FGM IN SENEGAL:
EXECUTIVE SUMMARY

June 2015

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

It is estimated that 25.7% of women aged 15-49 have undergone FGM in Senegal.[1] This figure has not changed significantly in recent years.[2] 23.4% of women aged 15-49 who live in urban areas have had FGM, and 27.8% of those who live in rural areas. However, the majority of Senegalese residents reside in rural areas. Dakar, the capital, contains 49% of the country's urban population and has a prevalence rate of 20.1%. The regions with the highest prevalence are in the south and east: Kédougou (92%), Matam (87.2%), Sédhiou (86.3%), Tambacounda (85.3%) and Kolda (84.8%). The regions with the lowest prevalence are in the west: Diourbel (0.5%), Thiés (3.5%), Louga (7.3%), Kaolack (5.6%) and Fatick (7.3%). These regional differences have complex roots beyond ethnicity and are partly due to historical, political, economic and colonial influences.[3]

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

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

More generally, FGM is seen as part of cultural identity, yet 48.5% of women aged 15-49 believe FGM has no benefits.[4] Men aged 45-49 have the highest level of support for the continuation of FGM, and women of the same age-range have the lowest level of support. Young women have the highest level of support for continuation at 23.3%.[5] Of women that have had FGM, there is a 52.4% rate of support for continuation, versus a low 2.6% rate of support among women who have not had FGM. This level of support varies by urban and rural residence, wealth quintiles and mother's education.[6]

FGM is practised mainly on infants and young girls. For example, 88.9% of Soninké girls were cut between birth and their first birthday. However, the Diola are more likely to cut girls later (48.6% between ages 2 and 4, and 29.1 % between the ages of 5 and 9).[7] Daughters of younger women are less likely to be cut than the daughters of older women (over age 25).[8] The Demographic and Health Survey does not collect data on type of FGM performed in Senegal; it only determines whether or not a woman was 'sewn closed' (analogous to Type III). Many women surveyed did not know what type of FGM they had. For daughters aged 0-9, the group with the highest percentage of daughters having been 'sewn closed' is the Soninké (36%).[9] With regards to practitioners, traditional circumcisers are most prevalent (91.4%), followed by non-specified practitioners (7.6%) and traditional birth attendants (1%).[10] There is no reported medicalisation of FGM.

Senegal criminalised FGM in 1999, following an amendment to the Penal Code. The National Reproductive Program has been in place since 1997 to support efforts to abolish the practice. With respect to the knowledge of the law against FGM, reports show that there is very widespread awareness of the law.[11] A study on FGM was launched in 2000, led by the Minister of Family and National Solidarity. The Government also adopted an Action Plan in 2005, and a second in 2009 in collaboration with the United Nations Joint Programme to eradicate FGM by 2015.

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

We propose measures relating to:

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

- *Increased collaborative projects and networking* between different organisations working to end FGM, to strengthen and reinforce messages and to accelerate progress.

Further research is needed in the following areas:

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

1 Agence Nationale de la Statistique et de la Démographie (ANSD) [Sénégal], et ICF International (2012) *Enquête Démographique et de Santé à Indicateurs Multiples au Sénégal (EDS-MICS) 2010-2011*, p.295. Calverton, Maryland, USA: ANSD et ICF International. Available at http://dhsprogram.com/pubs/pdf/FR258/FR258.pdf. ***Referred to throughout this document as the 'DHS/MICS 2010-11'.***

2 Ndiaye, Salif, et Mohamed Ayad (2006*) Enquête Démographique et de Santé au Sénégal 2005*. Calverton, Maryland, USA: Centre de Recherche pour le Développement Humain [Sénégal] et ORC Macro, p.238. Available at http://dhsprogram.com/pubs/pdf/FR177/FR177.pdf. ***Referred to throughout this document as the 'DHS 2005'.***

3 Ndiaye, Salif, et Mohamed Ayad (2006*) Enquête Démographique et de Santé au Sénégal 2005*. Calverton, Maryland, USA: Centre de Recherche pour le Développement Humain [Sénégal] et ORC Macro, p.238. Available at http://dhsprogram.com/pubs/pdf/FR177/FR177.pdf. ***Referred to throughout this document as the 'DHS 2005'.***

4 DHS 2005, p.251.

5 Agence Nationale de la Statistique et de la Démographie (ANSD) [Sénégal], et ICF International (2015) *Sénégal : Enquête Démographique et de Santé Continue (EDS-Continue 2014)*, p.105. Rockville, Maryland, USA: ANSD et ICF International. Available at http://dhsprogram.com/pubs/pdf/FR305/FR305.pdf.

6 DHS/MICS 2010-11, p.302.

7 DHS/MICS 2010-11, p.300.

8 Kandala and Komba (2014) *Female Genital Mutilation: Geographic Variation of Female Genital Mutilation and Legal Enforcement in Sub-Saharan Africa: A Case Study of Senegal*.

9 DHS/MICS 2010-11, p.298.

10 DHS/MICS 2010-11, p.297.

11 - Shell-Duncan *et al.* (2013) 'Legislating Change? Responses to Criminalizing Female Genital Cutting in Senegal', *Law & Society Review* 47(4).
- UNICEF (2010) *L'Etat d'Application de la loi sur l'Excision au Sénégal*.

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