
COUNTRY PROFILE:
FGM IN SENEGAL
JUNE 2015
28 TOO MANY
FGM...
let's end it.

EXECUTIVE SUMMARY

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

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

Determining prevalence rates 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 rate of practise, followed by the Soninke, Poular and Diola. The Wolof have the lowest rate. As discussed in this report these rates of practise vary significantly according to the regions in which people reside. Moreover, there are issues associated with self-reporting FGM status, particularly due to the criminalisation of FGM. Between 2010 and 2014 there were conspicuously high percentage drops reported in all ethnic groups.

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

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

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

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

There are numerous International Non-Governmental Organisations (INGOs) and NGOs working to eradicate FGM using a variety of strategies, including a harmful traditional practices (HTP) approach, addressing health risks of FGM, promoting girls' education, and using media. For example, Tostan uses their Community Empowerment Programme (CEP), while the Grandmother Project uses a community intergenerational dialogue approach. Singer Sister Fa works with several NGO partners and uses her music to promote the abandonment of the practice. Furthermore the Comité Sénégalais sur les Pratiques 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 address the local drivers for FGM.
- Sustainable funding. This is an issue across the development (NGO) sector; organisations working against FGM in Senegal need to work with Government programmes and also reach out to others for opportunities to partner.
- Considering FGM within the Millennium Development Goals (MDGs), which are being evaluated this year, and re-positioning FGM in a status of high importance in the post-MDG framework at a global level.
- Facilitating education and supporting girls through secondary and further education
- Improving access to health facilities and managing health complications of FGM
- Increased enforcement of the FGM law and ensuring those responsible for FGM are prosecuted

- Fostering the further development of effective media campaigns which reach out to all regions and sections of society
- Encouraging faith-based organisations (FBOs) to act as agents of change, and challenge misconceptions that FGM is a religious requirement and be proactive in ending FGM
- Increased collaborative projects and networking between different organisations working to end FGM to strengthen and reinforce messages to accelerate progress.

Further research is needed in the following areas:

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

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