of the woman. This FGM is completely against Islam’* (Topping, 2014).

Opinion amongst scholars of The Gambia’s Supreme Islamic Council is divided, with some arguing that the passages in the Qur’an indicate FGM is not prohibited (and is, therefore, justified), while others argue that it is not promoted and thus is not a religious obligation. There is also division of opinion along ethnic lines, given that most Wolof Muslims in The Gambia do not practise FGM.

The importance of engaging religious leaders in the discussion is well-recognised and is a priority in national efforts to address FGM. The Supreme Islamic Council is engaged in the dialogue on FGM. At an International Forum on HTPs hosted in The Gambia in May 2009, the opening address was supported by the Grand Imam of the Banjul Mosque. The event led to signing of the Brufut Declaration – which committed all those present to working towards abandonment of FGM. It states: *‘religion is often misrepresented to sustain (...) FGM/C’ and urges ‘informed religious scholars be engaged in the movement to end FGM/C’* (Wassu Gambia Kafo, 2009).

Since 2009, forums have been organised for dialogue and discussion amongst organisations, Ministries and the Supreme Islamic Council. In September 2011, a conference of Islamic Scholars

**Percent distribution of men's views on FGM by ethnic group and religious affiliation**



**Fig. 24: Percent distribution of men's views on FGM by ethnic group and religious affiliation (Kaplan *et al.*, 2013c).**

from West Africa was hosted in Mauritania to discuss harmful practices towards women, specifically FGM. The Islamic scholars present agreed that the Islamic principle of 'do no harm' supersedes all others. A Fatwa (religious instruction) was issued to this effect stating: 'the form of FGM/C (...) is not justified and it is prohibited by Sharia' (Wassu Gambia Kafo, 2011). Although two Gambian Islamic scholars present at the conference supported this Fatwa, the Supreme Islamic Council in The Gambia has not (as of March 2015) publicly disassociated FGM from Islam (Jammeh, 2014).



**Fig. 25: A young girl attending the praying ground in Gunjur for Koriteh prayers to mark the end of Ramadan (Photograph by Lilli Loveday©)**

## MEDIA

### PRESS FREEDOM

Media freedom is guaranteed by The Gambian Constitution, but there are significant restrictions on reporting. The Gambia is ranked 152<sup>nd</sup> out of 179 countries in the Reporters Without Borders Press Freedom Index (2013). Journalists and media outlets are heavily controlled and often subject to harassment, intimidation and arrest. Strict laws exist alongside the Constitution, including the Newspaper Registration Act (2004) and the Newspaper Amendment Act (2004). In July 2013, the National Assembly passed an amended Information and Communication Act, introducing higher fines up to GMD 3 million and imprisonment of up to 15 years for anybody found spreading false news on the internet, in country or abroad (RSF, 2014). Determination of whether information is considered 'false' is based on vague definitions, leaving room for sanctioning of legitimate news operations and the justification of arrests.

The Government monitors media outlets and enforces bans on information which is perceived to be 'anti-establishment'. Access to openly dissident online newspapers, such as *The Gambia Echo* and *Freedom Newspaper*, is prohibited. The radio station Teranga was closed down in 2012 and in 2013 the *Daily News* and *The Standard* were ordered to close (Freedom House, 2013). The ban on *Daily News* remains while the others have been lifted (RSF, 2014b).

### MAIN NEWS OUTLETS IN THE GAMBIA

There are both state-owned and independent media outlets in The Gambia. The Government owns one newspaper and there are an additional seven privately-owned printed publications (all published in English) including:

*Gambia Now* (Government-owned); *The Standard*; *The Point*; *The Observer*; *Forayaa*; *The Voice*; *Today*; *The Daily Express*



Online news sources include:

*Jollof News; Senegambia News; The Gambia Echo; Hello Gambia; Freedom Newspaper; Gainako, Kibaaro*

The Government owns and runs the media house Gambia Radio and Television Station (GRTS), which operates the only national television station, Gambia Television. Other international channels are accessible via subscription. The Government also owns GRTS radio and there are an additional eight private radio stations broadcasting in The Gambia (Freedom House, 2014) as well as various online stations (IREX, 2012).

Radio stations include:

Radio Gambia (state-owned); West Coast Radio; Paradise FM; City Limits; Radio 1 FM; Capital FM; BBC World Service; Unique FM; Teranga FM

## ACCESS TO MEDIA

Access varies by media type and by region. Media is more accessible in the urban centres along the coast, with relatively low levels of uptake of printed newspapers in rural regions, given low literacy rates and poor distribution networks. Cost is also a factor limiting newspaper purchases, as well as people's ability to purchase/run televisions and own subscriptions.

The Gambia Television station is widely accessible, while the Gambia Radio Station is limited in some areas. Radio is an important media source and a primary source of information in rural areas. However, given media restrictions, most private radio stations do not produce their own news and are cautious about reporting anything likely to be considered anti-establishment.

Mobile phone usage is high in The Gambia, with over 1.5 million having access to a mobile phone in 2012 (World Factbook). Internet usage was estimated at 12% of the population in 2012 (Freedom House, 2013) and likely to be increasing significantly with a growing boom

in telecommunications and the arrival of 3G accessibility, though variable by region. Despite blocks on various online media outlets the internet is an important source of 'unedited' information and social networking is popular, especially amongst the urban youth (IREX, 2012).

## MEDIA AND FGM

Public campaigns in The Gambia against FGM date back to the 1990s. As media is heavily dictated by the Government's approved 'standards of acceptability' it is important to consider the Government's position on FGM when creating programmes and publications. In 1997, the Vice President indicated Government support to '*discourage such harmful practices*' (Bojang, 1997), while media outlets (primarily radio stations) were forbidden from openly discussing the health-related implications of FGM and delivering advocacy messages against the practice (Equality Now, 1997). Although this ban was subsequently lifted, evidence indicates that NGOs using media for advocacy against the practice still face restrictions. The Gambian Radio Station, for example, still limits broadcasts explicitly addressing FGM (as of 2013).



**Fig. 26: CEP participant, Sambang Juwara from Kerewan, leads women in singing about the positive changes in their communities at the closing ceremony of the Youth Caravan in Sutukonding (© Tostan, Photograph by Lilli Loveday)**

There are, however, success stories in media campaigning on FGM. In 2010, the campaigning organisation GAMCOTRAP organised a capacity building workshop for media practitioners on

HTPs and domestic violence. Thirty journalists and reporters from radio stations, print media and online news outlets, as well as the Gambia Press Union, received training on how to report on FGM (GAMCOTRAP, 2010). Newspaper publications have included reports on FGM-related activities and events, including of the Youth Forum on FGM in October 2014 (*The Point*, 2014), at the launch of 'The Girl Generation Campaign', and of public declarations of abandonment, such as 'Gambia: 21 Serahuleh Communities Abandon FGM in URR' (*The Daily Observer*, 2013b).

Others have presented sides of the debate, with *The Point* (2014b) publishing an article entitled, 'FGM: should we 'drop the knife' or hold on to it?' In addition in The Gambia's Upper River Region radio programmes that discuss FGM/C, among other topics, have become popular with some 220,000 listeners who often call in to discuss and debate the practice. These radio programmes have reportedly contributed to a decline in public support for FGM/C and child marriage in the region.

A new media campaign 'EndFGM' was launched in The Gambia on 30 January 2015 by *The Standard* Newspaper (headed by Sainey Darboe, Editor). This is a collaborative campaign with UNFPA, Think Young Women and Safe Hands for Girls, The Girl Generation and *The Guardian* Global Media Campaign based in the UK. *The Guardian* launched the global campaign in the UK in 2014 to 'amplify the work being done by grassroots activists and campaigners trying to work towards the end of Female Genital Mutilation' (*The Standard*, 2015).

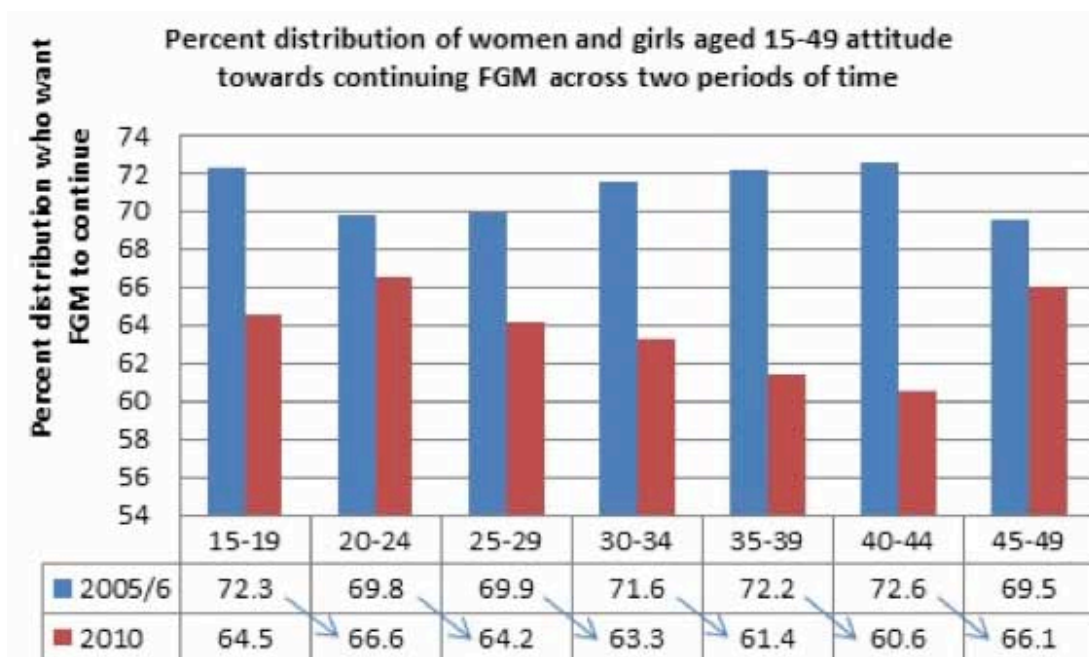
## ATTITUDES AND KNOWLEDGE RELATING TO FGM

Various studies have been undertaken in The Gambia, providing a picture of the attitudes and knowledge among various groups in relation to FGM. The largest survey data available of FGM prevalence and attitudes is the MICS, with results from the DHS Survey in 2013 forthcoming. The MICS 2010 provides a review of women's knowledge and attitudes towards FGM, but not men's. According to MICS 2010 99.7% of women surveyed (a total of 14,685) had heard of FGM, demonstrating high levels of awareness of the practice among women.

There are two ways to make comparisons between the age data sets gathered by MICS 2005 and MICS 2010 to measure the change of opinions of whether FGM should continue. The first is a straight comparison between the age cohorts in 2005 and 2010. Figure 27 shows a decline across all ages of women and girls in wanting FGM to continue. The least change is found in the age cohorts of 20-24 year olds and 45-49 year olds between 2005 and 2010. Older women (except the oldest group surveyed) showed that they changed from being the group who most wished to maintain the practice to a group that wish to see it abandoned more than younger cohorts.

This shows an age specific change in attitude, but it is also possible to make a tentative comparison between the shifts in opinion within a cohort as it ages. This is not an exact figure as comparisons between surveys are not completely accurate, but it highlights a trend in all age sets that women who previously wished to see FGM continue have reported a change in attitude (highlighted by arrows in Figure 27). The largest shift in attitude is found in those aged 30-39 in 2005 (71.9%) and aged 35-44 in 2010 (61%).

There is significant variation among women from different economic backgrounds regarding the continuation of the practice, with the highest number of women believing that FGM should



**Fig. 27: Percent distribution of women’s and girls’ (aged 15-49) attitudes towards continuing FGM across two periods of time (MICS 2005/6 and 2010)**

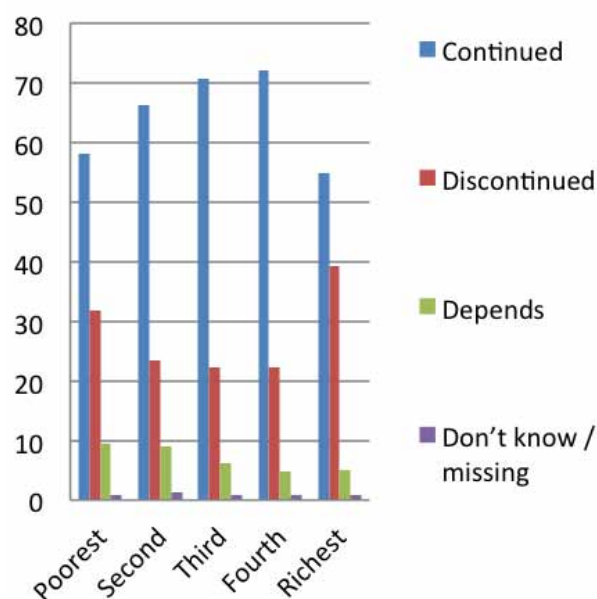
continue from the fourth richest quintile. The poorest and richest quintiles have the lowest response rate in favour of continuation of the practice (58% and 54.9% respectively).

Though the wealth quintiles could be acting as proxy for other determinant factors, such as ethnic group or education, there is a clear pattern shown in Figure 28 which warrants further investigation. Figure 28 highlights that the wealthier the women became (up to the very wealthiest) the stronger their desire to see FGM continue and the less doubt they had, reflected in the fall of ‘it depends’ category. Rural or urban location has little influence on whether women believe the practice should continue or not, with only a 1.2% difference between urban women’s support for FGM (63.6%) and rural women’s (64.8%).

Table 5 shows that the variation among women from different ethnic backgrounds regarding the continuation of the practice is pronounced, with 72.2 percentage point difference between the Mandinkas (representing the highest rate of support for continuation at 83.9%) and the Wolofs (representing the lowest rate of support for continuation at 11.7%).

There is also a high rate of support among the Sarahule, the Bambara, the Fula and the Jola. The number of women who reported that continuation depends (on un-named factors) is high among some groups, but present among all and offers scope for intervention.

**Percent distribution of women who believe the practice should continue by wealth quintile**



**Fig. 28: Percent distribution of women who believe FGM should continue, presented by wealth quintile (MICS, 2010)**

Though not comparable to the scale of the MICS survey, a study undertaken by Kaplan *et al.* (2013) explores the attitudes and knowledge of male respondents to FGM. Their findings show that among men aged between 16 and 60+ years old, 70% indicated that FGM took place in their family/ household, while lower rates (39%) were able to state the age at which FGM was performed.

Ethnicity of household head	Percent distribution of women and girls (aged 15-49) who believe the practice should be:			
	Continued	Not continued	Depends	Don't know/missing
Aku/Crole/Marabou	13.7	82.0	4.4	0.0
Bambara	76.5	17.2	4.7	0.3
Fula/Tukulor/Lorobo	70.3	22.9	6.0	0.9
Jola/Karoninka	72.6	21.3	5.3	0.8
Mandinka/Jahanke	83.9	12.1	3.5	0.5
Manjago	16.6	65.8	16.0	1.6
Sarahule	81.5	12.9	5.4	0.2
Serere	35.6	54.3	9.3	0.8
Wolof	11.7	70.8	14.7	2.8
Total	64.2	28.2	6.6	1.0

**Table 5: Percent distribution of women and girls on the different views of continuing FGM, presented by ethnicity of the household head (MICS, 2010)**

Under a third of men reported knowing of any related health consequences (28.3%). Figure 29 shows that over half of the men believed that men have a role to play in preventing FGM (51.6%), while 34.8% of those that reported that FGM took place in their household said they had a role to play in the decision-making. The majority (60.9%) of respondents said they would have their daughter cut, and 61.8% agreed that FGM should be continued. There is significant variation

in attitudes regarding the continuation of FGM among men from different ethnic backgrounds, with the variation between different ethnic groups corresponding to that recorded for women.

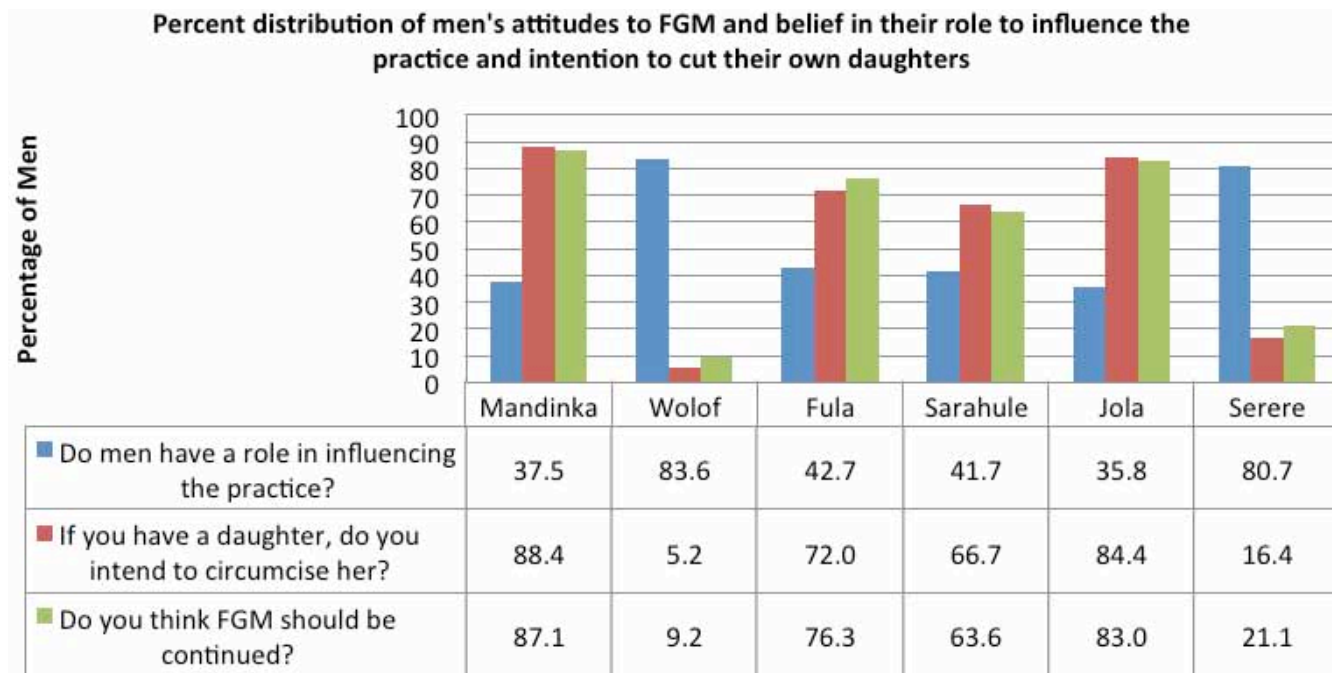
The Mandinka men reported the highest rate of support for the practice compared to the Wolof who reported the lowest (9.2%). However, across ethnic groups the men with the highest awareness of health impacts of FGM were the least likely to support its continuation.

Figure 29 shows a discrepancy between men's attitudes to whether the practice should continue in general and their attitude towards cutting their own daughters. Among the Mandinka, Sarahule and the Jola, a higher percentage of men said they intend to cut their daughters than wanted the practice to continue. Conversely, among the other ethnic groups (Fula, Wolof and Serere) more men wanted to see the practice continue but did not intend to cut their own daughters. Further research is needed to understand these findings.

## REASONS FOR PRACTISING FGM AND ITS PERCEIVED BENEFITS

FGM is a social norm and a deep-rooted cultural tradition, often enforced by community or peer pressure and the threat of stigma. Norms are distinctive in that they determine the 'informal rules of the game' and are accompanied by associated social benefits as well as social sanctions. Although communities in The Gambia in which FGM is found have different specifics around the practice, within each practising community it manifests deeply entrenched gender inequality. The reasons behind FGM in The Gambia are complex and multifaceted with various reasons justifying its continuation, and these reasons are explored below.





**Fig. 29: Percent distribution of men's attitudes to FGM and belief in their role to influence the practice and intention to cut their own daughters (Kaplan *et al.*, 2013)**

The MICS does not record the reasons why FGM is practised. However, a study undertaken by Shell-Duncan *et al.* of women in rural and urban communities in The Gambia highlights the advantages (and disadvantages) associated with the practice (Shell-Duncan *et al.*, 2010). Evidence indicates that women believe FGM is most closely associated with the observance of tradition (93%), with demonstrating respect to elders (88%) and with cleanliness (82%). There is also a belief that FGM enables a young girl to ‘know the eye’ – an expression meaning that a girl has been indoctrinated into the social hierarchy (and learnt the associated respect patterns and rules of interaction). The data is not disaggregated by ethnic group.

Figure 31 shows that few women agreed with most of the reasons given against FGM. The majority of women acknowledged that it is extremely painful (87%), with a proportion (47%) linking the practice to the occurrence of tetanus and to causing heavy bleeding (47%), but the link to transmission of HIV caused uncertainty. It has been found that making a link between HIV and FGM has proved a useful way to allow communities to change their practice because the newness

of the threat of HIV means it does not imply the tradition was ‘wrong’, only that the situation has changed.

Only a minority (10%) believed FGM can cause problems during child birth and there was uncertainty and disagreement regarding the impact of FGM on male sexual satisfaction, with only 10% agreeing that men enjoy sex more with uncut women and the majority (56%) stating they were unsure. This last point raises questions for further research to ascertain if it is important for women to believe they are meeting men’s sexual preferences and therefore fulfilling men’s sexual satisfaction by undergoing FGM.

There is no systematic analysis among men of the perceived benefits of FGM, although anecdotally there are indications that men believe FGM to be necessary in order to stop the clitoris from ‘growing too long’ (in-country research). The president of the Supreme Islamic Council, Muhammed Alhajie Lamin Touray, is reported to have commented: ‘*the clitoris makes a woman itch, making her want to scratch all the time and [I’ve heard] that the clitoris makes water leak from her private parts*’ (Lloyd-Roberts, 2013).



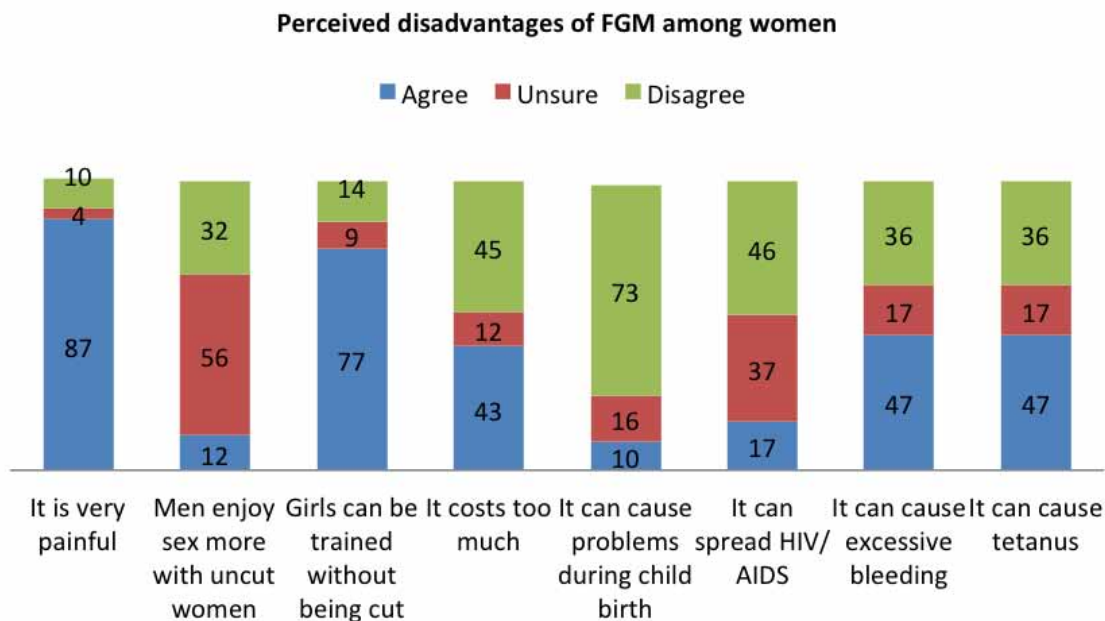


Fig. 30: Women's responses of their views about a range of advantages of FGM (Shell-Duncan *et al.*, 2010)

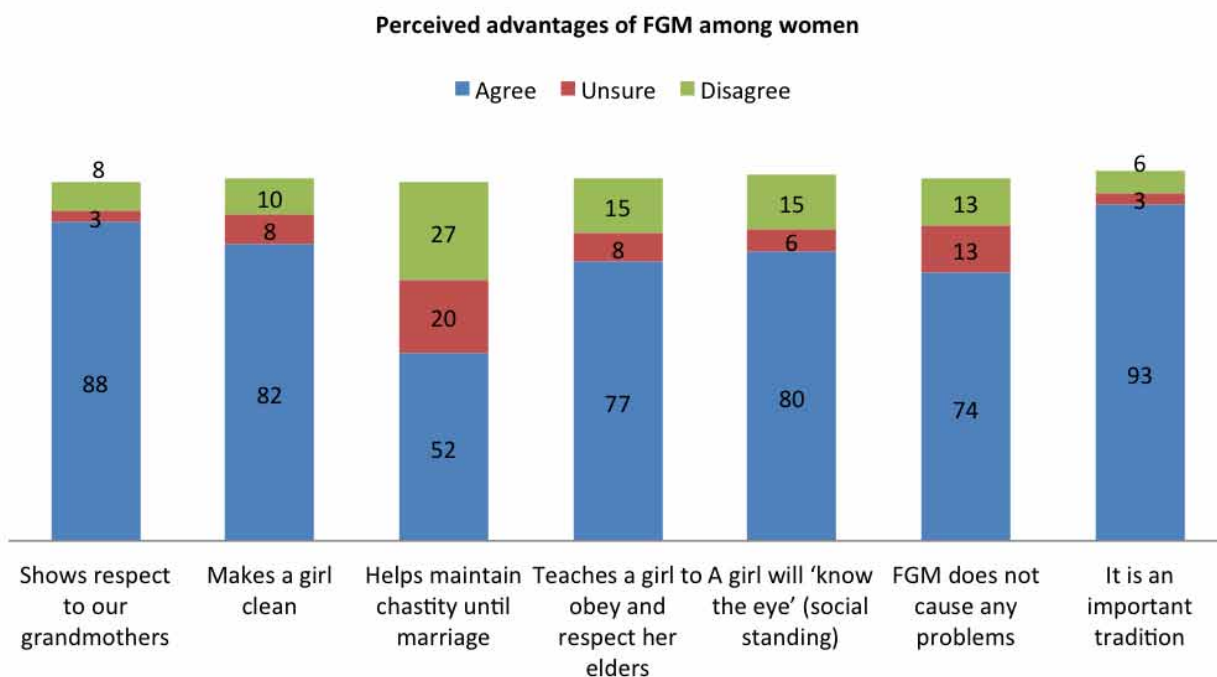


Fig. 31: Percent distribution of responses by women of their views about a range of disadvantages of FGM (Shell-Duncan *et al.*, 2010)

However, during interviews with male participants of an NGO intervention programme in the Upper River Region, a number reported that FGM creates marital discord and unhappiness, making sexual intercourse problematic. One

interviewee indicated that this can be a powerful motivation for triggering change in the practice given the social shame associated with divorce (in-country research).

## SOCIAL ACCEPTANCE /CULTURAL IDENTITY

FGM is viewed as an integral step towards becoming a socially-defined woman and is a means of preserving dignity and ensuring good social standing (Hernlund, 2000). In a study carried out in the 1990s a young girl from The Gambia was asked why she had been cut, responding ‘it has been done to our mothers, and our mothers did it to us, and we will do it to our children’ (Walker and Parmar, 1993). FGM is seen as a way of both honouring elders and instituting the established relationships between girls and their community (what is referred to as ‘knowing the eye’).



**Fig. 32: Aja Drummeh and her mother Isatou Fatty, celebrate the first International Day of the Girl in 2011 (@Tostan, Photograph by Lilli Loveday)**

Elder women are central to the process because they gain the respect of younger women by undertaking the practice and further assert their authority through perpetuating the tradition. Therefore, the benefits are considered to be both for the girl being cut as well as others in the community. The wider social significance is evidenced by the fact that grandmothers (maternal and paternal) are regarded as the main decision-makers on whether FGM takes place, or not (Shell-Duncan *et al.*, 2010).

In an earlier study Hernlund (2000) also links the practice to the resource-scarce nature of The Gambia, highlighting that in resource-poor areas, where women (and men) rely more heavily on one another both socially and economically, the importance of the peer convention is amplified.

Heavy reliance on one another means that nobody wants to do anything which might mean that they are shunned from society.

A recent study undertaken by Bellemare *et al.* appears to contradict the social convention theory as applicable to The Gambia, indicating that the driving force is ‘all within the family’, rather than the community at large (Bellemare *et al.*, 2014). The study compares data from Senegal (using 2010/2011 DHS data) and The Gambia (drawing on MICS 2005/2006 data).

By analysing the relationship between whether a woman reports having undergone FGM and whether she supports continuation of the practice, and quantifying the contribution of individual, household, and village/wider-level factors, the study assesses why FGM persists. The study reports that in The Gambia, 85% of the relationship between FGM status and support for the practice can be explained by individual and household factors (i.e. is driven within the family), with only 15% attributable to the village level and beyond (i.e. is driven by the community). This is versus Senegal, where 49% of the relationship is explained by factors at the village level and beyond.

The report asserts that interventions in The Gambia should be targeted at the individual/household level as opposed to being targeted at the wider community, and uses this data to explain why village-level campaigns have been successful in Senegal but not had the same impact in The Gambia. Following these findings, it would be anticipated that a ‘tipping point’ model of norm change could be followed, with an initially small number of individual-level decision-makers followed by more widespread abandonment.

## The power of *solima* and social sanctioning others

Uncut women are labelled as *solima* – a loaded term which implies that the woman is not only uncut but is also rude, ignorant, unclean and lacks maturity and civilised behaviour. *Sollima* is highly derogatory and considered a loaded, serious insult (Shell-Duncan *et al.*, 2010; Hernlund, 2000; Afri Group Consult, 2010).

Not being cut carries significant social sanctions, with the social threat of being ostracised and isolated. These last throughout a woman's life and bring shame and embarrassment, with uncut women being prohibited from attending certain ceremonies, including their own daughter's cutting. This is a socially-powerful motivation for adult women to be cut. The isolation and negative terming associated with being uncut is counteracted by the feelings of belonging and acceptance once cut, signifying the power of the social drivers.

*'[E]ven the children insult their mates who are not circumcised as solema...At times you will see those children crying bitterly...they will not stop complaining to their mothers. In this way the mother will end up taking the daughter to circumcision. If not, neither mother nor the child will be at ease or comfortable.'*

- Middle-aged woman (quoted in Hernlund and Shell-Duncan, 2007)

The study is statistically significant, but acknowledges that the definition of persistence is narrow and that estimates are suggestive rather than perfectly identified. Findings are also based on now 'out-of-date' data, with various interventions and wider debates on FGM having taken place in The Gambia in the period since 2005/2006. Further research is needed to compare findings between 2005/2006 and 2010 MICS data to understand whether the 'tipping point' model is being observed.

### CLEANLINESS/PRESERVATION OF VIRGINITY AND BETTER MARRIAGE PROSPECTS

Maintaining cleanliness and hygiene are considered to be important benefits of FGM in The Gambia, and it is also linked with preserving a girl's virginity before marriage. People have the belief that removal of the clitoris controls female

sexual desire, a factor which is exacerbated in a predominantly Muslim society with Islam often viewing '*female sexuality [as] potent*' '*with a predilection to create havoc and chaos in the male*' (Haddad, 1998).

Cleanliness is also linked to the requirements of Islam, with uncut women often considered to be unclean and therefore unable to offer prayers to Allah.

Shell-Duncan *et al.* (2010) used quotes from men to illustrate the participants' views of uncut women as being out of control of their sexual desire: '*If a woman is not circumcised, she will be in the habit of requesting sex always. If the husband is tired of that, he may divorce her. After divorce, she will be lonely and that will lead to prostitution*'. Similarly, '*The more you are not circumcised, the more you are addicted to sex*' (Shell-Duncan *et al.*, 2010).

Marriageability is not considered to be a significant direct factor in the decision making around FGM. However, the links of FGM to perceived social acceptability, and the belief that girls who have been cut have been taught to obey, could indirectly secure opportunities for marriage.

### RELIGIOUS REQUIREMENT

FGM is perceived to be an Islamic requirement by many, although it is also practised by some Christian communities. This is true for Gambian males and females, with nearly half (46.2%) of the men surveyed by Kaplan *et al.* (2013) considering the practice to be mandatory under Islam. This perception, however, varied significantly across ethnic groups: Mandinka – 72.8%, Wolof – 47%, Fula – 56%, Sarahule – 75%, Jola – 36.4% and the Serere – 10.3%. In another study it was reported that 80% of women regard FGM as an Islamic *sunna* (duty), rather than a *farata* (obligation) 20%, but there is a belief that practising FGM demonstrates special piety (Shell-Duncan *et al.*, 2010).

## LAWS RELATING TO FGM

### INTERNATIONAL & REGIONAL TREATIES

The Gambia has signed, though not always 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 The Gambia 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) (ratified in 1993)
- Convention on the Rights of the Child (CRC) (ratified in 1990)
- Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the 'Maputo Protocol') (ratified in 2005)
- Universal Declaration on Human Rights (UDHR)
- International Covenant on Civil and Political Rights (ICCPR) (accession 1979) and optional protocol (accession 1988)
- International Covenant on Economic, Social and Cultural Rights (ICESCR) (accession, 1978)
- African Charter on the Rights and Welfare of the Child (ratified in 2000)
- African Charter on Human and People's Rights (the 'Banjul Charter') (ratified 1983)

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

In December 2012 the UN passed an historic and unanimous resolution, calling on countries to eliminate FGM, and in 2013 the 57<sup>th</sup> 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, The Gambia 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 para-medicalisation 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

The age of suffrage is specified in the Constitution as 18, and is provided for under Article 26.

The Constitution does not detail age of sexual consent, and it is not made explicit in the Children's Act, though is understood to be 18 under Article 27 (Children's Act, 2005; African Child Policy Forum, undated).

In Article 27 no legal, minimum age of marriage is specified. However, the Children's Act 2005 prohibits a child (under 18) from contracting a valid marriage and parents/guardians/others from giving a child in marriage (Children's Act, 2005: Articles 24 and 25). Four types of marriage are recognised (Mohammedan (governed by Shari'a Law), civil, Christian and customary). Recognition under Article 7 means that cases of early and forced marriage are observed with some girls married as young as 12, since Customary Law does not specify any minimum age (UN Economic Commission, undated).

### CONSTITUTION

The 1997 Constitution does not provide specific provision against FGM. It recognises the fundamental rights of individuals, stating at Article 17 (2) that *'Every person in The Gambia, whatever his or her race, colour, gender, language, religion, political or other opinion, national or social origin, property, birth or other status, shall be entitled to the fundamental human rights and freedoms of the individual contained in this Chapter'*.

Given the various physical and psychological implications of FGM, it could arguably be considered a violation under these provisions.

### NATIONAL LAWS AGAINST FGM

FGM is not explicitly illegal in The Gambia. This is despite the requirement under Article 4 (2) of the Maputo Protocol that state parties (The Gambia being a signatory) enact specific legislative measures to eliminate FGM.

Several policies detailing protection from HTPs have been elaborated by the Government. Article 19 of the Children's Act 2005 states: *'no child shall be subjected to any social and cultural practices that affect the welfare, dignity, normal growth and development of the child and in particular, those customs and practices that are prejudicial to the health of the child, discriminatory to the child on the grounds of sex or other status'*. The Women's Act (2010) prohibits all forms of gender-based violence, including HTPs and the National Gender Policy 2010-2020 has a specific objective to: *'lobby for the elimination of all forms of discriminatory and harmful sexual and cultural practices'* (Objective 5) (Women's Act, 2010; National Gender Policy 2010-2020). Despite this, the law does not specifically mention FGM.

FGM could, arguably, be considered a violation of the law under sections 210 and 212 of Chapter XXII ('Offences Endangering Life and Health') of The Gambia's Criminal Code. Section 210 states that any person aged above 16, with responsibility for a child under the age of 14, found to have treated or exposed a child to unnecessary suffering or injury and Section 212 refers to the unlawfulness of causing grievous harm to any person.

### LEGAL SYSTEM AND LAW ENFORCEMENT

The Gambia's legal system is based on English Common Law, Customary Law and Shari'a Law. Provision in the Constitution for Customary and Shari'a Law allows for justification of HTPs.

Despite mounting pressure for specific legislation outlawing FGM in The Gambia, and the preparation of a draft Bill on FGM, it is yet to be passed into law. Reluctance to make explicit the illegality of FGM is highlighted by the fact that specific references protecting women and girls from FGM were removed from the Children's Act 2005 and the Women's Act 2010 before they were enacted (Global Fund for Women, undated). The Female Lawyer's Association Gambia (FLAG) is looking at bringing a test case on FGM using the Children's Act, and is working with the support of GAMCOTRAP.

For new Bills to be signed into law, the Constitution states that the Bill must be made public on at least two occasions, that it must be supported by the votes of at least three quarters of the National Assembly members and that it must be approved by the President (Article 226, Constitution, 1997). The President has issued statements in support of FGM (see Challenges section), and various members of the National Assembly have publicly advocated for continuation of FGM. However, the Vice President, Aja Isatou Njie Saidy, has spoken in favour of reform, while noting the challenges of bringing about change and the need for the Government to be convinced of the empirical evidence on the harmful effects of FGM (FGM Network, 2009).

## INTERVENTIONS AND ATTEMPTS TO

### ERADICATE FGM

#### BACKGROUND

Efforts have been made to address FGM since the mid-1980s, when the first campaigning group with a specific focus on HTPs, including FGM, was established. NGOs are encouraged to exercise high levels of sensitivity in their activities, with their work closely monitored. In 2010, the NGO Affairs Agency was moved to within the Office of the President. All NGOs are required to conform to Government development plans and the constraints have led many NGOs to limit their activities or exercise caution in publicising their work (Frontline Defenders website).

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, GAMCOTRAP, 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.

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. The organisations with a specific focus on FGM – or with a significant profile working more widely across the country on related issues – are profiled in the section on INGO/NGO interventions, and Appendix I provides a more complete list of organisations. Organisations collaborating or supporting interventions to promote the abandonment of FGM are also detailed.

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.



**Fig. 33: A woman dances in celebration at an Interzonal meeting in The Gambia (© Tostan, Photograph by Lilli Loveday)**

### GOVERNMENT POLICY AND SUPPORT

The Government holds an ambiguous position on ending FGM (as highlighted elsewhere in this report). Though several actions have blocked aspects of NGO programming, the Government are working with the UNJP towards abandonment. The United Nations High Commissioner for Refugees (UNHCR) noted in January 2015 that *'The Gambia was careful about legislating against the practice of female genital mutilation because this would drive the practitioners underground and it had in place a national plan of action against female genital mutilation'* (UNHCR, 2015).

This may be one reason why there is no law. However, it is also known that as long as religious leaders are opposed to ending FGM, the Government will continue to be cautious on the issue.

### ANTI-FGM INITIATIVES NETWORKS

Typically, NGO efforts in the campaign against FGM in The Gambia have been undertaken by a loose network of NGOs, with low accountability and limited political responsibility. In order to strengthen coordination, tracking of results and monitoring of progress, the Women's Bureau and Ministry of Women's Affairs have developed a National Plan for Accelerated Abandonment of FGM – an effort to coordinate the activities of development partners working to protect the rights of women and girls.

This effort has been supported by the UNICEF/ UNFPA Joint Programme and includes as a target the passing of legislation on FGM (UNDP/Women's Bureau, 2014). They also led the National Steering Committee on Gender Based Violence.

### OVERVIEW OF INTERVENTIONS

A Situational Analysis carried out by the Afri Consult Group in 2010 (Afri Consult Group) shows preliminary indications that individuals involved in FGM-related NGO programmes (either directly, or indirectly) are more likely to view the practice as harmful compared to those with no direct involvement (84% against 15.9%, respectively).

The report also highlights the need to understand the underlying drivers of FGM and to exercise caution in equating reporting of abandonment to actual change in terms of observed practice. There is evidence that FGM is continuing even in communities where it has reportedly been stopped.

It may be a case that participants 'know the right thing to say', given the increased prominence of FGM and as a reaction to the perceived attacks on culture/tradition from the 'outside'. The Situational Analysis highlights this, with one respondent from an NGO intervention community stating: *'they (NGOs) are trying to fool us but we are wiser than them. We will chop (eat) their money and yet continue to circumcise our daughters.'*



A broad range of interventions and strategies have been used by different types of organisations to promote abandonment of FGM in The Gambia. Often a combination of the interventions and strategies below are used, profiled below. It should also be noted that some organisations refer to old District names, which included in parentheses in Figure 4 on page 19.

**HEALTH RISK/HARMFUL TRADITIONAL PRACTICE (HTP) APPROACH**

Strategies that include education about the negative consequences of FGM have been the most frequently used globally for the eradication of FGM. Informing communities and individuals of the health risks associated with FGM has been a key component of the majority of the interventions in The Gambia.

Convincing people in areas of high FGM prevalence of the health problems can, however, be a challenge. Difficult childbirth and long post-partum recovery periods, which are often exacerbated by FGM, are often seen as the norm. Communities may not, therefore, attribute the complications of FGM to the procedure itself (Winterbottom, 2009). Organisations working with this strategy are Wassu Gambia Kafo (working not in the community but with healthcare providers and the Government), Safe Hands for Girls, APGWA, Future in Our Hands, Tostan and ActionAid.

**ADDRESSING THE HEALTH COMPLICATIONS OF FGM**

This intervention is used by BAFROW in their Well Woman clinics in several areas of The Gambia; they also run a fistula repair clinic. The work of Wassu Gambia Kafo is directed at research into the health complications in The Gambia from FGM and the training of medical staff and students of health sciences.



**Fig. 34: Wassu Gambia Kafo training for nursing students (© Wassu Gambia Kafo)**

**EDUCATING TRADITIONAL EXCISORS AND OFFERING ALTERNATIVE INCOME**

Although initiatives with FGM practitioners may be successful in supporting excisors in ending their involvement in FGM, they do not change the social convention that creates the demand for their services. Such initiatives may complement approaches that address demand for FGM, but alone they do not have the elements necessary to end FGM (UNICEF, 2005). APGWA, Tostan and GAMCOTRAP all use this method of intervention detailed below in their profiles.

**ALTERNATIVE RITES OF PASSAGE (ARP)**

For those ethnic groups where FGM is part of a rite of passage initiating girls into adulthood, one approach that has shown some success is Alternative Rites of Passage (ARPs). ARPs substitute the cutting part of the ceremonies with alternative rituals that preserve the cultural traditions but eliminate the cutting.

The success of ARPs depends on the group practising FGM as part of a community ritual, such as a rite of passage. In addition, ARPs will have limited impact unless they are accompanied by education which engages the whole community in collective reflection and leads to changes in the expectations of community members. The use of ARPs is further limited by the trend for



communities to cut girls at a younger age and with less ritual (UNICEF, 2005). Two NGOs run ARP programmes in The Gambia, APGWA and BAFROW, and they not only maintain the cultural training part of FGM practices but also keep the social position of traditional cutters intact.

### RELIGIOUS-ORIENTED APPROACH

A religious-oriented approach refers to approaches which demonstrate that FGM is not compatible with the religion of a community, thereby leading to a change of attitude and behaviour. Community-based initiatives emphasise the inclusion of village elders and religious leaders, in order to ensure their engagement with the dialogue and discussions.

APGWA, Tostan, Wassu Gambia Kafo, GAMCOTRAP all work with religious leaders, organising events to engage them in discussions, education and debate. The strength of the religious pro-FGM lobby makes this intervention of particular relevance in The Gambia.

### LEGAL APPROACH

This approach consists of lobbying the Government to enact legislation against FGM and advocating for effective enforcement of such legislation. Both GAMCOTRAP and the Child Protection Alliance (CPA) lobby the Government to pass legislation against FGM and to include it specifically in the Children's Act (2005). FLAG also work to promote awareness of existing frameworks protecting women's rights and was involved in the formulation of the draft FGM Bill for Parliament.

### RIGHTS APPROACH/ 'COMMUNITY CONVERSATIONS'/ INTERGENERATIONAL DIALOGUE

A rights-based approach acknowledges that FGM is a violation of women's and girls' rights. This approach is sometimes used alongside other strategies to address FGM, based on the social abandonment theory of FGM (derived from the social change theory behind foot-binding in China) (Mackie, 1996). The components of this theory

include: (i) a non-judgemental human rights approach; (ii) community awareness-raising of the harmfulness of the practice; (iii) a decision to abandon FGM that is a collective decision by the entire community; (iv) the requirement of community public affirmation of abandonment; (v) intercommunity diffusion of the decision; and (vi) a supportive change-enabling environment, including the commitment of the Government (Wilson, 2012/13).

This approach was pioneered by Tostan in Senegal (UNICEF, 2005). It is based on the principle of listening and questioning between different generations, aided by a facilitator. It enables participants to reflect on their values, customs, traditions and expectations and to consider whether, when, how and under what conditions change should take place (GIZ, 2011). Both Tostan and BAFROW use this intervention extensively.



**Fig. 35: A community elder at a village meeting in Mansajang, Upper River Region. Elders hold important decision-making positions and are specific targets for efforts to promote abandonment of FGM (Photograph by Lilli Loveday©)**

## PROMOTION OF GIRLS' EDUCATION TO OPPOSE FGM

Education may be the best long term strategy for ending FGM (see Education section). Many NGOs engage schools with awareness raising programmes on child rights and the dangers of FGM. Future In Our Hands, for instance, have a school development programme and also run education programmes on women's rights, and Tostan runs its Community Empowerment Programme (CEP).



**Fig. 36: SEGRA Training at Tabajang Lower Basic School in URR ©Future in Our Hands (Facebook page)**

## MEDIA AND COMMUNICATION

Within The Gambian context of limitations on media freedom, some organisations do use media networks to promote anti-FGM activities. The use of traditional media such as griots is well understood and utilised by a number of NGOs (see page 25). UNFPA supported APGWA in training traditional communicators, including developing video materials for dissemination as a tool for further sensitisation and awareness-raising. Safe Hands for Girls and GAMCOTRAP have developed this intervention as outlined below and Tostan works with radio programmes to reach communities with their message.

## WORKING WITH MEN AND BOYS

Many NGOs in The Gambia understand that changing social traditions should involve all

members of a community not just women and girls. Men and boys are explicitly included in the programmes of Tostan, APGWA, GAMCOTRAP, Safe Hands for Girls and Future in Our Hands. Details of their work are given broadly in the NGO specific profiles below.



**Fig. 37: A boy speaks at the third annual Tostan Gambia Youth Caravan in the URR (©Tostan, Photograph by Lilli Loveday)**

## INTERNATIONAL ORGANISATIONS

### ACTIONAID / ACTIVISTA

ActionAid has worked in The Gambia since 1979; its programmes target four thematic areas: health, education, water and livelihoods. Through its Women's Rights programme, ActionAid works with communities to talk about the damaging effects of FGM. It provides training for TBAs, sets up forums for discussing girls' rights and the health risks of FGM.

With funding from the Global Fund, Activista (the youth activist affiliation of ActionAid) has also organised awareness raising events (Activista website). In November 2014, they organised a workshop on gender based violence, with speakers highlighting the negative consequences of FGM. FGM was included as part of a broader focus on gender and violence, with HIV/AIDs as well as other health and rights issues simultaneously discussed (*Foroyaa Newspaper*, 2014). ActionAid and Activista prepared an educational video on perspectives on FGM in recognition of International Women's Day 2014.

### AFRICAN CENTRE FOR DEMOCRACY AND HUMAN RIGHTS STUDIES (ACDHRS)

The African Centre for Democracy and Human Rights Studies (ACDHRS) has its headquarters in The Gambia. The ACDHRS undertakes various activities, serving as a bridge between NGOs, government and the public. It works to promote NGO networking (and in this role has offered to head up a new network of anti-FGM activists), institution building, leader training and education activities, disseminate information on the activities of human rights bodies, and undertaking research on human rights in Africa. An NGO Forum takes place twice a year, providing a platform for discussion among like-minded organisations (ACDHRS website).

## EQUALITY NOW

Equality Now advocates for women's and girls' rights through global and grassroots activism. Equality Now was established in 1992 and has a global Action Network of more than 35,000 members across 160 countries. FGM is a key focus area of campaigning, along with sexual health rights and equality. While Equality Now does not have a physical presence in country, it supports awareness raising activities on FGM issues through its online and global advocacy efforts. Equality Now reported on the Gambian Government's censorship of media efforts around FGM and called for global action to support the release of the GAMCOTRAP campaigners (see below) (Equality Now website).

### GLOBAL FUND FOR WOMEN

The Global Fund for Women aims to advance women's and girls' rights worldwide by supporting campaigns, service interventions and education efforts, including securing women's and girl's access to sexual and reproductive health rights. They fund activities which challenge laws, policies, cultures and behaviours that perpetuate violence and discrimination against women. In The Gambia, the Global Fund for Women has awarded six grants to GAMCOTRAP since 1997 totalling some US\$115,000. This funding has supported training and information campaigns for FGM practitioners and TBAs and an initiative to dispel links between Islam and FGM (Global Fund for Women website).

### INTER-AFRICAN COMMITTEE ON TRADITIONAL PRACTICES (IAC)

The Inter-African Committee on Traditional Practices (IAC) is an umbrella body based in Addis Ababa and Geneva, with national chapters in 29 African countries. It has been working on policy programmes to stop FGM for the last 28 years. The IAC collaborates with international organisations, including partnerships with UNFPA, WHO and UNICEF.



IAC programmes 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. GAMCOTRAP is the IAC national committee member for The Gambia (profiled below).

### **FUTURE IN OUR HANDS (FIOH)**

Future in Our Hands (FIOH) is a Swedish-based organisation operating since the 1980s, working on rights-based rural development in The Gambia. Intervention areas include: governance and organisational development, gender and equality (including FGM and early/forced marriage), youth empowerment and health. FIOH works to change the social norms and traditional beliefs around FGM, raising awareness of FGM and its consequences (FIOH website).

FIOH undertakes advocacy and education on women's rights and conducts women's skills training. Since 2012, FIOH has organised forums bringing together former cutters to act as 'tutors' informing the community – including practising cutters – of the risks of FGM. The forums, held in the Upper River Region and Central River Region, are open to men as well as women. They also support adult learning; one example being the REFLECT method (known locally as *mayo mango*, meaning ocean), which enables discourse between men and women on the gendered division of labour.

The School Development programme works to enhance the quality of education through development of a SEGRA (Serholt Early Grade Reading Ability) manual. They also work on improving the infrastructure of schools, in order to enable more children to access schooling.



**Fig. 38: School built through FIOH's Construction and Technical Programme (© Future in Our Hands website)**

### **SAFE HANDS FOR GIRLS**

Safe Hands for Girls was established in 2014 by Jaha Dukureh, a 24 year-old activist who grew up in The Gambia, and is an FGM survivor now living in the US. Supported by *The Guardian*, Safe Hands for Girls has launched a campaign calling on the United States Government to commission a report detailing the prevalence of FGM in the US.



**Fig. 39: Safe Hands For Girls in partnership with Think Young Women, Booth Campaign ©**

Although its focus is US-based, Safe Hands for Girls has a direct link to The Gambia and, going forward, has a critical role to play in the advocacy and campaigning efforts. In October 2014 Safe Hands for Girls facilitated the first National Youth Forum on FGM in The Gambia (funded by *The Guardian* and The Girl Generation) (*The Guardian*, 2014). The event brought together 100 young people (men and women) aged between 17-25 to teach them campaigning and social media skills,



as well as to share legal and medical information about FGM. In January 2015 Safe Hands for Girls additionally launched its Booth Campaign to end FGM in The Gambia, jointly funded by The Girl Generation and The Human Dignity Foundation. The campaign is geared towards raising awareness on FGM and conducting a perception study to inform future programmes. In partnership with Think Young Women, information booths were set up in Banjul, Kanifing and Brikama.

### TOSTAN

Tostan has worked in The Gambia since 2007 in partnership with the Government of The Gambia and UNICEF, implementing its Community Empowerment Programme (CEP) throughout the Upper River Region. It also 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. Tostan has worked in collaboration with other agencies to develop the National Plan of Action (NPOA) for accelerating the abandonment of FGM, which incorporates the CEP model.

There are currently 30 Fula communities actively engaged in the CEP (since July 2014), with a further 153 communities having already completed the three-year programme. There are a total of 183 interventions sites.

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.

Facilitators 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.



**Fig. 40: A group of women participate in a Kobi 2 lesson in Basse (© Tostan)**

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, including outreach across the border with Senegal and between inter-marrying communities. Meetings are facilitated between communities to further reinforce messages and reach a wider audience. An annual Youth Caravan is organised, giving young people the opportunity to travel throughout the Upper River Region to share human rights knowledge. On the final day, they gather to deliver a manifesto, calling on officials and the government to recognise their rights.

Tostan and community partners have also facilitated Public Declarations for 246 communities across The Gambia. In preparation, teams of community Social Mobilisation Agents (SMAs) are trained to discuss the issues with community leaders, religious leaders and others in order to prepare for a Public Declaration of Abandonment. Communities are not forced to declare abandonment of FGM and/or early/forced marriage, and Public Declarations take place only when there is local willingness.

## UNICEF / UNFPA

The Gambia is one of the 15 countries forming part of the UNFPA-UNICEF Joint Programme on FGM established in 2008. The UNICEF 2012-2016 Country Programme of Cooperation with the Government of The Gambia focuses on four key areas: child survival and development, basic education, child protection and social policy. The programme is implemented both locally, with a focus on the Central River and Upper River Regions, and nationally, in collaboration with various local NGOs. FGM and early/forced marriage are addressed as child protection issues (UNICEF-The Gambia website).

UNFPA works with ministries, GAMCOTRAP and the Family Planning Association to achieve the objectives of its 2012-2013 country programme (including reduction in maternal mortality and promotion of sexual and reproductive health rights). UNICEF and UNFPA are members of the National Steering Committee on FGM, supporting dialogue with religious leaders and implementation of activities to promote abandonment (Joint Programme Annual Report, 2013).

UNICEF has supported advocacy efforts for eliminating HTPs at the policy level, providing assistance to the National Steering Committee on Gender Based Violence and committed technical support for the development of the communication plan. UNICEF works in partnership with Tostan and the Government to implement the Joint Community-led Development in The Gambia Project, which has four objectives: 1) the creation of an enabling environment for FGM abandonment; 2) increasing knowledge of human rights and health-related issues; 3) increasing citizen participation and 4) a reduction in the prevalence of FGM by 40% in participating communities. Currently there are 30 participating communities funded by UNICEF, with a further 120 UNICEF-funded communities having already completed the CEP and/or the micro-credit components of the programme.

## WASSU UAB FOUNDATION / WASSU GAMBIA KAFO

Wassu UAB Foundation hosts the Transnational Observatory of Applied Research to New Strategies for the Prevention of Female Genital Mutilation/Cutting. The Transnational Observatory is integrated by the Interdisciplinary Group for the Study and Prevention of Harmful Traditional Practices (IGSP/HTP) and Wassu Gambia Kafo as its two research and training centres in Spain and in The Gambia.

The aim is to undertake comprehensive research to develop a methodology for implementation of interventions which are culturally appropriate, evidence-based and results oriented. Wassu Gambia Kafo has contributed to answering the Government's request for further evidence regarding the harmful effects of FGM and to producing the evidence base for bringing about high level change.

There are four key components to the programme:

**Research:** Field research is both qualitative and quantitative, with findings disseminated to social agents, including health workers, students of health sciences, community and religious leaders and TBAs, to share findings at the community level. Findings have been produced as academic research articles (see Kaplan studies).

**Training:** In 2010, Wassu Gambia Kafo signed a Memorandum of Understanding with the Ministry of Health to develop and lead the National Training Programme on FGM for Health Professionals. Training is provided at workshops.

**Education:** A ten-module manual on FGM has been integrated into the academic curriculum of all health science studies.

**Fora:** Wassu Gambia Kafo has organised events to bring together Government officials and INGOs/NGOs to speak about FGM. They hosted an event to engage religious leaders in the practice

(see Religion section). The health consequences and evidence from studies are used to guide discussion.



**Fig. 41: Sensitisation programmes for community leaders (© Wassu Gambia Kafo)**

## NATIONAL AND LOCAL ORGANISATIONS

### THE ASSOCIATION FOR PROMOTING GIRLS' AND WOMEN'S ADVANCEMENT (APGWA)

The Association for Promoting Girls' and Women's Advancement (APGWA) is a Serrekunda-based NGO founded in 1992 by a gender activist. It currently works in 90 rural villages campaigning for women's and girls' rights and against FGM. The focus of APGWA's activities has evolved, with the first six years being linked to sensitisation efforts. Training was provided to community members (training of trainers) using the International Labour Organisation (ILO) manual called 'Campaign for the Eradication of Female Circumcision in Africa'. The manual covers five modules, including 'involving women in eradication of FGM' and 'women speak on FGM'. APGWA also provided initial and annual refresher training for health workers including nurses, midwives, TBAs and Village Health Workers.

Between 2003 and 2009 APGWA introduced the 'Citizen Encampment', based on the rights-based approach to addressing FGM. During a week-long course male and female youths are educated on policy frameworks for the protection of human rights (CEDAW, UNCRC and others). They have also promoted girls' education, establishing the Sobeya Skill Training Centre in Tallinding. They are then encouraged to share their knowledge with the wider community (*The Daily Observer*, 2013). APGWA is represented on the National Steering Committee for the abandonment of FGM. APGWA has also provided skills training and alternative sources of income for former cutters, with training in soap making, gardening and other business activities.

APGWA promotes initiation without cutting through the establishment of Youth Camps. This alternative rite of passage approach involves young girls being taken to the bush and trained on family and wider cultural issues. Before communities agree to host a Youth Camp, APGWA staff meet local leaders (including the Imam, the Council of

Elders, and the Alkalo (Community Mayor)). The Youth Camp approach involves educating girls (and sometimes boys) about marriage rites, pregnancy, safe motherhood, the role of women leaders and the complications caused by FGM.

**THE FOUNDATION FOR RESEARCH ON WOMEN'S HEALTH, PRODUCTIVITY AND THE ENVIRONMENT (BAFROW)**

The Foundation for Research on Women's Health, Productivity and the Environment (BAFROW) was founded in Banjul in 1991 and has a presence across all regions of the country. BAFROW provides an integrated and holistic approach to service delivery in the areas of reproductive health and women's healthcare. BAFROW views the elimination of FGM as an important step towards achieving development goals.

Once a community has completed the various components of BAFROW's human-centred approach to development it is termed a 'model village'. Mandinaba in the Western Region has been declared a 'model village', meaning it has worked through the empowerment programme, the training and awareness raising programme, has established a Well Woman Clinic, worked through the environmental improvement programme and has developed collaborative partnerships.

Before beginning work in a community BAFROW conducts a baseline survey to assess the situation, including the extent of FGM and to build connections with the relevant individuals. Communities are sensitised and between one and three community counsellors are stationed in the community to provide support, deliver training and share the BAFROW curriculum. The curriculum for adult literacy covers FGM and health, FGM and religion and FGM and culture. Awareness-raising is undertaken over a couple of days, with longer-term efforts at sensitisation.

Though acknowledging that FGM is considered to be a cultural rite of passage for women,

BAFROW calls for its complete elimination and advocates establishing a situation whereby women undergo the ritual without the cutting. The alternative rite of passage promoted by BAFROW is referred to as 'initiation without cutting'. Families are encouraged to plant a tree at the end of the initiation process. Over a period of eight years, girls are monitored to check their status. Evidence from these investigations also enables BAFROW to understand the particular circumstances surrounding a girl, and whether or not she is subsequently cut. Excisors who abandon the practice are encouraged to take up alternative roles as health promoters and facilitators of change within their communities. BAFROW also implements a microcredit scheme, with beneficiaries receiving training in business management and livelihoods.

BAFROW provides social services as well as preventative and curative care to the community. They have established six family clinics and six mobile outreach facilities, which offer affordable services and which are staffed by trained midwives, nurses and counsellors (with special training in FGM, HIV and gender-based violence). The clinics are located throughout the country, with a clinic in Mandinaba providing obstetric fistula repair operations.

**CHILD PROTECTION ALLIANCE (CPA)**

The Child Protection Alliance is a network of 48 organisations and institutions working throughout The Gambia to protect children. It was established in 2001 and was the first inter-agency institution in The Gambia focusing explicitly on children and the protection and promotion of their rights. The CPA advocates for the legal prohibition against FGM, emphasising the need for the Children's Act to specify FGM as a violation.

They have also stressed the need for the Government to sensitise religious leaders on the negative impacts of FGM on women's reproductive and sexual health (CPA, 2014). The CPA's aim is to coordinate the efforts of actors working for



and with children, in order to promote the issue at the political level and to facilitate the voice of children in decision-making processes across all levels, including in the design and delivery of interventions.

The CPA indicates that its role is to act as a ‘watch dog’, and in 2002 a ‘Voice of the Young’ forum was founded to give youth a space to share opinions about matters affecting them (CPA website). The CPA has also organised workshops to raise awareness of children’s rights, with a particular focus on building understanding among religious and community leaders (Gov.UK, 2013). They have established school-based ‘Voice Clubs’ and 11 Community Child Protection Committees in the Lower and Central River Regions. These structures are designed to provide skills and knowledge of child protection issues and engage the community meaningfully in child protection issues (*Gambia Affairs*, 2014).

### FEMALE LAWYERS ASSOCIATION – GAMBIA (FLAG)

The Female Lawyers Association – Gambia (FLAG) operates a legal empowerment initiative aimed at enabling young women to be active participants in using the law. FLAG membership is limited to female members of the legal profession, and they provide legal services, legal aid and paralegal support in order to contribute to the realisation of women’s and children’s rights.

FLAG undertakes training and capacity building activities, equipping rural women with relevant knowledge on domestic violence and sexual health rights. They have conducted sensitisations of the National Assembly members on the 2013 Sexual Violence and Domestic Violence Bills. FLAG were also involved in reviewing the draft FGM Bill (see GAMCOTRAP below) and providing inputs before the Bill was shared with various members of a Parliamentary Committee.

### GAMCOTRAP

The Gambia Committee on Traditional Practices Affecting the Health of Women and Children (GAMCOTRAP) is the national committee of the Inter-African Committee. It was first formed in 1984 at the International Seminar on Traditional Practices Affecting the Health of Women and Children organised by WHO in Dakar. A Working Group on Traditional Practices was formed under the Women’s Bureau, but in 1992 became an independent NGO. GAMCOTRAP is a prominent campaigner against FGM in The Gambia and works to empower communities to bring about change through advocacy, capacity building and information sharing. GAMCOTRAP runs campaigns on the harmful effects of FGM and some of its core activities to date include:

**Policy/legal reform:** At the policy and legal level, GAMCOTRAP has been influential in pushing for legal reforms. It drafted a Bill to outlaw FGM, which was passed before the National Assembly; this was based on reviewing the Banjul Declaration and other relevant laws. It has not been passed into law and GAMCOTRAP’s efforts to raise awareness continue.

**Media advocacy:** GAMCOTRAP has led training for media personnel on how to investigate and report on the issue of FGM.

**Community outreach – Cluster Approach:** The community outreach programme is built around a multi-media strategy which shares information with communities. The outreach adopts a ‘cluster approach’, with groups of communities simultaneously targeted. The clusters are comprised of intermarrying communities that share a similar geographic location and each have their own excisor and TBA. Each cluster has around 10 communities. GAMCOTRAP has developed an understanding of the social networks and strategic decision-making processes which surround FGM, and filtered this into its approach and outreach efforts. Community clusters are targeted with frequent training and sensitisation programmes.

**Religious leaders:** Religious leaders are a specific focus of GAMCOTRAP’s campaign and they have worked with Islamic scholars to disseminate messages to de-link FGM from Islam. They have targeted the Supreme Islamic Council as well as Arabic teachers in the Upper River and Central River Regions.

**Alternative Employment Opportunity (AEO) Strategy:** The AEO targets cutters and provides alternative employment opportunities. Women receive training in business and entrepreneurship and are awarded micro credit grants.

**Dropping the Knife Ceremonies:** The first ceremony was organised in 2007, launching a movement of communities committing publicly to abandoning FGM (see foreword for case study).

**Bridge building sensitisation:** GAMCOTRAP organised a series of awareness raising meetings in villages and towns in Spain throughout 2008. The visit was undertaken in collaboration with the Catalan Agency for Development Cooperation in order to build understanding among outside countries of the realities surrounding FGM in The Gambia.

### THINK YOUNG WOMEN

Think Young Women is a women-led non-profit organisation. It aims to address issues affecting young women by developing their ability to be the voice of change in order to emphasise the need to support and achieve women’s rights. It works in a number of areas including health and reproductive rights, women’s rights and building women’s political participation. Think Young Women participated in the 2014 Youth Summit on FGM in The Gambia. Most recently, in January 2015, it has also been in partnership with Safe Hands for Girls on the Booth Campaign to raise awareness and undertake a perception study on FGM in The Gambia.

## 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, giving no access to computers/internet and incomplete coverage of mobile phones make communication and coordination difficult. Other more direct challenges to interventions are:

- The lack of specific anti-FGM legislation and the continued observance of customary and Shari’a law
- The highly sensitive and potentially repressive political atmosphere
- Evidence suggesting an increase in anti-Western sentiment which can adversely affect the perception of the work and motivations of NGOs in country
- ‘Fluctuations’ in government position regarding FGM – and threats to those campaigning against the practice
- Regional variations and variations in the reasons for continuing FGM make it challenging to address specific factors surrounding FGM – calls for holistic approach
- Powerful religious stance that is supportive of FGM continuation
- Reported friction and a lack of collaboration and cooperation amongst different organisations working on FGM
- Creating/maintaining anti-FGM dialogue in communities

### POLITICAL ENVIRONMENT AND LEGISLATION

In a public address in 1999 President Jammeh stated that no protection would be afforded to people publicly speaking against FGM: *‘there is no guarantee that after delivering their speeches,*

they will return home' (Amnesty International, 2000). Similarly, in 2009, the President warned human rights defenders: *'be rest assured that your security, and personal safety would not be guaranteed by my Government. We are ready to kill saboteurs'* (Frontline Defenders, 2009). Simultaneously, the Government has worked alongside NGOs promoting an end to FGM and government officials have been present at various 'abandonment' ceremonies. It therefore should be emphasised that efforts must be sensitive.

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.

#### **LACK OF COOPERATION AMONG NGOS**

The major challenge highlighted by the Afri-consult report (2010) was a lack of collaboration and information sharing among NGOs working in the field. The report commented that NGOs seem to be competing rather than working collaboratively. This competition may be exacerbated by competition for funding of projects, with each NGO working to their own agenda.

#### **MAINTAINING DIALOGUE AND AUTHORITY IN COMMUNITIES**

In January 2015, the UNHCR noted that a real challenge in the fight against FGM was to maintain the voice and status in the community of 'Circumcisers', which they said may be addressed by the 'Dropping the Knife Campaign' aimed at changing attitudes and mind-sets, and raising awareness and educating traditional practitioners on the issue (UNHCR, 2015).

## **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 The Gambia.

#### **ADOPTING CULTURALLY RELEVANT PROGRAMMES**

Shell Duncan's report in 2011 found that FGM is maintained in The Gambia by peer pressure rather than the social convention of pressure from the community. Interventions should be addressed to women and their networks to stop prejudicial exclusion of uncut women from women's social networks and the support that they offer.

#### **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) 57<sup>th</sup> 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, at the 59<sup>th</sup> session of CSW 2015 as well as 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. Though access to education is available in The Gambia, the power of traditional education to silence women from complaining about pain or abuse should be challenged strongly.

### **FGM, MEDICAL CARE AND HEALTH EDUCATION**

Several studies mentioned in this report highlight high levels of ignorance about the health implications of FGM among both the public and HCPs. Though FGM is now in the medical school's curriculum, a wider dissemination of the information is required including educating current HCPs.

### **FGM, ADVOCACY AND LOBBYING**

Advocacy and lobbying is essential to ensure that the Government continues to be challenged on its hesitancy to criminalise FGM, and to support programmes that tackle FGM.

### **FGM AND THE LAW**

We support the ongoing campaign efforts fighting for the criminalisation of FGM and the specific inclusion of FGM prohibition in the Children's Act.

### **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. They can also work with global bodies such as the UN and its agencies.

### **COMMUNICATION AND COLLABORATIVE PROJECTS**

There are a number of successful anti-FGM programmes currently operating in The Gambia, 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 The Gambia 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 packs and providing links/referrals to other organisations will all



strengthen the fight against FGM.

### **FURTHER RESEARCH**

There are four areas of FGM initiatives which would benefit from more research:

1. Systematic structures for monitoring and evaluation existing programmes to see what does work
2. Men's preferences for cut or uncut women, given anecdotal evidence that FGM interferes with good sexual relationships and given the uncertainty expressed by women on men's preference.
3. Reasons for why individuals and communities do abandon FGM to contextualise the statistics on FGM eradication and will help to implement intervention programmes more effectively
4. Understand why more men wanted to see the practice to continue but did not intend to cut their own daughters.

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

Note: This is not an exhaustive list of all the organisations working in The Gambia. 28Too Many recognises that there are many more, particularly at a grassroots level, working on these issues.

### ActionAid/Activista

Africa in Democracy and Good Governance

Africa Muslims Agency

African Centre for Democracy and Human Rights Studies (ACDHRS)

Agency for the Development of Women and Children (ADWAC)

ASB Gambia Health Clinic

Association for Gambian Women Empowerment (AGWE)

Association for Intervention, Cooperation and Development (AICOS)

Association for Promoting Girls' and Women's Advancement (APGWA)

Association for the Advancement of Women Entrepreneurs (AAWE)

AVISU Agency for Village Support

BAFROW The Gambia Foundation for Research on Women's Health, Productivity and the Environment

Campaign for Development and Solidarity (FORUT)

CARITAS Gambia/Catholic Development Office (CaDO)

Catholic Relief Services (CRS)

Child & Environment Development Association (CEDAG)

Child Protection Alliance (CPA)

Childfund (The Gambia)

Concern Universal

Derek Bailey Foundation

Disability Africa

Equality Now

Female Lawyers Association – Gambia (FLAG)

Forum for African Women Educationalists - Gambia (FAWEGAM)

Future In Our Hands (FIOH)

Gambia Christian Council

Gambia Girl Guides Association

Gambia Goes

Gambia Home Economics Association (GHEASC)

GAWFA Finance Company Gambia

Global Fund for Women

Institute for Human Rights and Development in Africa

International Institute for Child Protection

Inter-African Committee (IAC)

Islamic Relief Association

Marlborough Brandt Group

National Youth Association for Food Security (NAYAFS)

National Council for Civic Education

National Youth Council

Needy Charity Foundation

Nova Scotia-Gambia Association

Safe Hands for Girls

Saint Martha's Society

Self-Reliant Development Association (SERDA)

Society for Women & AIDS in Africa - Gambia (SWAAGAM)

SOS Children's Villages

RAINBOW (Research Action and Information Network for the Bodily Integrity of Women)

TANGO

The Gambia Committee on Traditional Practices Affecting the Health of Women and Children (GAM-COTRAP)

Think Young Women

Tostan

Trust Agency for Rural and Urban Development (TARUD)

Tumana Association for Development

United Nations Children's Fund (UNICEF)

United Nations Population Fund (UNFPA)

Wassu UAB Foundation/Wassu Gambia Kafo

WISDOM

Women Advancement and Child Care (WACC)

Women Centre for Education and Empowerment (WCEE)

Women in Services Development Organisation & Management (WISDOM)

Women Living Under Muslim Laws (WLUML)

Wulli and Sandu Development Association

Young Women's Christian Association (YWCA)

## APPENDIX II - REFERENCES

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