




COUNTRY PROFILE: FGM IN SENEGAL

June 2015

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



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Foreword

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

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

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

In Senegal FGM is a social norm, practised to guarantee social acceptance, and is part of women's cultural identity. Although reasons for performing FGM are varied across ethnic groups, many Senegalese women believe FGM benefits cleanliness and hygiene, aids marriage prospects, preserves virginity and is a religious requirement. There is a strong link between FGM and religion in the north of Senegal, with historically powerful influencers upholding the practice. The reality is that FGM causes infections, infertility, haemorrhage, pain, depression and psychological trauma, but, even with the known risks, the practice continues, and, in 2014, 49.% of women aged 15–49 who have undergone FGM still believe the practice should continue.¹

The joint Demographic and Health Survey and Multiple Index Cluster Survey report from 2010/2011 shows that 25.7% of Senegalese women (aged 15–49) have experienced FGM. The prevalence of FGM has changed little in recent years, and prevalence is similar when measured according to women's place of residence: 23.4% of women living in urban areas have undergone FGM, as have 27.8% of women living in rural settings.²

FGM in Senegal is usually performed on young girls. Many ethnic groups perform the 'sewn closed' type of FGM, and 91.4% of FGM is performed by 'traditional circumcisers'.³ This 'sewn closed' method is similar to FGM Type III and causes severe birth complications.

Senegal criminalised FGM in 1999, and knowledge of this law is now widespread. In addition, the Government, in collaboration with the UNFPA-UNICEF Joint Programme to Eliminate Female Genital Mutilation, launched a national action plan in 2009, which is in line with the Millennium Development Goals and aims to eradicate FGM by 2015. Also, there are many international and national non-governmental organisations (NGOs) working to end FGM in Senegal, and as we continue to work with

many of those featured in this report, it is encouraging to find that there are significant attitude changes reported in areas of NGO intervention.

I am pleased to share 28 Too Many's Country Profile: FGM in Senegal, which is our ninth country report. We are grateful to all the NGOs and activists who have contributed and provided information on current anti-FGM projects in Senegal. In particular, we thank Tostan, The Orchid Project, Sister Fa and also The Grandmother Project for sharing the case study shown at page 35, which details how FGM can end when the harmful element is removed from other positive aspects of Senegalese cultural tradition.

As this report is published, I will be in Senegal, having travelled from The Gambia before heading to Mali to further my understanding of FGM in West Africa. I am looking forward to meeting again with our partners from the Inter-African Committee on Traditional Practices and the NGOs working in the region to understand how we can support the change that is taking place and ensure that future generations of girls live free from FGM.

Dr Ann-Marie Wilson
28 Too Many Executive Director

1 DHS 2014, p.105.

2 DHS-MICS 2010–11, p.295.

3 DHS-MICS 2010–11, pp.295 & 297.

Information on Country Profiles

Background

28 Too Many is an anti-FGM charity, created to end FGM in the 28 African countries where it is practised and in other countries across the world where members of those communities have migrated. Founded in 2010 and registered as a charity in 2012, 28 Too Many aims to provide a strategic framework where knowledge and tools enable in-country anti-FGM campaigners and organisations to be successful and make a sustainable change to end FGM. We are building an information base, which includes 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 improve understanding of the issues relating to FGM in the wider framework of gender equality and social change. By collating the research to date, this Country Profile can act as a benchmark to reflect the current situation. As organisations continue to send us their findings, reports, tools and models of change, we can update these reports and show where progress is being made. While there are numerous challenges to overcome before FGM is eradicated in Eritrea, 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 28 Too Many. We invite comments on the content and suggestions on how the report could be improved as an information tool, and seek updates on the data and contact details.

When referencing this report, please use: **28 Too Many (2015; updated 2018) *Country Profile: FGM in Senegal*. Available at <http://www.28toomany.org/Senegal/>.**

Acknowledgements

28 Too Many is extremely grateful to everyone who has assisted us in accessing information to produce this Country Profile, including community groups, local non-governmental organisations (NGOs), community-based organisations (CBOs), faith-based organisations (FBOs) and international organisations. We thank them, as it would not have been possible without their assistance and collaboration.

28 Too Many carries out all its work as a result of donations and is an independent, objective voice unaffiliated with any government or large organisation. That said, we are grateful to the many organisations that have supported us so far on our journey and the donations that enabled this Country Profile to be produced.

For more information, please contact us on info@28toomany.org.

The Team

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

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

Cover: Jessie Boucher (undated) *Stunning Faces*. Available at www.jessieetlaurent.com.

Please note the use of a photograph of any girl or woman in this Country Profile does not imply that she has, nor has not, undergone FGM.

2018 Team

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List of Abbreviations

INGO and NGO acronyms are found in Appendix 1

AIDS	Acquired Immunodeficiency Syndrome
CBO	community-based organisation
CEDAW	Convention on the Elimination of Discrimination against Women
CEP	community empowerment programme
CRC	Convention on the Rights of the Child
DHS	Demographic and Health Survey
ENDA	Environmental Development Action in the Third World
FBO	faith-based organisation
FGC	female genital cutting
FGM	female genital mutilation
GBV	gender-based violence
GDP	gross domestic product
GHD	Girl's Holistic Development Project
GII	Gender Inequality Index
HIV	Human Immunodeficiency Virus
HTP	harmful traditional practice
ICCPR	International Covenant on Civil and Political Rights
INGO	international non-governmental organisation
MDG	Millennium Development Goal
MFDC	Movement of Democratic Forces in the Casamance
MICS	Multiple Indicator Cluster Survey
MMR	maternal mortality ratio
NGO	non-governmental organisation
SIGI	Social Institutions and Gender Index
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNJP	UNFPA-UNICEF Joint Programme to Eliminate Female Genital Mutilation
US	United States of America
WHO	World Health Organization

Please note that, throughout the citations and references in this report, the following abbreviations apply.

'DHS 2005' refers to:

Salif Ndiaye and 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. Available at <https://dhsprogram.com/pubs/pdf/FR177/FR177.pdf>.

'DHS-MICS 2010–11' refers to:

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*. Calverton, Maryland, USA: ANSD et ICF International. Available at <https://dhsprogram.com/pubs/pdf/FR258/FR258.pdf>.

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

Statistics on the prevalence of FGM are compiled through large-scale household surveys in developing countries – the Demographic and Health Survey (*DHS*) and the Multiple Indicator Cluster Survey (*MICS*).

The DHS data does not directly measure the FGM status of girls aged 0–14, although pre-2010 surveys asked women whether they had at least one daughter with FGM. However, this data cannot be used to accurately estimate the prevalence of FGM in girls under the age of 15. From 2010, the DHS methodology changed so that women are asked the FGM status of all their daughters under 10 or 15 years, depending on the country. Analysing FGM among girls in 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 (and potentially the effect of laws criminalising the practice). However, unless they are adjusted, these figures do not take into account the fact that these girls may still be vulnerable to FGM after the age of 14. In the case of Senegal, the DHS-MICS 2010–11 only reports on the status of daughters aged 0–9, meaning a cohort of girls is missing from the data.

Additionally, due to the relatively small number of women surveyed in Senegal, when the data is further divided up according to women's places of residence or ethnicities, for example, there is a high level of statistical uncertainty. These figures should therefore be viewed with caution. This is particularly true for the Wolof and Mandingue, and for non-Muslims.

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 practices 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

There is only a slight variation in FGM prevalence according to whether women live in urban or rural areas (the majority of Senegalese residents live in rural areas): 23.4% of women who live in urban areas have had FGM, compared to 27.8% of those who live in rural areas.³ Dakar, the capital, contains 49% of the country's urban population and FGM prevalence in Dakar is 20.1%. The regions with the highest prevalence of FGM 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 (both 3.8%), Kaolack (5.6%) and Fatick (7.3%).⁴ These regional differences have complex roots beyond ethnicity and are partly due to historical, political, economic and colonial influences.

in Senegal, the region in which a woman lives is a larger determiner of her risk of being cut than is her ethnicity. However, in general, the Mandingue have the highest prevalence, followed by the Soninké, Poular and Diola. The Wolof have the lowest (less than 1%).⁵

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 (*ñaaakaya*). Some Poular and Mandingue are reported to practise FGM to ensure their daughters' virginites 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 part of people's cultural identities, yet 48.5% of women aged 15–49 believe FGM has no benefits.⁶ The highest level of support for the continuation of FGM is among women aged 35–39 (18.1%). Among women who 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 according to whether women reside in urban or rural areas, their wealth quintiles, and mothers' levels of education.⁷

FGM is practised mainly on infants and young girls. Daughters of younger women are less likely to be cut than daughters of older women (i.e. those over the age of 25).⁸

Of women aged 15–49 who have undergone FGM, 9.9% have been nicked with no flesh removed, 52.7% have had flesh removed, 13.8% have been 'sewn closed' (Type III/infibulation) and 23.6% either do not know or the data in relation to them is missing.⁹ The ethnic group with the highest

percentage of daughters aged 0–9 who are ‘sewn closed’ is the Soninké (36%), and the region with the highest prevalence of daughters who are ‘sewn closed’ is Tambaccoundra, although both these figures are based on a small number of girls.¹⁰

With regards to FGM practitioners, ‘traditional circumcisers’ are most often used (91.4%), followed by ‘other traditional’ practitioners (7.6%) and matrons/traditional birth attendances (1%). There is very little medicalised FGM reported.

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. 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 UNFPA-UNICEF Joint Programme to Eliminate Female Genital Mutilation, with the aim of eradicating FGM by 2015.

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

We propose measures such as:

- **Adopting culturally relevant programmes.** In Senegal, while there needs to be strong national and international messages 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 reach out to others for opportunities for partnership.
- **Considering FGM within the Millennium Development Goals,** which are being evaluated this year, and repositioning 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 the health complications of FGM.**
- **Increasing enforcement of the FGM law and ensuring those responsible for FGM are prosecuted.**
- **Fostering the further development of effective media campaigns** that reach out to all regions and sections of society.
- **Encouraging faith-based organisations to act as agents of change** and to challenge misconceptions that FGM is a religious requirement.

- **Increasing 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.
- With so many communities declaring abandonment, further investigation and a measure of the significance of abandonment is required.
- Changes in the methodologies used by the Demographic and Health Surveys in each of their surveys make it difficult to draw comparisons between data and between countries, and greater consistency would therefore be useful.
- Studies on the medical consequences of FGM in the Senegalese context.

1 DHS-MICS 2010–11, p.295.

2 UNICEF (2013) *Statistics/Info by Country: Senegal*.

3 DHS-MICS 2010–11, p.295.

4 DHS-MICS 2010–11, p.295.

5 DHS-MICS 2010–11, p.295.

6 DHS 2005, pp.251–252.

7 DHS-MICS 2010–11, p.302.

8 NB Kandala and PN Komba (2015) 'Geographic variation of female genital mutilation and legal enforcement in sub-Saharan Africa: a case study of Senegal', *American Journal of Tropical Medicine and Hygiene* 92(4), pp.838–847.

9 DHS-MICS 2010–11, p.295.

10 DHS-MICS 2010–11, p.298.

11 Bettina Shell-Duncan, Ylva Hernlund, Katherine Wander and Amadou Moreau (2013) 'Legislating Change? Responses to Criminalizing Female Genital Cutting in Senegal', *Law & Society Review* 47(4), pp.803–835.

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 Nations¹

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) (FGM) is defined by the World Health Organization (WHO)² as comprising '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. At least 125 million girls and women alive today have had FGM in the 28 African countries where FGM is practised, in Yemen and in Indonesia.

History of FGM

FGM has been practised for over 2,000 years.³ Although it has obscure origins, there has been anthropological and historical research conducted on how FGM came about. It is found in traditional group or community cultures that have patriarchal structures. Although FGM is practised in some communities in the belief that it is a religious requirement, research shows that FGM pre-dates Islam and Christianity. Some anthropologists trace the practice to 5th century BC Egypt, with infibulations being referred to as 'Pharaonic circumcision'.⁴ Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young female herders, as a custom among stone-age people in Equatorial Africa, or as 'an outgrowth of human sacrificial practices, or some early attempt at population control'.⁵

There were also reports in the early 1600s of the practice in Somalia as a means of extracting higher prices for female slaves, and in the late 1700s in Egypt to prevent pregnancy in women and slaves. FGM is practised across a wide range of cultures and it is likely that the practice arose independently among different peoples⁶, aided by raids from Sudan for Egyptian slaves and concubines and the trading of maids through the Red Sea to the Persian Gulf⁷.

Global 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 to the Democratic Republic of Congo in Central Africa. It also occurs in some countries in Asia and the Middle East and among certain diaspora communities in North and South 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.

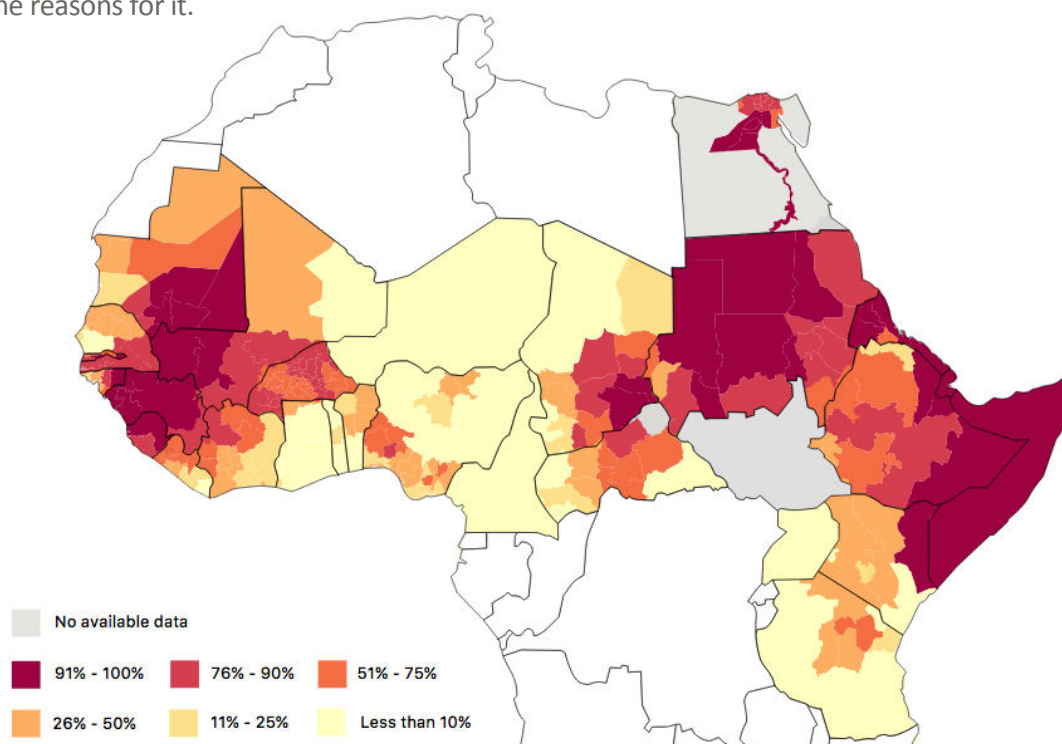


Figure 1: Prevalence of FGM in Africa (© 28 Too Many)⁸

The WHO⁹ classifies FGM into four types:

Type I	Partial or total removal of the clitoris (clitoridectomy) and/or the prepuce
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). [Note also that the term ‘excision’ is sometimes used as a general term covering all types of FGM.]
Type III	Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, pulling, piercing, incising, scraping and cauterization.
Re-infibulation	The procedure to narrow the vaginal opening in a woman after she has been deinfibulated (i.e. after childbirth); also known as re-suturing.

Table 1: Types of FGM as classified by the WHO

FGM is often motivated by beliefs about what is considered appropriate sexual behaviour. Some communities consider that it ensures and preserves virginity and marital faithfulness and prevents promiscuity/prostitution. There is a strong link between FGM and marriageability, with FGM often being a prerequisite to marriage. FGM is sometimes a rite of passage into womanhood and necessary for a girl to go through in order to become a responsible adult member of society. FGM is also considered to make girls ‘clean’ and aesthetically beautiful. Although no religious texts require the

practice, practitioners often believe it 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.¹⁰ 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, incontinence, cysts, psychological problems, infertility, an increased risk of new-born deaths and childbirth complications including fistula, and the need for later surgeries. For example, a woman with Type III infibulation will likely need to be cut open later to allow for sexual intercourse and childbirth.¹¹

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 profiles provide research into the situation regarding FGM in each country, as well as more general information relating to the political, anthropological and sociological environments in the country, to offer a contextual background. This can also be of use in relation to diaspora communities that migrate and maintain their commitment to FGM.

The country profiles also offer analyses 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 that 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 connect with many anti-FGM campaigners, CBOs, policy-makers and influencers. 28 Too Many wishes to continue to build upon its in-country networking to aid information-sharing, education and awareness of key issues, enabling local NGOs to be part of a greater voice to end FGM locally and internationally.

- 1 UN General Assembly (2009) *The girl child: report of the Secretary-General*, p.17. Available at <http://www.refworld.org/docid/4ac9ac552.html>.
- 2 World Health Organization (2015) *Female Genital Mutilation*. Available at http://www.who.int/topics/female_genital_mutilation/en/.
- 3 Alison T. Slack (1988) 'Female Circumcision: A Critical Approach', *Human Rights Quarterly*, Vol. 10, p.439.
- 4 *Ibid.*, p.444.
- 5 Lightfoot-Klein cited in Ann-Marie Wilson (2013) 'How the methods used to eliminate foot binding in China can be employed to eradicate female genital mutilation', *Journal of Gender Studies*, 22:1, p.4. Available at <http://dx.doi.org/10.1080/09589236.2012.681182>.
- 6 *Ibid.*
- 7 Mackie cited in Ann-Marie Wilson, *op. cit.*
- 8 **Click for source document:** Burkina Faso: DHS 2010; Benin: DHS 2011-12; Cameroon: DHS 2004; CAR: MICS 2010; Chad: EDS-MICS 2014-15; Côte d'Ivoire: DHS 2011-12; Djibouti: MICS 2007; Egypt: EHIS 2015; Eritrea: EPHS 2010; Ethiopia: DHS 2016; Ghana: MICS 2011; Guinea: DHS 2012; Guinea-Bissau: MICS 2014; Kenya: DHS 2014; Liberia: DHS 2013; Mali: DHS 2012-13; Mauritania: MICS 2015; Niger: DHS 2012; Nigeria: DHS 2013; Senegal DHS-Cont 2015; Sierra Leone: DHS 2013; Somalia: MICS 2006; Sudan: MICS 2014; Tanzania: DHS 2015-16; The Gambia: DHS 2013; Togo: DHS 2013-14; Uganda: DHS 2011.
- 9 World Health Organization (2016) *WHO guidelines on the management of health complications from female genital mutilation*, pp.2-4. Available at <http://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/> (accessed 18 June 2017).
- 10 *Ibid.*, p.1.
- 11 World Health Organization (2016), *op. cit.*, p.vii.

General National Statistics

This section highlights a number of indicators of Senegal's context and development status.

Population

14,951,888 (1 June 2015)¹

Growth rate: 2.6%²

Median age: 18.4 (2014 est.)

Human Development Index Rank

163 out of 187 in 2013³

Health

Life expectancy at birth (years): 63⁴ or 60.95⁵

Infant mortality rate (per 1,000 live births): 44 deaths⁶

Child mortality rate (per 1,000): 60 (2013)⁷

Maternal mortality rate (per 100,000 live births): 320 (2013)⁸

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

HIV/AIDS – adult prevalence: 0.5% (2014 est.)

– people living with HIV/AIDS: 39,000⁹

– deaths: 1,900 (2012 est.)

Literacy (percentage who can read and write)

Adult (age 15 and over): 52%

Female: 38.7%; Male: 61.8%

Youth (ages 15–24):

Female – 74%; Male – 59%¹⁰

GDP (in US dollars)

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

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

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

Urbanisation

Urban population: 42.5% (2011)

Rate of urbanisation: 3.32% annually (2010–2015 est.)

Religions

Muslim – 94%; Christian – 5%; other – 1%

Ethnic Groups

Although Senegal has more than 20 ethnic groups, more than 90% of the population belongs to five dominant ethnic groups: Wolof – 43.3%; Pular – 23.8%; Serer – 14.7%; Diola – 3.7%; Mandinka – 3%; Soninké – 1.1%; European and Lebanese – 1%; other – 9.4%

Languages

French (official)

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

Unless otherwise stated, all statistics are taken from Central Intelligence Agency (2015) *The World Factbook: Senegal*. Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/sg.html>.

- 1 Country Meters (2015) *Senegal*, 1 June. Available at <http://countrymeters.info/en/Senegal>.
- 2 UNICEF (2013) *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change*. Available at https://www.unicef.org/publications/index_69875.html.
- 3 United Nations Development Programme (2014) *Human Development Report. Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience*.
- 4 UNICEF (2013), *op. cit.*
- 5 Central Intelligence Agency, *op. cit.*
- 6 UNICEF (2014) *The State of the World's Children Report 2015: Statistical Tables*.
- 7 UNICEF (2013), *op. cit.*
- 8 *Ibid.*
- 9 *Ibid.*
- 10 UNICEF (2014), *op. cit.*

Millennium Development Goals

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



Post-MDG Framework

As the MDGs are approaching their 2015 deadline, the United Nations (UN) is evaluating the current MDGs and exploring future goals. After 2015, the UN will continue its efforts to achieve a world of prosperity, equity, freedom, dignity and peace.

Currently, the UN is working with its partners on an ambitious post-2015 development agenda and striving for open and inclusive collaboration on this project.¹

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) covering areas such as climate change, sustainable human settlement, economic development, jobs/decent work, and national and global governance.² 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).³

FGM will not be stopped in Senegal by the end of 2015. 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 2010 to 2020 to be the Decade for African Women will certainly assist in promoting gender equality and the eradication of gender violence in Senegal.

¹ United Nations (undated) [website]. Available at <http://www.un.org/en/index.html>.

² United Nations (2014a) *Report of the Open Working Group on Sustainable Development Goals established pursuant to General Assembly resolution 66/288*.

³ United Nations (2014b) *The Road to Dignity by 2030. Ending Poverty, Transforming All Lives and Protecting the Planet*.

Anthropological Background

Traditional African societies are based on community and conformity to social norms. However, these values are not taught in Western-style education nor upheld in the media. Instead, the younger generation is taught individualism and personal aspiration, and this impairs communication between older and younger generations, as older members feel unable to relate and fear that their knowledge is irrelevant in modern society.¹

Communities in the north and south of Senegal worry about a **generational gap** growing and an associated loss of culture.² A grandmother from the Casamance region is reported to have claimed, 'We are no longer black except by our skin colour. We are not white either. We have ceased being ourselves and we no longer know who we are.'³

The **percentage distribution of ethnic groups** in Senegal is as follows: Wolof – 43.3%; Pular – 23.8%; Serer – 14.7%; Diola – 3.7%; Mandinka – 3%; Soninké – 1.1%; European and Lebanese – 1%; other – 9.4%.

For continuity, this Country Profile duplicates the spellings of ethnic group names used by the DHS reports.

Ethnic Tensions

In general, there is little tension between ethnic groups in Senegal, as the ethnic groups are largely associated and share many customs. This understanding is reinforced by '**joking**' relationships, which pair groups in bonds of mutual insults. These are taken in good humour and help to emphasise differences as well as make them more acceptable. Examples of this are found between the Serer and Toucouleur, and the Serer and Diola.

However, conflict persists in the **Casamance region**, which is inhabited by the Diola (Jola). The region is remote and borders The Gambia. The previous president (Wade) announced in 2004 that he would sign a peace treaty with separatist factions in the Casamance region (The Movement of Democratic Forces in the Casamance or *MFDC*), who have created conflict since its establishment in 1985. This conflict is due in part to the region being inhabited by different ethnic groups, but mainly by the Jola, who are animists or Christians and do not share in Senegal's national identity and socio-economic interests.

The worst years of conflict thus far were between 1992 and 2001, which saw over 1,000 battle-related deaths. Violence again broke out in 2007, resulting in refugees fleeing to Guinea Bissau. The Government estimates that, as of 2013, there were 10,000 internally-displaced persons, while humanitarian agencies estimate the number to be as high as 40,000.

The US Department of State reported that MFDC rebels have been accused of planting landmines, kidnapping civilians, robbing and harassment.⁴ Senegal has further expressed concern that The Gambia's President Jammeh's connections with the Diola in the Casamance will exacerbate the separatist movement, with the possibility that the region will join The Gambia.⁵

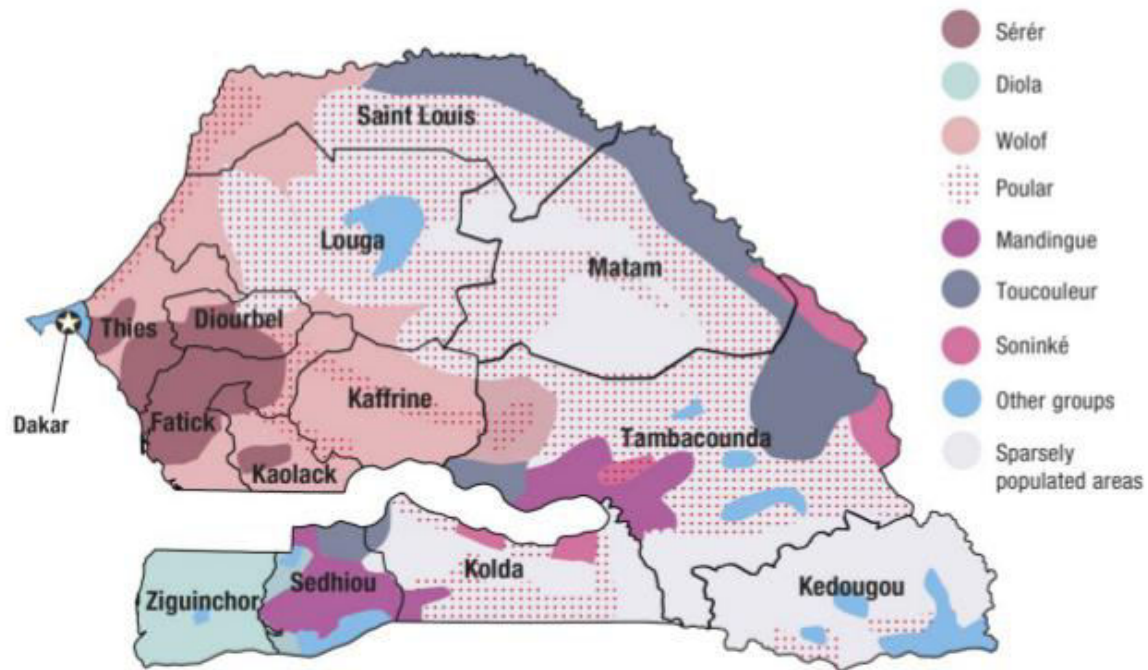


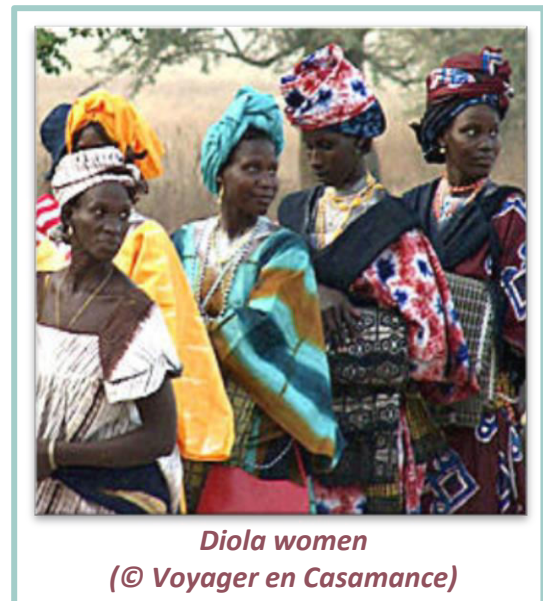
Figure 3: Ethnic groups in Senegal (© 28 Too Many)

Ethnic Groups

In this section the prevalence of FGM is taken from two reports, the DHS 2005 and the DHS-MICS 2010–11. These two sets of data are given to illustrate that, in some cases, there appears to be a significant fall in prevalence. Such significant drops across a short period of time are unlikely, however, and may have resulted from minor methodological differences between reports or statistical uncertainty. The relatively small number of women surveyed means that, when statistics are broken down into ethnic groups, the ‘power’ of the data is lowered. Any large drops or increases should therefore be viewed with caution.

Diola/Joola/Jola

The Diola have many sub-group identities that are highly fragmented and distinctive. None have a caste system, and political organisation is typically at village level.⁶ Historically, the Diola largely rejected Islam for traditional beliefs or Christian conversion. During the Soninké-Marabout wars in the 19th century, they resisted efforts to make them abandon their traditional beliefs in favour of Islam.⁷ This is no longer the case for the Diola who live in Upper Casamance (which borders The Gambia), where, in the 20th century, due to a number of political and economic reasons, they were forced to change their agriculture to cash cropping groundnuts, similar to the Mandingue, who arrived in the area at the end of the 19th century. Interactions with their new neighbours led to the adoption of Islam and numerous traditions and customs – including FGM, which is viewed by the Mandingue as part of their religion.⁸



FGM prevalence according to the DHS 2005: 59.7%; according to the DHS-MICS 2010–11: 51.5%.⁹

Mandingue/Mandinka/Malinke/Mandingo

The Mandingue account for 3% of the population.¹⁰ They are also known as the Mandingos or Malinke and they have their origins in Mali, spreading throughout West Africa between the 13th and 16th centuries. The Mandingue are organised into four social groups – slaves, artisans, commoners and nobles – although nowadays slaves exist only in name. Commoners are ‘free-born’ and are usually farmers, traders or clerics, while nobles are members of the royal household or potential holders of power. The artisan group is comprised of griots, blacksmiths, carpenters and leather workers. Marriage between class groups is traditionally restricted, as is marriage from other castes to members of the artisan group.

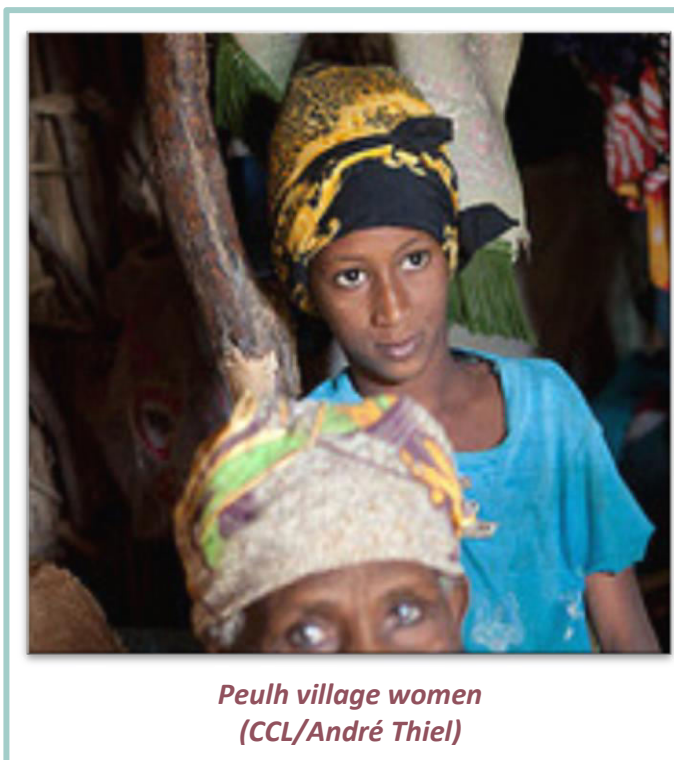
FGM prevalence according to the DHS 2005: 73.7%; according to the DHS-MICS 2010–11: 81.8%.¹¹

Some Mandingue practise ‘sealing’, which is analogous to Type III FGM, to ‘ensure’ their daughters’ virginity at marriage. Of girls and women who have undergone FGM, 9.8% of women aged 15–49 and 13.1% of girls under the age of 10 are ‘sewn closed’.¹² Most Mandingue girls traditionally went through an initiation ritual called *ñyaakaa* between the ages of four and ten, which involves FGM. However, in 2010–11, 94% of girls aged 0–9 were reportedly cut before the age of four.¹³

Poular/Peulh/Fula/Tukolor

The Poular are traditionally pastoralists, originating from the Upper Senegal River region and forming the second-largest ethnic group in Senegal. The DHS surveys group the Poular together with the Tukolor, and the groups are closely related, yet distinct. Combined, they account for 23.8% of the population.¹⁴

The origin of the Poular people – also known as Fulani, Fulbe and Puel – is debated. Poular oral tradition places their ancestry with Caucasians or Semites entering the West Africa region, while other accounts link their origins to intermarriage between Saharan Berbers, Serere and Wolofs. The Poular and the Tukolor were reportedly among the first to embrace Islam, the Tukolor before the Poular, and the Tukolor are known for their religious zeal.¹⁵



***Peulh village women
(CCL/André Thiel)***

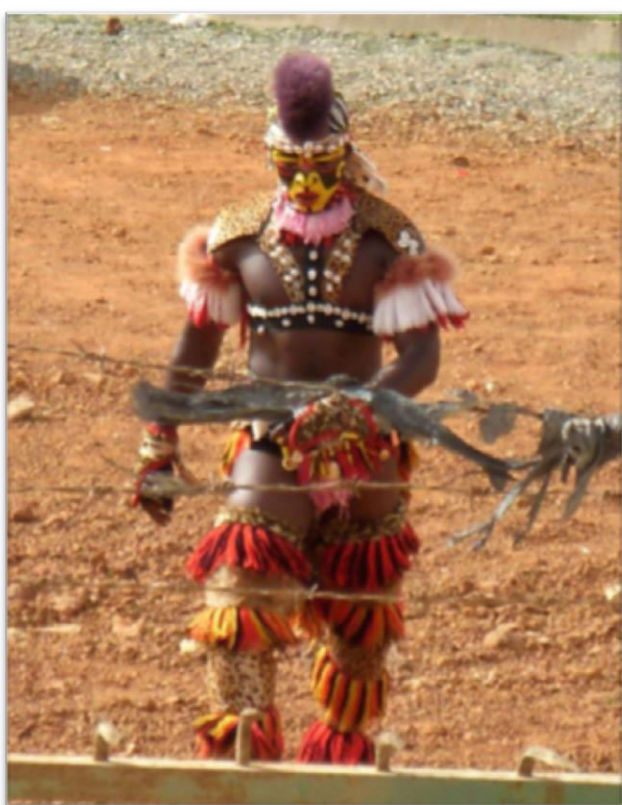
FGM is widely practised by Poular communities across Senegal. Some Poular practise Type III to ‘ensure’ their daughter’s virginity at marriage (14.6% of women and 22% of daughters aged 0–9 with FGM were reportedly ‘sewn closed’ in 2010–11).¹⁶

FGM prevalence according to the DHS 2005: 62.1%; according to the DHS-MICS 2010–11: 54.5%.¹⁷

Serer/Serrer/Serere

The Serer account for 14.7% of the population.¹⁸ They are reported to be the most traditional people in Senegal, resistant in the past to adopting Islam and slow to adapt to modernisation.¹⁹ While many Serer have adopted Islam, some are Christian. Socially, the Serer are organised into five class groups: the ruling noble class, soldiers, commoners (the *Jambur*), artisans and slaves.

FGM prevalence according to the DHS 2005: 1.8%; according to the DHS-MICS 2010–11: 2.2%.²⁰



A 'false lion' (simb) dancer who participates in a Serer ceremony prior to matches of traditional wrestling (CCL/Erica Kowal, 2006)

Soninké

The Soninké comprise 1.1% of the population.²¹ They are exclusively Muslim, and their origin is unclear.

FGM is widely practised by the Soninké. It is usually performed in the first weeks of life, without ceremony, and is viewed as a religious practice by 38.8% of Soninké women who have heard of FGM.²²

FGM prevalence according to the DHS 2005: 78.2%; according to the DHS-MICS 2010–11: 64.9%.²³

The Soninké have the highest rate of the practice referred to as 'sealing' (analogous to Type III FGM), to 'ensure' their daughters' virginity at marriage. 36% of Soninké daughters under the age of ten who have undergone FGM are 'sewn closed'.²⁴

Wolof

The Wolof (also known as Jollof/Jolof) account for 43% of the population.²⁵ They constitute the largest ethnic group in Senegal and are widespread across the Senegambia region. The Wolof language is widely spoken throughout the country, either as a first or second language, and is increasingly the language used by politicians to get across their messages.

Islam is the predominant religion of the Wolof. Wolof social organisation is complex and historically rigid, based on a division of society into royals, noblemen, freeborn and slaves, as well as subdivisions within these basic groups.²⁶ Education and wealth have led to some relaxation of the social divisions by redefining people's social statuses along lines other than castes. Traditionally, marriage is prohibited between the different castes, although there is evidence of intermarriage between the Wolof and other ethnic groups.

The Wolof appear to have the lowest prevalence of FGM of all the ethnic groups.

FGM prevalence according to the DHS 2005: 1.6%; according to the DHS-MICS 2010–11: 0.9%.²⁷



*Wolof children from Dakar
(CCL/Guillaume Colin and Pauline Penot)*

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- 1 - Kate Goodpaster (2009) *Cultural Oppression in Post-Colonial Education*.
 - The Grandmother Project (2012) *Girls and Grandmothers Hand in Hand Dialogue Between Generations for Community Change*.
 - 2 - Sarah O'Neill (2012) *Defying the law, negotiating change: the Futanke's opposition to the national ban on FGM in Senegal*. Doctoral thesis, Goldsmiths, University of London: Goldsmiths Research Online.
 - The Grandmother Project, *op. cit.*
 - 3 The Grandmother Project, *op. cit.*
 - 4 US Department of State (2013) *Human Rights Report: Senegal*.
 - 5 - David Levinson (1998) *Ethnic Groups Worldwide*. Arizona: Oryx Press.
 - Minority Rights Group International (2008) *World Directory of Minorities and Indigenous People – Gambia: Overview*.
 - 6 Minority Rights Group International, *op. cit.*
 - 7 - Andrew Burke (2002) *Lonely Planet: The Gambia and Senegal – Population and People*. Hong Kong.
 - Access Gambia (undated) *Gambian Culture, Traditions & Society*.
 - 8 Liselott Dellenborg (2000) *A Reflection on the Cultural Meanings of Female Genital Cutting: Experiences from Fieldwork in Casamance, Southern Senegal*.
 - 9 - DHS 2005, p.238.
 - DHS-MICS 2010–11, p.295.
 - 10 Central Intelligence Agency, *op. cit.*
 - 11 - DHS 2005, p.238.
 - DHS-MICS 2010–11, p.295.
 - 12 DHS-MICS, 2010–11, pp.295 & 298.
 - 13 DHS-MICS 2010–11, p.300.
 - 14 Central Intelligence Agency (2015) *The World Factbook: Senegal*. Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/sg.html>.
 - 15 Andrew Burke, *op. cit.*
 - 16 DHS-MICS 2010–11, pp.238 & 243.
 - 17 - DHS 2005, p.238.
 - DHS-MICS 2010–11, p.295.
 - 18 Central Intelligence Agency, *op. cit.*
 - 19 Elizabeth Berg, Ruth Wan and Ruth Lau (2009) *Senegal*. Marshall Cavendish.
 - 20 - DHS 2005, p.238.
 - DHS-MICS 2010–11, p.295.
 - 21 Central Intelligence Agency, *op. cit.*
 - 22 DHS-MICS 2010–11, p.301.
 - 23 - DHS 2005, p.238.
 - DHS-MICS 2010–11, p.295.
 - 24 DHS-MICS 2010–11, p.298.
 - 25 Central Intelligence Agency, *op. cit.*
 - 26 Access Gambia, *op. cit.*
 - 27 - DHS 2005, p.238.
 - DHS-MICS 2010–11, p.295.

Political Background

Historical

The Senegalese region has been inhabited since the Paleolithic era. The first migration waves occurred from the north and east, with the last waves being the Wolof, Fulani and Serer ethnic groups. The area was once part of the Ghana Empire, and the Kingdom of Tekrur. In the 13th and 14th centuries, it belonged to the Mali and Jolof (Djolof) Empires.

By the mid-15th century, Europeans were trading in the Senegambia region. The Dutch West India Company gained control of the island of Gorée in 1627, and the French and English also competed for control of Gorée and St. Louis. Following the conclusion of the Seven Year's War, Senegal was returned to France. In the colonial period, Senegal had a significant role in the slave trade.

During French colonialism there were four main communes – Saint Louis, Dakar, Gorée and Rufisque – and there was a single seat for a deputy in the French parliament. This remained the only parliamentary representation from Africa anywhere in a European legislature until 1940. In 1848 residents were granted full French citizenship; however, there were significant legal and social barriers. Labelled *originaires*, African-born residents retained their so-called personal status in African and/or Islamic Law. It was only the few who attained higher (French) education – called *évolué* – who gained citizenship.

In 1959 there was a brief merger of Senegal and French Sudan, which created the Mali Federation, but this dissolved in 1960. April 4, 1960 marked Senegal's independence as a republic led by President Léopold Senghor of the Senegalese Progressive Union (Socialist Party of Senegal). Senghor retired in 1980 and was succeeded by Abdou Diouf (serving from 1981 to 2000). At this time there was also a brief confederation of Senegambia (1982–89).



Note: Regions have the same name as their main towns

Figure 4: Regional map of Senegal (@28 Too Many)

Current Political Conditions

Senegal has remained one of the most stable African democracies and has a long history of international peacekeeping and regional mediation. Senegal has 11 administrative regions, a president as the head of state and a prime minister as the head of government.

In 2000, the opposition leader, Abdoulaye Wade, won the election. Macky Sall succeeded Wade in the 2012 elections, which were deemed free and fair, yet police violence at political rallies resulted in 25 injuries and deaths during the election campaign. The Sall Government continues to investigate the Wade administration on corruption charges and misappropriation of government funds.¹

¹ US Department of State (2013) *Human Rights Report: Senegal*.

Sociological Background

Role of Women

Article 7 of Senegal's 2001 Constitution guarantees **equality between women and men**.¹ However, discriminatory practices persist, despite a legal framework that does much to protect women's bodily integrity. While in urban areas laws protecting women are generally respected, life in rural areas is dominated by customary and religious practices, and few women are aware of their legal rights.²

Senegal was ranked 41st out of 86 in the 2012 **Social Institutions and Gender Index (SIGI)**, with a SIGI value of 0.23. This score represents a decline from the 2009 SIGI ranking, which placed Senegal 52nd out of 102 countries, with a value of 0.11.³ The country's 2014 value is 0.2, and the level of gender inequality under the SIGI's new categories is 'medium'.⁴

The **Gender Inequality Index (GII)** is a measure of gender-based inequalities in economic activity (measured by market participation), empowerment (measured by number of women in parliament and attainment of higher education) and reproductive health (measured by maternal mortality and adolescent birth rates). Senegal's GII value of 0.537 ranked it 119th out of 151 countries in 2013, which is a slight improvement from 0.554 in 2010.⁵



*Women in Simbandi
(CCL/Tpafrika.it)*

The Family Code (Article 111) provides a minimum age at **marriage** of 16 for women and 18 for men, but an exemption can be granted after investigations by the president of the regional court.⁶ The payment of dowry is legal and, while marriages between brothers-in-law and sisters-in-law are forbidden, the practices of *levirate* and *sororate* (whereby a man inherits his dead brother's widow or his dead wife's sister, respectively) are legal, as the original marriage is dissolved by death.

Customary and civil marriages co-exist in Senegal. Polygamy is allowed, and men may marry up to four women. Marriage registration is obligatory. According to the DHS-MICS 2010–11, 34.5% of married women are in polygamous unions.⁷

Forced marriage is prohibited, and personal consent for marriage must be given, even where one party is a minor. Having sexual relations with girls under the age of 13 is prohibited under Article 300 of the Penal Code;⁸ however, such unions are reportedly common, especially in rural areas, in

arranged and religious marriages.⁹ The DHS-MICS 2010–11 reports that 16.2% of women aged 25–49 were married by the age of 15 and 40.3% were married by the age of 18.¹⁰

Physical Integrity

Women’s physical integrity is protected mainly through Senegal’s 1999 revised Penal Code, which criminalises domestic violence, sexual assault and rape. **Domestic violence** is punishable by up to five years’ imprisonment and a fine. The prison term increases to 20 years where the act of domestic violence causes lasting injury and a life sentence where it results in death (see Articles 297-*bis* and 320).¹¹

The DHS-MICS 2010–11 reports that 60% of women agree her husband is justified in beating her for one of the given reasons. Women feel that their partner’s violence would be justifiable on the grounds of refusing to have sex with him (46%), arguing with him (44.5%), neglecting the children (40.1%), going out without informing him (39.9%) and burning the food (24.4%).¹²

Although **rape** is criminalised under the Penal Code, spousal rape is not recognised by the law. Very few rape cases are taken to court, and, of those that are, few result in a conviction. In part, this is because sexual violence and rape remain taboo topics and cases are often settled out of court. The penalties for rape include fines and a prison sentence ranging from five to ten years.¹³

Resources and Entitlements

Women’s resources and entitlements are guaranteed by the Constitution and Family Code. The default **marital property** regime for civil marriages is the separation of property, and it is the original owner who legally administers property during the marriage. However, the Family Code states that men are legally head of the household and, as such, they tend to have greater access to agricultural inputs. Despite legislation, bequests, including land inheritance, are common, and ownership is primarily obtained through paternal lineage. Customary practices relating to **land ownership** that discriminate against women are specifically banned under the Constitution, and yet, in practice, continue to limit women’s access to land.¹⁴

Women and men have the same legal rights to **bank accounts and bank loans** (under Article 374 of the Family Code¹⁵), but women often struggle to obtain loans. In response to the difficulties rural women face in accessing credit, the Government has launched a large-scale microfinance initiative. A relatively low level of French literacy also complicates access to bank loans and credit: French is the official language of the country, yet only 1 or 2% of Senegalese women speak it (compared to 15–20% of men).¹⁶

Civil Liberties

The Constitution (Article 8) provides for **freedom of movement** for all citizens.¹⁷ However, married women do not have the right to choose where to live, as this right falls exclusively to their husbands. Despite the freedom of movement provisions, data suggests that women’s daily movements are constrained.¹⁸ According to the DHS-MICS 2010–11, 52.9% of women report that it is primarily their husbands who decide whether they can visit family and relatives.¹⁹

Women in Senegal enjoy full **political rights** to vote and stand for election. In May of 2010 the National Assembly adopted the Law on Equality of Men and Women in Electoral Lists, and in 2012 64 women were elected as members of parliament (out of 150 seats, which is 42.7%). The legislation ensures that political parties submit alternating lists of female and male candidates, with a male:female ratio of 50%; lists that do not comply are not admissible.²⁰



*Women in Diebategunda, Cassamance
(CCL/tpafrica.it)*

- 1 *Senegal's Constitution of 2001* (2001) [English translation 2012 by William S. Hein & Co., Inc.]. Available at https://www.constituteproject.org/constitution/Senegal_2009.pdf?lang=en.
- 2 Social Institutions & Gender Index (2014a) *Senegal*. Available at <https://www.genderindex.org/country/senegal/>.
- 3 Social Institutions & Gender Index (2012) *2012 SIGI*, p.13. Available at <https://www.oecd.org/dev/50288699.pdf>.
- 4 Social Institutions & Gender Index (2014b) *2014 Results*. Available at <https://www.genderindex.org/ranking/>.
- 5 United Nations Development Programme (2014) *Human Development Report. Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience*.
- 6 Code de la Famille: Sénégalais (1989) *Article 11*, p.22. Available at http://www.equalrightstrust.org/ertdocumentbank//CODE_FAMILLE.pdf.
- 7 DHS-MICS 2010–11, p.59.
- 8 Code Penal: Sénégal (1977) *Article 300*, p.50. Available at <http://www.equalrightstrust.org/ertdocumentbank//CODE%20PENAL.pdf>.
- 9 Social Institutions & Gender Index (2014a), *op. cit.*
- 10 DHS-MICS 2010–11, p.63.
- 11 Code Penal: Sénégal, *op. cit.*, pp.49 & 52.
- 12 DHS-MICS 2010–11, p.286.
- 13 Code Penal: Sénégal, *op. cit.*, pp.49 & 52.
- 14 Social Institutions & Gender Index (2014a), *op. cit.*
- 15 Code de la Famille: Sénégalais, *op. cit.*, pp.59–60.
- 16 Social Institutions & Gender Index (2014a), *op. cit.*
- 17 Senegal's Constitution of 2001, *op. cit.*, p.6.
- 18 Social Institutions & Gender Index (2014a), *op. cit.*
- 19 DHS-MICS 2010–11, p.282.
- 20 Social Institutions & Gender Index (2014a), *op. cit.*

Overview of FGM in Senegal

This section gives a broad picture of the current state of FGM in Senegal. Other sections of this report give more detailed analyses of FGM prevalence set within anthropological and sociological frameworks, and of efforts towards its abandonment. For example, an analysis of the relationship between FGM and education may be found in the Education section.

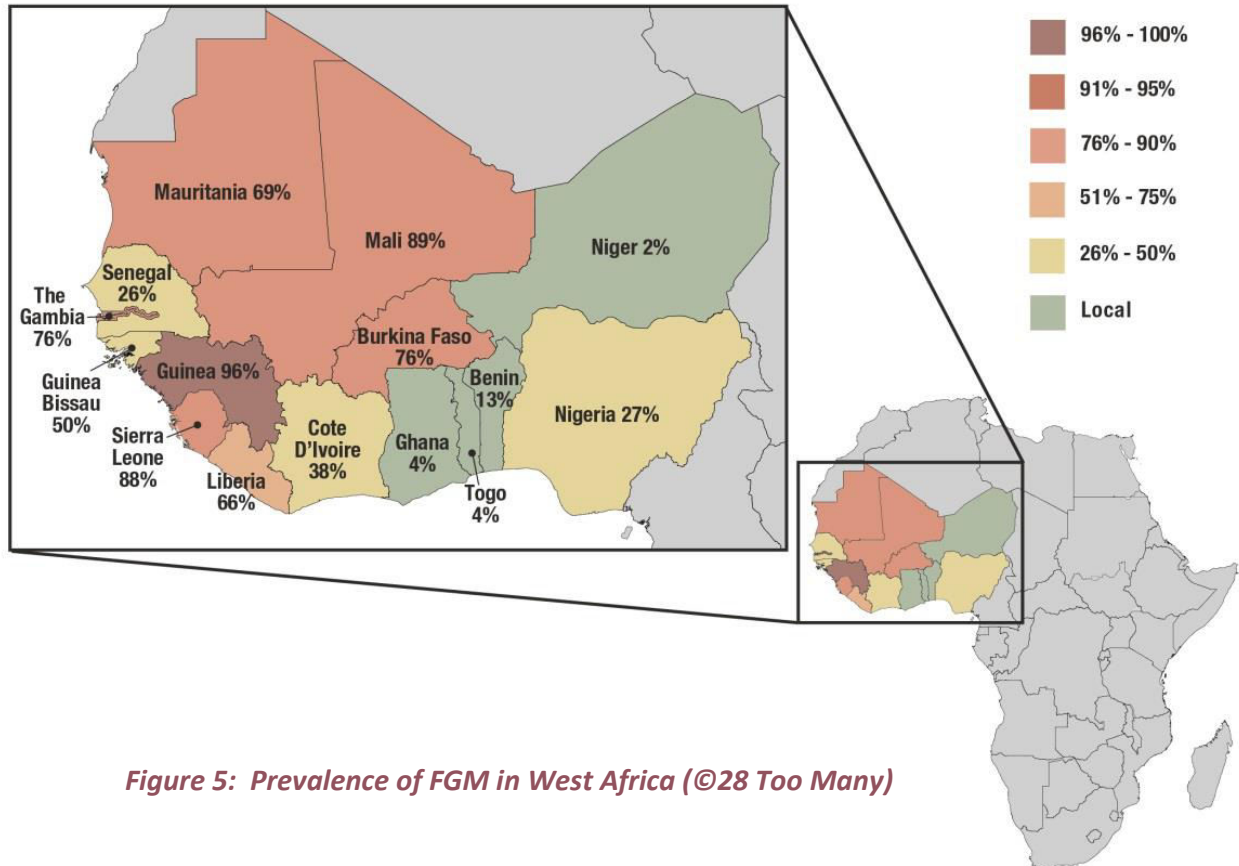


Figure 5: Prevalence of FGM in West Africa (©28 Too Many)

National Statistics and Trends Relating to FGM

The estimated prevalence of FGM in women (aged 15–49) is 25.7%.¹ Senegal is a ‘moderately low prevalence’ country, according to the UNICEF classification. UNICEF states that no significant changes in FGM prevalence can be observed in Senegal since the first survey in 2005.²

The DHS-MICS 2010–11 found a widespread **awareness of the law** against FGM.³

Prevalence of FGM According to Place of Residence

The population of Senegal mostly resides in rural areas (55% in 2013). The Dakar area, with a 96% urban population, has almost half of the country’s urban population (approximately three million people).⁴

Figure 6 shows that there is a 4.4 percentage-point difference in FGM prevalence between those women aged 15–49 living in rural areas and those living in urban environments.

A 2015 study by Kandala and Kompa of the raw DHS data showed ‘a clear pattern of regions with higher risk of FGM’. They were the south-eastern regions of Kolda, Sédhiou and Tambacounda, and the eastern region of Kédougou. The study also concluded that FGM prevalence is lowest in the Dakar region.⁵

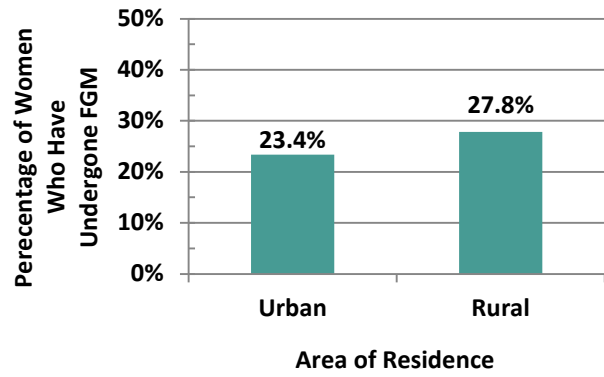


Figure 6: Percentage of women aged 15–49 with FGM, according to area of residence⁵

Regional differences in FGM prevalence (for the DHS figures, see Figure 7) are not simply explained through the ethnic-group demo-graphics of an area; rather, they appear to be a function of historical, political, economic and colonial influences on the peoples and how they identify with the state as it was and is in its modern form. Modernity is feared by many in remote rural locations, such as the Fouta Toro in northern Senegal and Casamance, as it appears to undermine traditional values such as respect for elders, which is a cornerstone of many traditional African societies.⁶ Similarly, in the Fouta Toro, ‘NGOs can be seen as outsiders bringing a subtle form of cultural colonialism disguised as development. The state is seen to be corrupted by the international community.’⁷ This stance allows FGM to become a symbol of resistance and, thus, prevalence remains high.

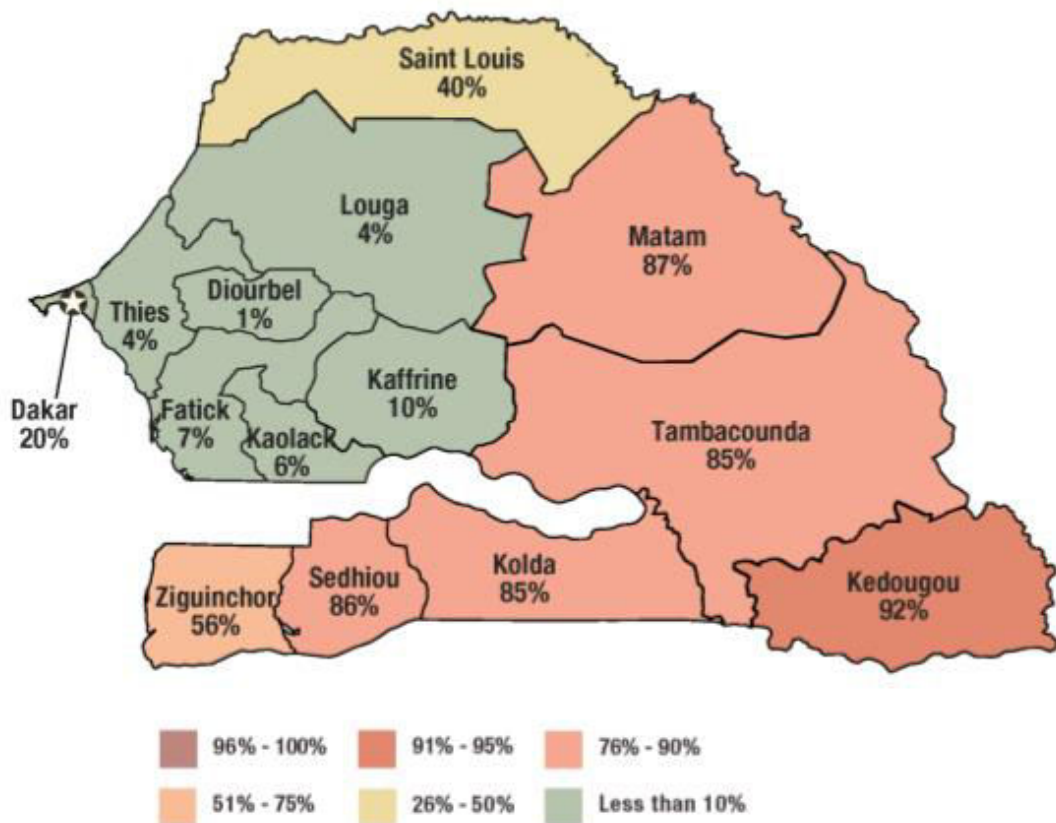


Figure 7: Prevalence of FGM in Senegal by region⁸ (©28 Too Many)

Prevalence of FGM According to Ethnicity

Ethnic Group	2005	2010–11
Wolof	1.6%	0.9%
Poular	62.1%	54.5%
Serer	1.8%	2.2%
Mandingue	73.7%	81.9%
Diola	59.7%	51.5%
Soninké	78.2%	64.9%

Table 2: Prevalence percentages of FGM by ethnicity in 2005 and 2010–11⁹

Table 2 demonstrates a problem with self-reported data on FGM prevalence, as well as statistical uncertainty caused by the relatively small numbers of women surveyed. For example, in the five years between surveys, the Soninké figures reportedly dropped from 78.2% to 64.9%, which is highly unlikely.

A 2013 study in Ghana explores the problem with reliance on self-reporting of FGM and the factors that may affect the answers given at any one time. The study interviewed the same 2,000 women at a five-year interval in relation to FGM. In the interim, the law that had been passed against FGM in Ghana just before the first survey was widely publicised. 13% of women who had stated in the first survey that they had FGM denied this status five years later. The report states:

Investigation of the possibility of response bias assumes growing importance as the legislation and informational campaigns against the practice increase, possibly affecting survey-response validity When the goal of an intervention is to stop the practice, the intervention may simply change women’s responses to survey questions about their circumcision status. Anti-circumcision laws are also likely to change the reliability of self-reported data. Although no generic solution exists for this problem, results must be interpreted with caution, because research aimed at evaluating means of preventing the practice will be compromised if social-mobilization interventions affect the propensity for denial as much as or more than they affect the practice itself.¹⁰

Figure 8 shows that figures are strikingly different for FGM prevalence of daughters (aged 0–9) and women (aged 15–49), but there is an age cohort missing from the data, which is girls aged 10–14. However, as the vast majority of girls are cut before the age of nine, even if this cohort were included, it would not explain the difference.

It should be noted, however, that the number of daughters included in the survey, when broken down by ethnic group, is extremely small, and the statistical uncertainty of this data could therefore contribute to the disparity.

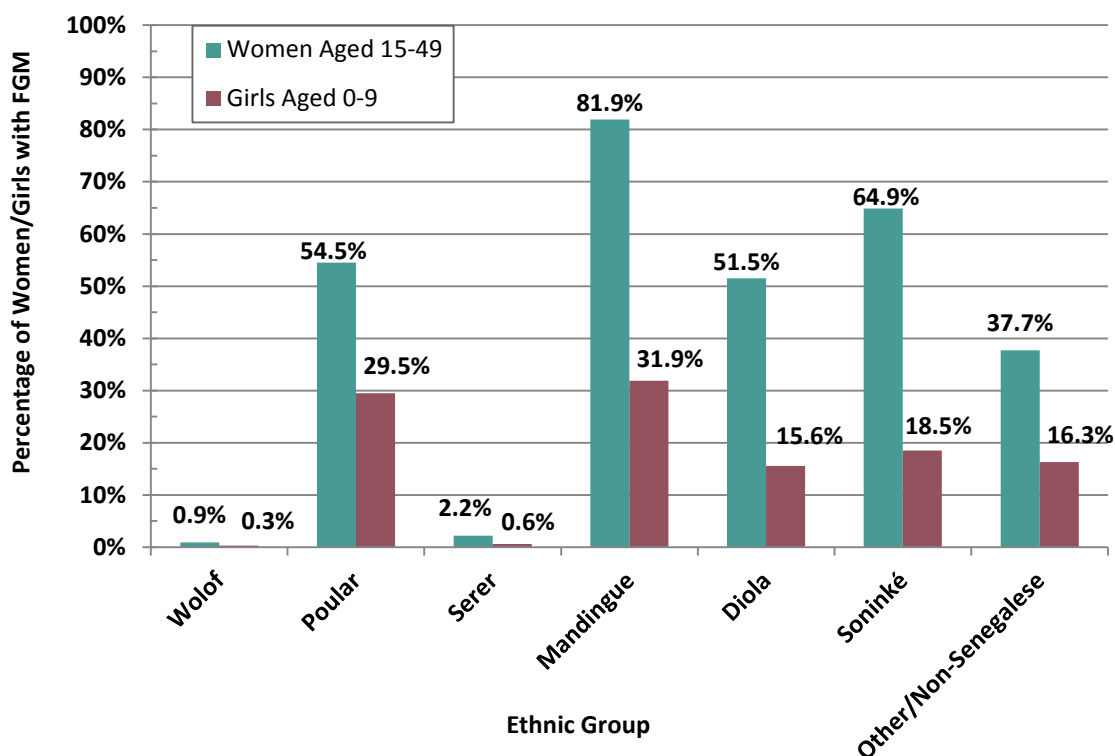


Figure 8: FGM prevalence among women aged 15–49 and daughters aged 0–9, according to ethnicity¹¹

Area of Residence	Wolof	Poular
Dakar	0.2%	33%
Ziguinchor	6%	76%
Diourbel	0%	2%
Saint-Louis	4%	67%
Tambacounda	17%	93%
Kaolack	0.4%	13%
Thiés	0.3%	10%
Louga	0%	12%
Fatick	1%	16%
Kolda	30%	92%
Matam	35%	91%
Kaffrine	1%	45%
Kédougou	unavailable	95%
Sédhiou	unavailable	95%

Table 3: Variability of FGM prevalence within two ethnic group (Wolof and Peulh), depending on the region of Senegal in which women reside¹²

Table 3, using data from the DHS-MICS 2010–11, highlights that, in Senegal, the region in which a woman is born largely determines her risk of being cut. 12% of Poular women living in Louga, for example, have had FGM, compared to 91% of Poular women living in Matam. Similarly, the prevalence of FGM among Wolof women living in Louga is nil, but 35% for Wolof women in Matam. (As discussed above, due to the small numbers of women surveyed, individual figures should be treated with caution.)

It is posited by UNICEF that women from minority groups within different regions adopt the social behaviour of the majority groups.¹³ This appears to be the case for the Diola in Upper Casamance, who live closely with the Mandingue, where in the past 50 years they have adopted Islam as their religion and the women have taken on initiation into the women’s secret society (*ñaaakaya*), which includes FGM. The women strongly defend their right to initiation on religious grounds, as they lost their central ritual role as guardians of agricultural and human fertility when the men converted to Islam for political and economic reasons. Most Diola men are now not in favour of FGM, but the women view this as men trying to undermine women’s autonomy.¹⁴

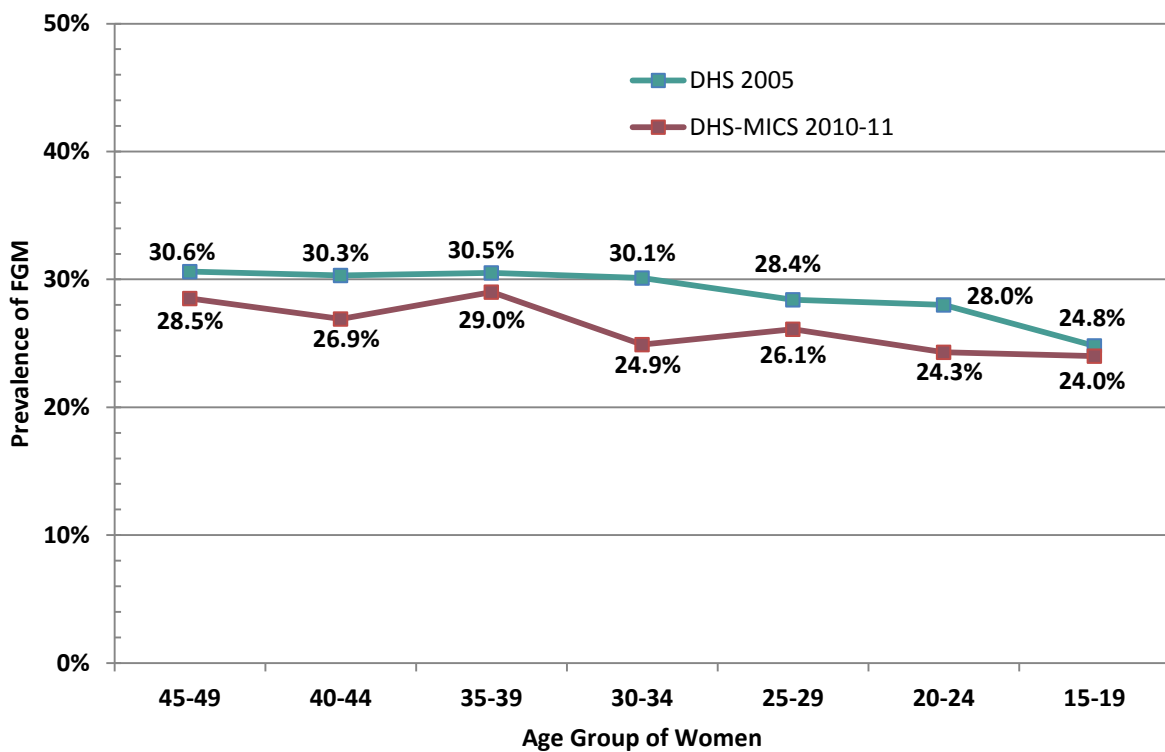


Figure 9: Prevalence of FGM among Senegalese women aged 15–49, 2005 and 2010–11¹⁵

Figure 9 shows the prevalence of FGM among women aged 15–49 as reported in the DHS 2005 and the DHS-MICS 2010–11 surveys. Although the drops in prevalence are not statistically significant, it is interesting to note that across all age groups the prevalence reported is lower. This may indicate a drop in prevalence, or it may suggest that fewer women are willing to report that they have been cut.¹⁶

FGM is practised mainly on children in infancy in Senegal. It is not possible to make a full comparison of the ages at which women were cut to the ages at which girls are being cut, as the age groups used are not the same in the surveys and the number of daughters is extremely low.¹⁷

Types of FGM Practised and Practitioners

There appears to be little medicalised FGM in Senegal, though there has been a slight change in the type of traditional **practitioner** women use. The categories of practitioner reported in the DHS-MICS 2010–11 were ‘traditional circumciser’ (91.4%), ‘traditional birth attendant’ (1%) and other non-specified traditional practitioners (7.6%).¹⁸ This ‘other’ category has grown from 0.3% in 2005, although this may simply be due to different categorisations of ‘other’ between the surveys.¹⁹

Figure 10 shows the percentage distribution of the type of FGM women (aged 15–49) who have been cut have undergone.

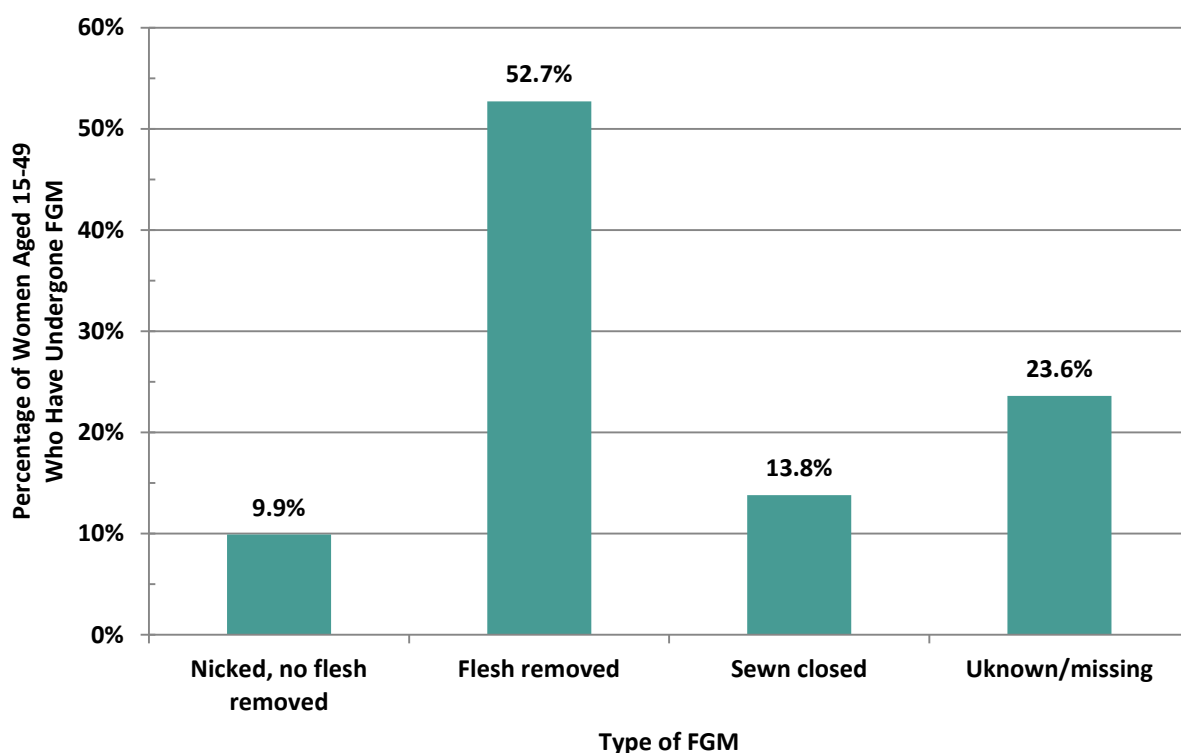


Figure 10: Percentage distribution of women aged 15–49 who have undergone FGM, according to type of FGM they have undergone²⁰

A comparison between the percentages of women aged 15–49 and daughters aged 0–9 who are ‘sewn closed’ cannot be made as there is a high proportion (23.6%) of women with FGM who either do not know the type of FGM they had or for whom the data is missing. Of those women who have been cut, 13.8% report being sewn closed. Among daughters aged 0–9, this figure is 21.3%, and there appears to be an ethnic variation; however, due to the small number of daughters in the survey, more data would be required to confirm this (see Figure 11).

For detailed information about the medicalisation of FGM, please see 28 Too Many’s report, which is available at <http://28toomany.org/fgm-research/medicalisation-fgm/>.

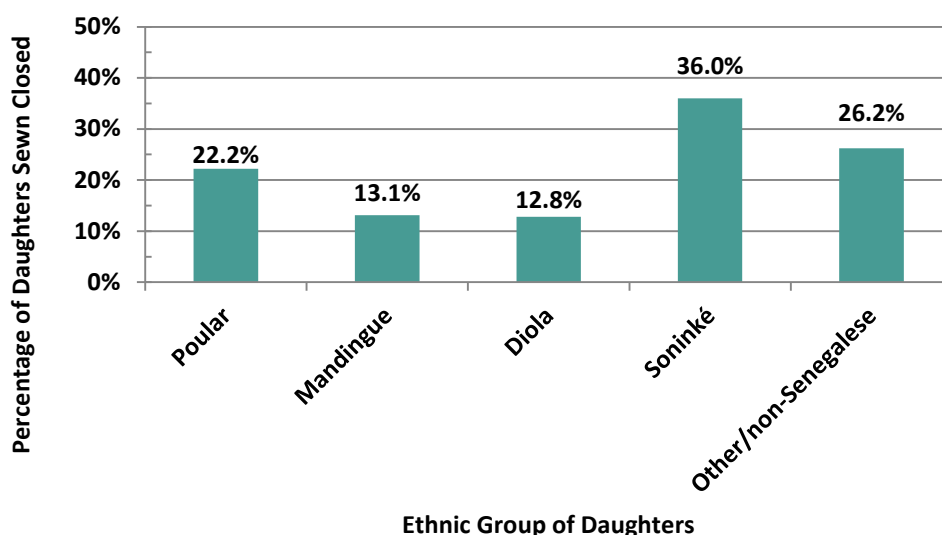


Figure 11: Percentages of daughters (aged 0–9) whose genital area is sewn closed (NB: there is no data available for the Wolof and Serer ethnic groups)²¹

1 DHS-MICS 2010–11, p.295.

2 UNICEF (2013) *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change*. Available at https://www.unicef.org/publications/index_69875.html.

3 DHS-MICS 2010–11, p.294.

4 DHS-MICS 2010–11, p.295.

5 Ngianga-Bakwin Kandala and P.N. Komba (2015) 'Geographic variation of female genital mutilation and legal enforcement in sub-saharan Africa: a case study of Senegal', *American Journal of Tropical Medicine and Hygiene*, 92(4), pp. 838-847.

6 - Liselott Dellenborg, 'A reflection on the cultural meanings of female circumcision: Experiences from fieldwork in Casamance, southern Senegal' in Signe Anfred (ed.) (2004) *Rethinking Sexualities in Africa*. Uppsala: Nordic Africa Institute.

- Sarah O'Neill (2012) *Defying the law, negotiating change: the Futanke's opposition to the national ban on FGM in Senegal*. Doctoral thesis, Goldsmiths, University of London: Goldsmiths Research Online.

7 Sarah O'Neill, *op. cit.*

8 DHS-MICS 2010–11, p.295.

9 - DHS 2005, p.238.

- DHS-MICS 2010–11, p.295.

10 EF Jackson, P Akweongo, E Sakeah, A Hodgson, R Asuru, JF Philips (2003) 'Inconsistent reporting of female genital cutting status in northern Ghana: explanatory factors and analytical consequences', *Studies in Family Planning*, 34(3), pp.200–210.

11 DHS-MICS 2010–11, pp.295 & 298.

12 UNICEF (2013) *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change*, p.37. Available at https://www.unicef.org/publications/index_69875.html.

13 *Ibid.*

14 Liselott Dellenborg, *op. cit.*

15 - DHS 2005, p.238.

- DHS-MICS 2010–11, p.295.

16 DHS 2005, p.238.

- DHS-MICS 2010–11, p.295.

17 DHS-MICS 2010–11, pp.297 & 300.

18 DHS-MICS 2010–11, p.297.

19 DHS 2005, p.243.

20 DHS-MICS 2010–11, p.295.

21 DHS-MICS 2010–11, p.298.

Case Study: The Grandmother Project

We have decided that the traditional approach is not the best. We need to change our ideas. We need to change with the times.¹

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

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

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



*Grandmother Project's activities in Vélingara, Tambacounda Senegal
(Photographer: Mariette Baynton/© The Grandmother Project)*

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

The approaches of the programme that the GMP identified as most important to this change were the respect given to grandmothers, continued intergenerational dialogues, introduction of information about FGM (rather than messages of abandonment) and never identifying or stigmatising cutters.

¹ The GMP cited in Kimberley Brown (2014) 'Grandmothers Propel Social Change', *WorldView*. Available at http://www.grandmotherproject.org/wp-content/uploads/WorldView-Fall-2014_GrandmothersPropelSocialChange.pdf

Laws Relating to Women and Girls

For information on international and African regional laws relating to FGM, please refer to the **law factsheet** on our website.

International and Regional Treaties

Many of the international human-rights conventions and treaties related to the practice of FGM have been signed and ratified by Senegal. This provides a strong basis for the characterisation of FGM as a violation of international human rights. The ratification of these conventions places a legal obligation on Senegal to work towards fully adhering to their provisions, with the aim of eradicating FGM. Senegal has ratified or signed up to the following conventions and treaties:

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

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

In December 2012 the UN passed a historic and unanimous resolution calling on countries to eliminate FGM, and in 2013 the 57th UN Commission on the Status of Women agreed on conclusions that included a reference to the need for states to develop policies and programmes to eliminate FGM as well as other forms of violence against women.¹ In proving its commitment and fulfilling its legal obligation to eradicate FGM, Senegal will need to adopt and implement laws, policies and programmes that work towards the elimination of FGM and all other forms of violence against women.

The **CEDAW** and the **CRC** explicitly prohibit traditional practices that discriminate against women and harm children. Under the ICCPR, FGM is a violation of a person's physical integrity, liberty and

security of person. Under the **ICESCR**, FGM is a violation of the right to health. The **Banjul Charter**, under Article 16, includes the right to health and 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 members 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 prejudicial to the health or life of the child; and
- (b) those customs and practices discriminatory to the child on the grounds of sex or other status.²

The Maputo Protocol also explicitly refers to FGM under Article 5, whereby:

State Parties shall prohibit and condemn . . . through legislative measures backed by sanctions, (b) all forms of female genital mutilation, scarification and paramedicalisation of female genital mutilation and all other practices in order to eradicate them . . .³

National Laws

The Constitution

The Constitution does not specifically prohibit FGM. It does, however, provide for the fundamental right of the person. Article 7 states, 'Every individual has the right to life, to liberty, to security . . . notably to protection against all physical mutilations.'⁴

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

Age of Suffrage, Consent and Marriage

The age of suffrage is specified in the Constitution as 18, and is provided for under Article 3.⁵

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

According to Article 111 of the Family Code, the minimum age of marriage for girls is 16.⁶ However, marriage of girls under 16 is allowed given a waiver by the president of the regional court, after investigation. Parental or guardian consent must also be sought for marriages of minors, according to Articles 103 and 104 of the Family Code.⁷ Islamic religious marriages are recognised by law. According to Article 18 of the Constitution and Article 103 of the Family Code, both parties to the marriage must give free consent and forced marriage is a criminal offence.⁸

National Laws Against FGM

In January 1999 an amendment to the Penal Code (Article 299 *bis*) criminalised FGM in Senegal.⁹ The law specifically prohibits the violation of 'the integrity of the genital organs of a

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

Legal System and Law Enforcement

Senegal’s legal system is based on French civil law. Customary and personal law are not recognised by the Constitution as valid sources of law.¹⁰

Advocacy for abandoning FGM has existed in Senegal since the 1990s. In 1997, the Ministry of Health launched a National Reproductive Programme, which contained a sub-programme on FGM and violence against women. The general objectives of the programme were to:

support the struggle to abolish FGC/M and other forms of violence against women, girls and adolescents in order to protect their reproductive health, promote respect for their fundamental rights and improve their social and economic status.¹¹



**Administrative authority figure
wearing an ‘end FGM’ scarf
(Used with permission; © COSEPRAT)**

- 1 United Nations (2012) *Advancement of Women: Report of the Third Committee*.
- 2 *African Charter on the Rights and Welfare of the Child* (1990) Article 14(1) and Article 21. Available at http://www.achpr.org/files/instruments/child/anchpr_instr_charterchild_eng.pdf.
- 3 *Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa* (2003) Article 5, p.7. Available at http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf.
- 4 *Senegal’s Constitution of 2001* (2001) [English translation 2012 by William S. Hein & Co., Inc.], p.5. Available at https://www.constituteproject.org/constitution/Senegal_2009.pdf?lang=en.
- 5 Senegal’s Constitution of 2001, *op. cit.*, p.4.
- 6 *Code de la Famille: Sénégalais* (1989) p.22. Available at http://www.equalrightstrust.org/ertdocumentbank//CODE_FAMILLE.pdf.
- 7 *Code de la Famille: Sénégalais, op. cit.*, p.22.
- 8 - Senegal’s Constitution of 2001, *op. cit.*, p.8.
- *Code de la Famille: Sénégalais, op. cit.*, p.22.
- 9 *Code Penal: Sénégal* (1977) pp.49–50. Available at <http://www.equalrightstrust.org/ertdocumentbank//CODE%20PENAL.pdf>.
- 10 Social Institutions & Gender Index (2014a) *Senegal*. Available at <https://www.genderindex.org/country/senegal/>.
- 11 Anika Rahman and Nahid Toubia (2000) *Female Genital Mutilation: A Guide to Laws and Policies Worldwide*. Zed Books.

Understanding and Attitudes

A widespread, correct understanding of FGM is a prerequisite to changing attitudes; thus, exposure to accurate information is essential.

Knowledge and Support of FGM

There is little variation in women’s knowledge about FGM, either by their place of residence or ethnicity.

The highest level of support for the continuation of FGM is found among women aged 35–39 (18.1%), although there is not a great difference between that age group and the others. Of women who have had FGM, 52.4% believe it should continue, compared to 2.6% of women who have not been cut. 12.6% of women who have heard of FGM and live in urban areas believe it should continue, compared to 20.9% of those who live in rural areas.¹

UNICEF acknowledges that answers in formal surveys regarding questions about continuing FGM are opinions held at only one point in time. Responses can, moreover, be influenced by intense exposure to abandonment messages and the desire of the respondent to give the ‘correct’ answer. The report quotes research by Hernlund and Shell-Duncan in Senegal, which found that attitudes towards FGM by communities, as well as individuals, may potentially move from support to a desire for abandonment and, in some instances, back again. The authors claim that ‘the construction of a person’s “opinion” about the practice is more correctly an ongoing position vis-à-vis fluctuating needs and realities, representing contingencies that affect decision-making.’²

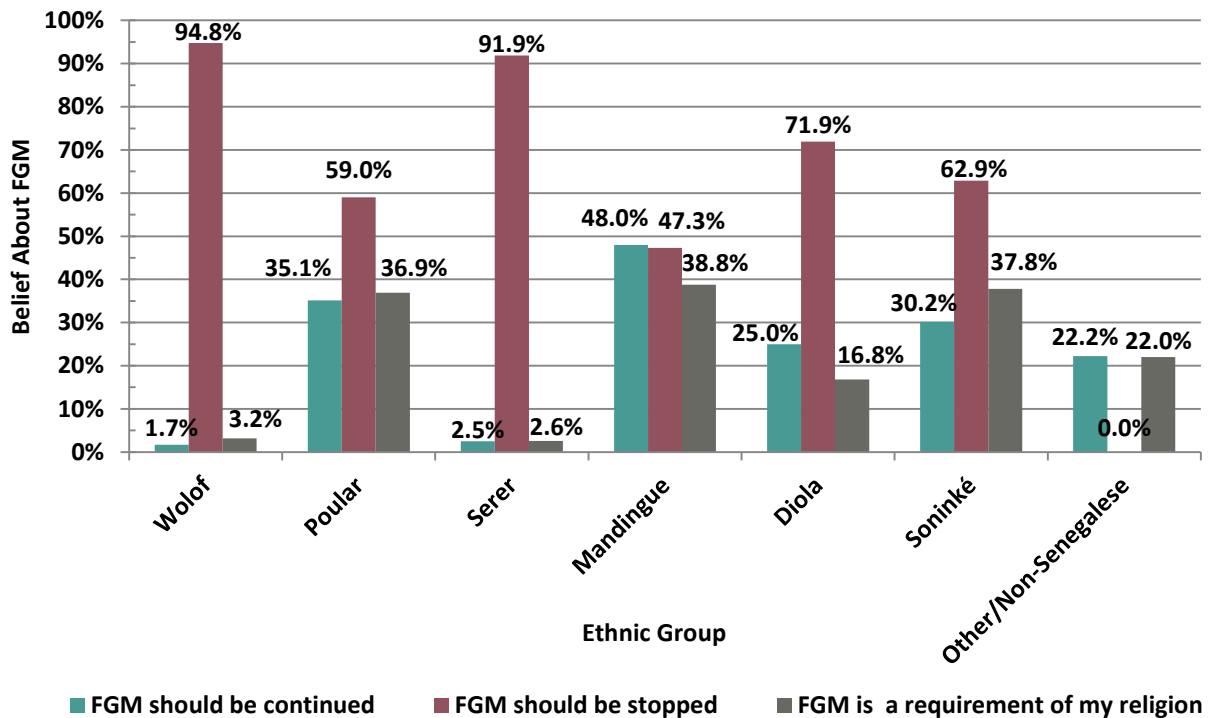


Figure 12: Percentage of women aged 15–49 who have certain beliefs about FGM, according to their ethnic group³

Figure 12 shows that, of women aged 15–49 who have heard of FGM, about two-thirds or more within each ethnic group believe that FGM should stop. The exception is the Mandingue, among whom 47.3% of women said that FGM should stop. The percentages of women who believe that FGM is a religious requirement are largely similar in each ethnic group to those of women who believe that FGM should be continued. The exception is that, for the Mandingue and the Diola, there are perhaps cultural values upholding the practice that are of slightly greater importance than religious considerations, although these figures should be treated with caution due to the smaller number of women from those groups surveyed. They do indicate, however, that more than one approach to tackling abandonment is required.

Both Tostan’s Community Empowerment Programme (CEP) and the Girl’s Holistic Development Programme of The Grandmother Project have had a significant impact on women’s reported support for FGM abandonment. By January 2013, 7,200 communities across Senegal who had directly or indirectly participated in Tostan’s CEP declared their intention to abandon FGM. Tostan is keen to point out, ‘That’s not to say that 100 percent of the community supports or embraces the declaration . . . but it is a milestone that signifies a readiness for change and lays a foundation for the community members to continue working together in their efforts to abandon the practice entirely.’⁴

The Grandmother Project took a baseline survey of attitudes in the 20 villages in Vellingara where it worked in 2008, at the beginning of the Girl’s Holistic Development Programme, and then a further survey after two years. They asked mothers and grandmothers, ‘Would you be ashamed to have an uncut [grand]daughter?’, to which 45% of mothers and 47% of grandmothers originally replied in the affirmative; during the programme, this fell to 3% of mothers and 5% of grandmothers. A second question was asked about whether there is a ‘cultural obligation to perform FGM’. 88% of mothers and 85% of grandmothers initially said that there was, and these figures fell to 9% and 5% respectively.

Reasons for Practising FGM and Its Perceived Benefits

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

Community/Social Acceptance/Tradition

Many women in Senegal view FGM as part of their cultural identity and the law against it as an attack on their culture, imposed as a twofold cultural imperialism by both ‘whites’ and the Senegalese Government.⁵ The DHS 2005 was the last survey to ask about the perceived benefits of FGM for girls, and in this survey 45.3% of women who had undergone FGM felt that it was important for social recognition.⁶

Cleanliness/Hygiene

It is said by some women that uncut women smell bad.⁷ In 2005, when the DHS asked directly about the benefits of FGM, 6.4% of women aged 15–49 believed it benefitted cleanliness and hygiene. Among women who had had FGM, 20% had this belief.⁸

Marriage Prospects

Marriage between different ethnic groups is not uncommon, nor is it uncommon between groups that have different or even no FGM practices. In some cases, some uncut women will be socially excluded until they undergo FGM. In 2005, when the DHS asked directly about the perceived benefits of FGM, 7.1% of women who have had FGM believed it improved marriageability.⁹

Preserve Virginity

The high levels of FGM Type III ('sewn closed') among some ethnic groups is reflected in the groups that believe FGM helps preserve virginity. In the DHS 2005, approximately 20% of Poular and Soninké women aged 15–49 felt this to be true.¹⁰ From conversations with excisors in the Fouta Toro, northern Senegal, O'Neill reports that some believe that the incantations repeated during the performance of FGM prevent any man from penetrating the girl until she marries.¹¹

Religious Requirement

In total, 17.1% of women aged 15–49 who have heard of FGM believe it is a religious obligation. However, 50.6% of women in the same age-group who have undergone FGM believe it to be so. This belief is most common among women aged 45–49 (20.1%) and becomes less common among women with greater levels of education and wealth.¹²

No Benefit

In 2005, 48.5% of women aged 15–49 who had heard of FGM believed it had no benefits, compared to only 17.8% of women in this age group who had had FGM themselves.¹³



***Human rights drawings at a public declaration, Kendougou
(Used with permission; ©Tostan Senegal)***

1 DHS-MICS 2010–11, p.302.

2 UNICEF (2013) *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change*. Available at https://www.unicef.org/publications/index_69875.html.

3 DHS-MICS 2010–11, pp.301 & 302.

4 Tostan (2015) [website]. Available at <https://www.tostan.org/>.

5 Sarah O'Neill (2012) *Defying the law, negotiating change: the Futanke's opposition to the national ban on FGM in Senegal*. Doctoral thesis, Goldsmiths, University of London: Goldsmiths Research Online.

6 DHS 2005, p.251.

7 O'Neill, *op. cit.*

8 DHS 2005, p.251.

9 DHS 2005, p.251.

10 DHS 2005, p.251.

11 O'Neill, *op. cit.*

12 DHS-MICS 2010–11, p.301.

13 DHS 2005, p.251.

Media

Press Freedom

Senegal was ranked 62nd out of 180 countries in the 2014 **Reporters without Borders World Press Freedom Index** because critical reporting is routinely suppressed by authorities through the use of defamation, libel and insult.¹

Article 8 of the Constitution protects both freedom of expression and **freedom of the press**, and Article 10 protects freedom of expression through speech, writing, images and peaceful marching.² These freedoms have occasionally been restricted by authorities under Article 80 of the Penal Code, which prohibits threats to national security (a phrase that is only vaguely defined).³ *Exclusif* magazine and the private daily *Le Quotidien* have both been suspended for defamation and fined; the managing director of *Exclusif* was also given a suspended prison sentence. Such measures have left reporters wary and prone to self-censorship.

President Sall vowed to decriminalise defamation following his election in 2012. While this promise has not yet been met, the press freedom climate in Senegal has steadily improved since Sall came to power.⁴

Major Media Outlets in Eritrea

Radio and television have a greater reach than the internet and newspapers, due to high levels of illiteracy. In addition, most newspapers are unaffordable on an average salary⁵, and only 19% of the population has internet access, though this number continues to grow⁶. Radio is the dominant form of news transmission, through approximately 80 community, public and private commercial radio stations.⁷ There is a discrepancy between media access in urban and rural areas, as neither the Government nor media companies have taken steps to improve media access in rural areas. Radio is the most accessed medium in rural areas, whereas Senegalese private television is more popular in urban areas.⁸

Major news outlets include:

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

Online news sources include:

- *Actu Sen*
- *Dakar Actu*
- *Home View Senegal*
- *Leral*
- *Rewmi*
- *Arenbi*
- *DakarInfo*
- *Info Sen*
- *Leuk Senegal*
- *Sen 24 Heures*
- *Au Senegal*
- *Devoir Citoyen*
- *Journal de Dakar*
- *Nettali*
- *Sene News*

Radio stations include:

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

Access to Media

The Government has been developing telecommunications in the past few years, and **mobile phone** access has been steadily increasing. The number of mobile phones rose from 9.38 million to 10.71 million between 2011 and 2012, reaching 88% mobile penetration. By the end of June 2012, the country had 528,358 **internet** subscribers, there were 375,556 mobile internet users and 95,412 people were connected to ADSL lines.⁹

The DHS-MICS 2010–11 reports that 73.6% of households own a **radio** and 51.8% a **television**.¹⁰ Senegal is in 10th place for **Facebook** usage in Africa, with 4.69% of the population using the site.¹¹

Media exposure at least once per week	Female	Male
Reads a newspaper	12.4%	24.1%
Watches television	62.3%	74.6%
Listens to radio	62.9%	73.7%
All three media	9.9%	21.6%
No media	20.3%	10.6%

Table 4: Percentage of men and women aged 15–49 who access certain media at least once per week¹²

The figures for people’s access to television and radio at least once a week are almost the same as each other (Table 4), but this data masks a large difference in levels of exposure to media between people who live in urban and rural areas. 87.9% of women who live in urban areas and 37.3% of women in rural areas watch television once a week. Exposure to radio in urban and rural areas is more even: 69.3% of woman in urban areas listen to the radio at least once a week, compared to 56.7% of those in rural areas. 6.9% of women in urban areas and 33.3% of women in rural areas are not exposed to any of the three forms of media in a week.¹³

The Media and FGM

According to the African Media Barometer, there has been an increase in grassroots movements for ending violence against women and girls.¹⁴ **Sister Fa** is a prime example of female empowerment through the media. Sister Fa began rapping in 2000 and started her project Education sans Excision (‘Education without Cutting’) in 2010, working in conjunction with NGOs like The Orchid Project, Tostan and World Vision. She has toured villages in Senegal, mainly performing in secondary



*Sister Fa, a Senegalese singer and campaigner
(Used with permission; © Sister Fa)*

schools, sensitising and educating people about the harmful effects of FGM. The tour was promoted on a popular television show with DJ Sega on the Walfra Djiri station. When Sister Fa makes public radio and television appearances, she often faces antagonism and public threats, but she refuses to let such threats prevent her from speaking out against FGM.¹⁵

The **Orchid Project** in the UK is supporting work with Tostan in the use of IT, specifically mobile devices such as tablets, to film people in one village or community talking about why they have chosen to abandon FGM. This is then shown on the tablet in another village, to spread the abandonment campaign. This method of using current information technology also facilitates education about IT.¹⁶

- 1 Reporters Without Borders (2014) *World Press Freedom Index 2014*. Available at <https://rsf.org/en/world-press-freedom-index-2014>.
- 2 *Senegal's Constitution of 2001* (2001) [English translation 2012 by William S. Hein & Co., Inc.], p.6. Available at https://www.constituteproject.org/constitution/Senegal_2009.pdf?lang=en.
- 3 *Code Penal: Sénégal* (1977) p.15. Available at <http://www.equalrightstrust.org/ertdocumentbank//CODE%20PENAL.pdf>.
- 4 - US Department of State (2013) *Human Rights Report: Senegal*.
- Freedom of the Press (2014) *Senegal Report*.
- 5 African Media Barometer (2008) *Country Report: Senegal*.
- 6 International Telecommunications Union (2012) *Measuring the Information Society*.
- 7 US Department of State, *op. cit.*
- 8 African Media Barometer, *op. cit.*
- 9 itnewsafrika.com (2012) *Senegal's Mobile Penetration Passes 88 Percent*.
- 10 DHS-MICS 2010–11, p.20.
- 11 Embassy of the United States – Dakar, Senegal (undated) *Series of Trainings on New and Social Media*.
- 12 DHS-MICS 2010–11, pp.40–41.
- 13 DHS-MICS 2010–11, pp.40–41.
- 14 African Media Barometer, *op. cit.*
- 15 trust.org (undated) 'Senegal Rap Star Says Stop "Cutting" Our Girls', *Thomson Reuters Foundation*.
- 16 28 Too Many correspondence with The Orchid Project

Religion

Around 94% of Senegal's population identifies as Muslim, 5% as Christian and the remaining 1% as either practising an indigenous religion or not adhering to any religious principles.¹ Despite formal adherence to Islam or Christianity, at the spiritual level one witnesses a sort of religious syncretism, where people's ancestral beliefs are lived daily and determine their behaviour.²

Religious freedom is protected in the Constitution, which defines the state as secular (Article 1)³; however, while the Constitution and the Economic Community Of West African States protocol proclaim secularity, the reality in Senegal does not reflect this. Many legal reforms opposing Islamic belief have successfully been fought, and the Family Code has an obvious bias towards Muslim law.⁴

The interfaith peace and lack of **religious tensions** in Senegal can be explained by four factors. Firstly, there is the Senegalese conception of *Teranga*, an expectation of and pride in tolerance and camaraderie. Secondly, religions are not exclusionary: middle-class Muslim children often attend Catholic schools, and important public figures, such as the head of state, are often Catholic or are in dual-faith marriages. Thirdly, the Christian population is so small that it cannot be realistically viewed as a threat to the well-being of the Muslim majority. Finally, religious leaders often collaborate on issues of mutual concern affecting communities.⁵

Islam arrived in Senegal as early as the 9th century; however, the Islamic monks at this time only converted the ruling elite, which gave the impression that Islam was a 'religion of princes'. During the slave trade and European colonialism, Islam began to be the religion of the oppressed and opponents of colonisation. Religion and the state had a clear separation, and the Islam of the Brotherhoods became the religion of liberation, offering people hope, support and identity.⁶

Roman Catholicism first came to Senegal shortly after the Portuguese arrived in 1444. The input of Catholicism was sporadic until the French St. Joseph sisters arrived in 1819. Converts have mostly been from the Serer and Diola people, who are generally concentrated in the south-west but can also be found in Dakar. The Roman Catholic Church is the largest church in Senegal.⁷

The first record of **Protestant** influence in Senegal is in 1862, when a French governor in the south asked the Paris Missionary Society to provide a chaplain. The first baptisms took place 11 years after this first missionary was sent to Senegal.⁸

Religion and FGM

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

Religion	Percentage Who Believe FGM is Required by Religion
Muslim	17.6%
Christian	5.4%
Other/no religion	14.2%

Table 5: Among women who have heard of FGM in Senegal (aged 15–49), percentage who believe that the practice is required by their religion⁹

Religion	Should be Continued	Should be Discontinued	Depends
Muslim	17.1%	78.3%	4.6%
Christian	4.3%	90.2%	5.6%
Other/no religion	18.9%	69.3%	11.8%

Table 6: Opinions of women who have heard of FGM (aged 15–49) as to whether it should be continued, according to their religion¹⁰

There are no available statistics on men’s opinions on FGM and religion.

In 2009 an FGM practitioner was prosecuted for performing FGM on a 16-month-old girl. The prosecution caused outrage in local communities, and around 200 Marabouts (local Islamic preachers) spoke out in defence of the woman and the practice. Preachers in the north of Senegal have been reluctant to denounce FGM – one preacher even issuing a fatwa in favour of the practice. However, in 2010, leading Islamic clerics in neighbouring Mauritania took a stand and issued a fatwa condemning it.¹¹

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4 Fatou Kiné Camara and Abdourahmane Seck (2010) ‘Secularity and Freedom of Religion in Senegal: Between a Constitutional Rock and a Hard Reality’, *BYU Law Review*, 2010(3). Available at <https://digitalcommons.law.byu.edu/cgi/viewcontent.cgi?referer=https://www.google.com.au/&httpsredir=1&article=2534&context=lawreview>.

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- US Department of State (2012) *International Religious Freedom Report*.

6 Ute Gierczynski-Bocandé (undated) *Islam and Democracy in Senegal*. Available at http://www.kas.de/wf/doc/kas_12801-544-2-30.pdf?080116145231.

7 sim.org (undated) *Serving the Church Across Cultures: Senegal Profile*.

8 *WEC Senegal* (undated) [website]. Available at <https://sn.wecinternational.org/>.

9 DHS-MICS 2010–11, p.301.

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11 UNICEF (undated) *UNJP Senegal: Human Rights Key to Ending FGM/C. Legislation is just one aspect of an effective campaign*.

Education

Literacy and the Education System

The **adult literacy rate** in Senegal is 52% and the **youth literacy rate** (ages 15–24) for males is 74% and for females is 59%.¹ These low rates are due to challenges with quality of education and enrolment.

Education is available from pre-school to university. The Constitution guarantees **free and compulsory education** for children (Article 22).² Although education is compulsory, a lack of both schools and teachers means this is not a reality.³

Since Senegal's independence, **secular education** has followed the French model: pre-primary (ages three to six), primary (ages seven to 12), secondary middle school (ages 12 to 16) and secondary high school (ages 17 and 18), although the ages of pupils in each class vary due to the country's repeat-year system.⁴

Although the most widely used **language** in Senegal is Wolof and only 20% of the population is literate in French, the curriculum is taught in French. This excludes the majority of the population from jobs in the public and private sectors and from participating in politics.⁵ Arabic or Koranic schools are more popular; however, research suggests that the Arabic language is rarely spoken out of this context.⁶

Private education is also available in Senegal, and there has been a rise in attendance in this sector. Private schools have improved rates of gender equality, are better equipped and obtain better results, but are accessible mainly to the wealthy. Their growing numbers now demonstrate increasing divides, and public school is seen as a route for those who cannot afford private education.⁷ Private schools in Senegal can be secular, Catholic, Protestant or French-Arabic.⁸

Madrahssas (Islamic Education)

Ninety-four percent of the Senegalese population are Muslim. Traditional Koranic education is free, and schools begin enrolling pupils between the ages of three and five years. The majority of education at Islamic schools is to teach pupils to recite the Koran by heart, which does not require an understanding of Arabic.⁹ With a lack of governmental control in Koranic schools, there is no guarantee that children will receive proper schooling and a basic education.¹⁰ The prime minister has reported, 'One of the policies that we're trying to implement is to come up with the idea of upgrading the Koranic schools, giving them a curriculum where we would mix Koranic teaching with modern teaching, with math and French, and try to give training to the teachers.'¹¹

*'The ultimate aim of [a Koranic] school is to prepare the children to become good Muslims. The main values transmitted are obedience, respect, and submission. Pedagogical strategies may include corporal punishment and often begging for food, which is supposed to allow students to experience humility and solidarity, both highly valued in Sufi Islam.'*¹²

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



*Talibés pupils. Talibein Velingara
(©Bary Pousman, Wikimedia)*

Education and the Millennium Development Goals

The Senegalese Government has supported the MDGs through public programmes in areas such as water, health and education. Progress has been made on access to primary education, gender parity in primary education, maternal health and access to water in rural and urban areas. However, growth is slow and irregular, and the speed of progress is insufficient to reach the MDGs, including the goal of achieving gender parity in post-primary education by the end of 2015.¹³

Goal 1: Eradicate Extreme Poverty and Hunger

Senegal has made progress toward reaching this goal, and it is reported that food security has improved for 1.3 million children under the age of five through community nutrition programmes. 300,000 children have also received weekly micronutrients and de-worming medication.¹⁴ Senegal has been placed as a top-ten achiever in percentage-point progress for this MDG category.¹⁵

Goal 2: Achieve Universal Primary Education

Primary-education attendance has improved, growing from 54% in 1994 to over 82% in 2005. However, inequalities have not disappeared, but have shifted to the secondary-education level.¹⁶ It is expected that Senegal will meet its MDG of universal primary education by 2015.¹⁷ In an attempt

to reach the MDG of universal schooling, around 1,992 teachers were recruited directly from university, with a diploma but without educational training. Regional, in-service teacher-training roles were created by the Ministry of Education in Senegal to complement teacher recruitment.¹⁸

The Senegalese Government implemented a ten-year **Education and Training Development Programme** from 2001 to 2011. Assistance towards this programme came from international donors and allowed for increased access to education through the building of primary, middle, and junior-high schools.¹⁹ This prompted a rapid rise in primary-school enrolment, which resulted in more girls enrolling than boys. Results also showed a drop in the number of pupils re-sitting the year and a rise in those going to secondary school. Although this progress is positive, USAID notes that **quality of education** in Senegalese schools still has a long way to go. Schools still rely heavily on teachers who do not have appropriate training, and the number of students achieving the basics in French and mathematics remains low.²⁰

Primary schools outnumber secondary schools across Senegal; therefore, many students have to **leave their homes** to continue their education. This is **costly**, as students often have to pay for transport, school fees and books. Children in rural areas often face **long walks** to school, and this can affect parents' decisions to send their children to school.²¹ Girls, in particular, are affected by the location of middle schools as parents are reluctant to allow them to travel long distances.²²

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

Net attendance ratios (NARs) show the percentage of all children within the eligible age for each level of education who actually attend school at that level. Table 7 shows this data according to sex, place of residence and wealth quintile. The data shows a disparity in attendance both at primary level between rural and urban areas – 43.6% and 72.2% respectively – and at secondary level – 16.7% and 43.8% respectively. More girls than boys attend primary school (56.1% and 52.3% respectively), but more boys attend secondary education. Total figures show that just under half of all primary-aged children do not attend school, and around 70% of children aged 11–16 are not in school.²³

Place of Residence/ Wealth Quintile	Primary School NAR			Secondary School NAR		
	Female	Male	Total	Female	Male	Total
Urban	73.3%	71.2%	72.2%	43.4%	44.2%	43.8%
Rural	45.9%	41.3%	43.6%	15.4%	18.0%	16.7%
Poorest	44.4%	37.7%	41.0%	9.5%	12.9%	11.1%
Wealthiest	69.3%	70.8%	70.0%	51.6%	54.3%	52.9%
TOTAL	56.1%	52.3%	54.2%	27.4%	29.4%	28.4%

Table 7: Net attendance ratio (NAR) of children attending either primary or secondary school²⁴

Goal 3: Promote Gender Equality and Empower Women

Following Senegal's independence, the gap between female and male enrolment narrowed. The MDG of equality between the number of boys and girls enrolling in primary school has been achieved; in fact, it is in favour of girls. However, obstacles still remain, and there are still more boys than girls actually completing primary school.²⁵

UNESCO reports show that the percentage of **enrolled students compared to the percentage who actually complete the cycle** puts Senegal near the bottom of their list for African countries. In primary school, only 50% of pupils begin first grade and complete the cycle. Pupils drop out of school commonly during the transition from primary to secondary education and also during secondary education. In 2010, UNESCO reported that the net school enrolment rate was 75% – 78% girls and 73% boys.²⁶

There is progressive **political support** for pursuing gender parity in education. As part of the Research Triangle Institute's Project, a gender-integration guide was introduced. Gender equality was also taken into account by the Ministry of Education's guidelines for teacher transfers, and incentives were put in place for the recruitment and retaining of female teachers, particularly in rural areas.²⁷ Moreover, in 2012, the country held elections following the passing of a gender parity law that requires a minimum of 50% of their candidates in local and national elections to be female. The country now has a female prime minister, and female lawmakers have increased from 22% to 43%.²⁸



Students in Senegal (@ Wikiwand)

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

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

A figure issued by the Ministry of Education put the percentage of **teen pregnancy** due to sex with teachers at 40%, presenting a significant deterrent for families to sending their teenage girls to school. **Sexual harassment** can also be a reason for dropping out.

The **Grandmother Project** actively fosters relations between schools and grandmothers in communities, which breaks down social fears and misunderstandings within communities regarding the value of education.

Women's positions in society are affected by people's perceptions of socio-cultural 'norms', and this is another reason for the high dropout rate. The lack of female role models and gender-aware teachers has led to a lower performance of female students. The role and position of women in society therefore also contributes to the low literacy rates of girls and women.²⁹

Education and FGM

Several studies suggest that 'educational attainment alone did not change attitudes and practices[;] rather that it acted as a mediating variable through which other processes, such as the diffusion of new information, operate.'³⁰ The effects of education may not be immediate nor direct, but it is believed to be the best long-term intervention to address FGM. Data from the DHS-MICS 2010–11 shows that the percentage of daughters aged 0–9 who have FGM decreases from 15.4% if their mothers have had 'no' education to 7.5% if their mothers have had a primary level of education and to 3.4% if their mothers have had secondary or higher levels of education.³¹

Incorporating education about FGM into the Senegalese curriculum is an ongoing process. According to a 2011 UNFPA and UNICEF report, the Government was on course to integrate FGM education into the curricula of all schools and colleges; however, by 2013 it appeared that little had changed.³² There are ongoing calls for the Senegalese Government to act on this, although it is reported that the Group for the Study and Teaching of the Population has started training teachers to incorporate FGM into the curriculum.³³



*Great day at School in Kaplack
(© Angela Sevin)*

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

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- 13 Abdoulaye Diagne, François Joseph Cabral, Fatou Cissé and Anne-Sophie Robilliard (2011) *Assessing Development Strategies to Achieve the MDGs in The Republic of Senegal*.
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- 16 Karine Delaunay, *op. cit.*
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- 22 A. Brewer (2013) *Educating Senegalese Girls*.
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- 24 DHS-MICS 2010–11, p.28.
- 25 Laurie Lee (2013) '21st Century Progress in Africa: Achieving MDG 3 in Senegal', *Bill & Melinda Gates Foundation*, 19 September.
- 26 Ritsu Taniguchi, *op. cit.*
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- 31 DHS-MICS 2010–11, p.298.
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- 33 Jennifer Lazuta (2013) 'Female Genital Mutilation: Africa's Curse on Women', *Africa In Fact*, 1 August.

Healthcare

Status of the Healthcare System

Healthcare is provided by both the Government and private healthcare providers. The aim is to provide free healthcare for all, to improve the key health indicators identified in the MDGs.

The health system has three distinct levels: Central (ministry and government departments), Intermediary (medical regions that monitor private and public facilities) and Peripheral (75 health districts that provide local healthcare). Senegal has 22 hospitals, 78 health centres, 986 public health posts and 144 private health posts. There is approximately one health post per 13,083 inhabitants, and there are around 2,000 health huts.¹ For every 10,000 inhabitants, Senegal has one doctor, four nurses/midwives and three hospital beds.²

Senegal needs to further develop health infrastructure to ensure consistency in access between districts, particularly between urban and rural areas, and to promote health for the general population. This investment will help Senegal continue to make progress towards the health-related MDGs.

There has been a drive for sector-wide approaches in health, including the **Plan National de Développement Sanitaire 2009–2018** and the **Ministry of Public Health and Prevention Extended Programme of Immunisation (EPI) Comprehensive Multiyear Plan 2012–2016**. It has been suggested that the high turnover in positions in the health ministry and senior administration disrupts policy progress.³ The lack of stability adds additional challenges to working to strengthen the infrastructure.

Life expectancy in Senegal is 63 years.⁴

Health and The Millennium Development Goals

Goal 4: Reduce Child Mortality

The aim for Senegal, along with other African countries, is to reduce child mortality by two-thirds. Data suggests that there have been meaningful reductions in child and infant mortality overall in Senegal.⁵ The country currently has an infant mortality rate of 44 deaths per 1,000 live births and a child mortality rate of 60 deaths per 1,000 live births.

Goal 5: Improve Maternal Health

This goal was to reduce the maternal mortality ratio (MMR) by three-quarters. Senegal is reported to have a ratio of 320 maternal deaths per 100,000 live births as of 2013. Although this is significantly less than Africa as a whole, it remains short of the anticipated reduction in MMR to 218 deaths. The Ministry of Public Health and Prevention reports a disparity between rates in rural and urban areas, suggesting that rural areas experience a higher MMR as these are often both the

poorest and most isolated areas.⁶ Access to skilled healthcare professionals is key to the promotion of maternal health and the early recognition of complications. Data from 2010/2011 suggests that 65.1% of births are attended by skilled healthcare staff.⁷

Goal 6: Combat HIV/AIDS, Malaria and Other Diseases

This goal is for the spread of HIV/AIDS, malaria and other diseases, particularly Tuberculosis, to be reversed. Progress has been made in all of these areas, with continued downward trends in incidence, prevalence and death rates, but work needs to continue to ensure the continuation of this progress.

The United Nations Programme on HIV and AIDS Global Report highlighted that there has been a reduction in condom use.⁸ This has the potential to increase the spread of HIV and negatively affect overall health.

The Senegal National Program Against Malaria arranged for provision of mosquito nets through health facilities, subsidised sales and a free distribution campaign.⁹ These are important contributions to achieving the MDGs.

Women's Health

Reproductive Healthcare

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

According to the DHS-MICS 2010–11, 9.3% of women in the 15–19 age-range are married before the age of 15.¹⁰ This is a decrease compared to older age-groups, demonstrating that the age of first marriage is currently rising.¹¹ The age a woman is first married is important because this is usually the time when women begin sexual relationships and embark on child-rearing. The DHS-MICS 2010–11 also found that 9.6% of women in this same age-range had sexual intercourse at 15 years of age.¹²

The prevalence of contraceptive use is considered to be a significant factor in preventing the reduction of adolescent birth rates. Senegal has a contraceptive-use prevalence of 17.8% and a world ranking of 141.¹³ Some women have to be discrete in their use of contraceptives, as there can be spousal pressure to have children. Some husbands ask healthcare workers to stop supplying contraceptives to their wives. This is perhaps due to the social and cultural pressures to have large families.¹⁴

According to the DHS-MICS 2010–11, 93% of women received antenatal care by a healthcare provider. The recommended number of appointments is four, and 50% of women attend all four, while 4% of women attend only one.¹⁵ As would be expected, attendance is more frequent in urban areas than in rural areas.

Healthcare and FGM

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

Traditional 'circumcisers' perform the majority of FGM in Senegal.¹⁶ They are reported to use a variety of tools such as scissors, razor blades or even broken glass to excise the genitalia, usually without anaesthetic.¹⁷ They may also cut a number of girls at a time, increasing the risk of cross-infection (for example, of HIV) in addition to the high risk of haemorrhage, making FGM a public-health issue.¹⁸

There is little evidence that girls/women seek **treatment** for either the short- or long-term complications of FGM. This could be a result of traditional cultural beliefs that FGM forms part of the transition to womanhood and, therefore, the effects of FGM may not be openly discussed or recognised. Women may also believe that health consequences are due to witchcraft or God's will¹⁹, leading them to accept the physiological and psychological effects rather than seek support and treatment. There is also the practical issue of accessing health facilities and professionals that have the skills and resources to provide treatment.

A pilot scheme in Dakar offering **reconstructive surgery** for FGM survivors was being freely offered for a limited period in 2012.²⁰ It is unclear how many women accessed this surgery as it was described as a 'handful'. Although reconstructive surgery offers some hope for women, it is important to note that this depends on the severity of the FGM, and, if the cutting is too severe, success may be limited.²¹

Although the Government has criminalised FGM, it is now likely to be done at a younger age and in secret.²² This makes it less obvious to people who may report the practice and may impact on families' health-seeking behaviours.



*A girl from the Casamance region,
where FGM is practised
(CCL/Tpafrica.it)*

Reproductive Health Complications

There are many reproductive-health complications as a result of FGM and the lack of women's healthcare. Women may have to travel significant distances to reach a healthcare professional or a fully functioning medical facility, and many do not have access to modern transportation. This is particularly problematic in rural areas. It also results in either **a delay in women receiving healthcare assistance or in them never receiving professional support**. This is a significant issue for women who experience obstructed labour (dystocia), and this risk increases for adolescents and for women who have been infibulated.²³

There is a likelihood of **infection** from FGM both in the short and long term. Any unhealed or open area leaves conditions suitable for the multiplication of harmful bacteria, leading to conditions such as urinary tract infections, cysts, abscesses and pelvic inflammatory infections.²⁴ There is also evidence to suggest that menstruation may be a time when there is an increased vulnerability to infections, particularly if good hygiene facilities are unavailable.²⁵

Haemorrhage is a known birth complication for women who have had FGM of all types, due to the inelasticity of the scar tissue. This can lead to tearing during delivery and increased risk of the need for an episiotomy (a cut between the vagina and anus to ease delivery) or a caesarean section.²⁶ There is also a greater risk of post-partum haemorrhaging, meaning that a blood transfusion may be required. Unless a woman lives close to a large medical facility, it is unlikely that this will be available to her, due to issues relating to ethics, the availability of screened blood and the cold storage required to maintain the quality of blood products.²⁷

It is estimated that around two million women and girls across Asia and sub-Saharan Africa are affected by **fistula** (a hole that has formed between two body organs), a condition caused by long and obstructed labour²⁸, which is more common in adolescent mothers due to immaturity of their reproductive system. The Fistula Foundation suggests that 75% of women who have an obstetric fistula have been in labour for three or more days.²⁹ The prolonged pressure from the baby getting stuck in the birth canal damages the tissues between the vagina, the urethra and/or the rectum, resulting in urinary and/or faecal incontinence. As well as being physically devastating, fistula is a socially debilitating illness – sufferers may be mocked and ostracised due to the smell and leakage. Fistula can often be successfully treated by surgery.

There do not appear to be any dedicated fistula clinics or medical facilities that specialise in this type of surgery in Senegal. NGOs such as Tostan and the Fistula Foundation have been providing support and training to help with treatment, and Tostan runs Fistula repair surgery camps. Tostan has also launched a campaign to raise community awareness of this debilitating but treatable condition.³⁰

A multi-country study was set up to estimate the increased **costs in obstetric care** due to complications as a result of FGM. The annual cost was estimated to be US\$3.7 million and ranged from 0.1% to 1% of government spending on health for women aged 15–45.³¹

Place of Delivery

De Bernis *et al* suggest that it is the skill of the person attending the birth that may have the most significant impact on infant and maternal mortality and morbidity. This study found that, when trained personnel, in particular midwives, were in attendance, they recognised complications of

pregnancy and delivery earlier, leading to more timely interventions and improved outcomes. They also found lower mortality rates at the regional hospital compared to the district health facility, suggesting that both level of training and equipment availability further improve outcomes.³²

The DHS-MICS 2010–11 found that 93.1% of women living in urban areas and 60.2% in rural areas deliver in a health facility. In total, 72.8% of pregnant women go to a health facility to give birth.³³ The majority of women in health facilities are attended by a healthcare professional (88%), compared to only 5% of women who give birth elsewhere³⁴; this disparity again negatively impacts most women living in rural areas.

FGM is known to increase the risk of birth complications, including maternal and infant mortality.³⁵ The complications increase depending on the severity of the FGM, with infibulation/Type III resulting in the most harmful outcomes. There is a significantly greater risk of needing a caesarean section and other interventions for women who have experienced FGM, making the attendance of skilled healthcare professionals with access to appropriate equipment essential for this group.³⁶

Infant Mortality



***Women and baby in Diebete Kunda
(CCL/Tpafrica.it)***

Senegal has an infant mortality rate of 44 per 1,000 live births. Infant mortality has decreased by 45%, according to the DHS-MICS 2010–11 data, and Gueye and Ndiaye describe this as the most significant decrease since the 2001 data collection. They also note that there are significant differences in child and infant mortality rates, depending on the area where a child is living, with children residing in urban areas faring better than those in rural areas. There is considerable regional variation, as well – southern areas demonstrate higher mortality rates compared to other regions.³⁷

In a multi-country survey, the WHO demonstrated that death rates among new-born babies are higher in mothers who have had FGM. There was an increased need to resuscitate babies whose mothers had had FGM (66% higher in women with Type III). The death rate among babies during and immediately after birth was also much higher for those born to mothers with FGM: 15% higher in those whose mothers had had Type I; 32% higher in those whose mothers had had Type II; and 55% higher in those whose mothers had had Type III. The study estimated that FGM leads to an extra one to two perinatal deaths per 100 deliveries.³⁸

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Strategies to End FGM and Organisational Profiles

Background

Though the ban on FGM was legislated in 1999, campaigns against the practice existed in Senegal as early as 1984. The **IAC** was established in Dakar in 1984, and it sought to change social values and raise awareness of HTPs, specifically FGM. The IAC's main focus is eliminating the practice by raising awareness and educating.

Tostan, founded in 1991 by Molly Melching, has also been widely recognised for its work campaigning against FGM in Senegal. During the 1980s, while working in the Peace Corps and finding that international development methods were ineffective, Melching and a team of Senegalese cultural specialists established the Community Empowerment Program (*CEP*), which led to the founding of Tostan in 1991.

Demba Diawara, a village chief and Imam who worked with Tostan in 1997 and 1998, successfully managed to inspire 13 communities in Senegal to publicly declare to end FGM. Diawara credits this 'widespread change' to the understanding that 'a person's family is not their village', and that all of one's social network (both local and global) must be involved in enacting change.¹

Government Policy and Support

With the accession to power of President Wade in 2000, the new minister of family and national solidarity directed a new study of FGM. The goals of the study included developing an integrated approach to the fight against the practice; identifying those scattered groups working against the practice and their methods; tracking and assessing the situation of those women who have publicly abandoned the practice; reviewing the extent of the practice; and assessing the impact of the 1999 law criminalising the practice.²

In the same year, the Government produced and adopted the **Plan for National Action for the Abandonment of the Practice of Sexual Mutilation 2000–2005**, according to which FGM was hoped to be eradicated in Senegal by 2015. The main aims were to improve networking and coordination among actors involved in efforts to combat the practice, explaining the legal framework to them and integrating FGM into formal and non-formal education. The subsequent demographic study following the adoption of the Plan found that FGM was at a prevalence of 28% in Senegal. An evaluation of the Plan conducted in 2008 noted that, of approximately 5,000 villages practising FGM, 3,300 had pledged in public declarations to end the practice by 2008.³

A second action plan, the **National Action Plan for the Acceleration of the Abandonment of FGM 2010–2015**, was launched in 2009 by the prime minister with the help of the UNJP. The objective remains the complete eradication of the practice by 2015.⁴

Anti-FGM Initiatives Networks

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

Overview of Strategies to End FGM

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

Type of Strategy	Abbreviation
Alternative rites of passage	ARP
Human rights/community dialogue programmes	HR/CDP
Promotion of girls' education to oppose FGM	E
Educating traditional excisors and offering alternative income	EX
Addressing health complications of FGM	H
Health risk/harmful traditional practice	HTP
Legal	L
Medial influence	M
Working with men and boys	MB
Religious-orientated	R
Supporting girls escaping from FGM/child marriage	SG

Table 8: Strategies used by organisations to promote the abandonment of FGM



Symbolic burning of cutting instruments at an FGC Declaration Ceremony, Goudiry Village, 2015 (Used with permission; © Tostan Senegal)

International Organisations

Action Aid

Strategies: H / HTP / E / R / SG

www.actionaid.org

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

The Association of European Parliamentarians With Africa (AWEPA)

Strategies: HR / E / HTP / M / CDP

www.awepa.org

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



AWEPA banner
(Used with permission; © AWEPA)

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

Following this, AWEPA undertook a number of targeted activities in Senegal, including elected delegates visiting regions in the north and south-east to instigate debates on the abandonment of FGM. The discussions were welcomed, and communities requested that the representatives continue to work on the topic. Follow-up work addressed the issues of monitoring and evaluation, provided a strategy for field visits and ensured significant media coverage through radio, TV news and written articles.

In April 2014 a consultation mission resulted in a detailed action plan being made by the Task Force on FGM/C, to continue progress. One of the first activities was a high-level workshop on FGM for Senegal National Assembly Committee chairs in December 2014. It brought together 57 participants, including the vice-president of the National Assembly, chairs of different committees,

other MPs, experts, UNFPA representatives and members of the Comité de Pilotage to discuss FGM. AWEPA reports that all these activities have resulted in increased awareness among MPs in Senegal, a sharing of expertise and experience, increased interaction between all parties and stronger links between MPs and local leaders on the subject.

Environmental Development Action in the Third World (EDNA)

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

ENDA was established by the African Institute for Economic Development and Planning in 1972. Based in Senegal, it is active in 14 countries and has programmes involved with youth education, health promotion, democracy, governance and sustainable development. Work carried out in West Africa is undertaken under the subsidiary ENDA Graf Sahel. In addition, ENDA Health works on community-health initiatives throughout West Africa, including in Senegal. Priority areas include human rights and health, malaria, HIV/AIDS, and capacity-building and support for CBOs.

ENDA has been working to end FGM since the 1990s through activities such as organising a workshop on the harmful nature of the practice in 1993 and producing a report examining the incidence of FGM in Senegal in 1998. More recently, in 2010/2011, with the support of the International Development Research Centre, ENDA led a research project on FGM that looked at how modern communication tools such as mobile phones, the internet and community radio can be enlisted in the work to eradicate FGM in francophone West Africa.

Groupe Pour l'Abolition des Mutilations Sexuelles (GAMS)

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

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

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

The Grandmother Project (GMP)

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

GMP is an INGO working mainly in West Africa that recognises the influential role that grandmothers have within their families and communities and uses them as leaders for change and development. GMP's project in Senegal is called Girls' Holistic Development, which is about improving all aspects of their lives, including supporting them to pursue their education, as well as supporting intergenerational community forums to promote positive cultural values and to discuss HTPs such as FGM and child marriage. Grandmothers are supported to play a central role in discussions and problem-solving activities between all age groups, both male and female. They aim

to identify and perpetuate the 'good' traditions (such as songs, dances and storytelling) and eliminate the 'bad' traditions (such as child marriage, teen pregnancy and FGM). GMP has also facilitated programmes between schools and communities to break down some of the misunderstandings about modern education and successfully introduced curricula on traditional values into local schools with the active support of the Ministry of Education. One of the educational innovations is pamphlets like the one shown in the image below, which are used in schools.

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



African Proverbs for Today's Children, a partner project with World Vision in Vélingara, Tambacounda (Used with permission; © The Grandmother Project)

Inter-African Committee on Traditional Practices (IAC)

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

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

IAC programmes throughout Africa include training for professionals, women's and men's groups, peer educators and legal bodies. The organisation undertakes information and sensitisation campaigns, targeting groups such as religious leaders and traditional rulers, and provides training

and credit to ex-cutters, utilising them as agents for change. COSEPRAT is the IAC national committee member for Senegal.

Orchid Project

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

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

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

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

***Medina Yoro Foulah Kolda FGM-
 Abandonment Declaration
 (Used with permission;
 © Alicia Field Orchid Project)***



Plan International – Senegal

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

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

Save the Children – Senegal

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

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

Strategies used by Save the Children to end FGM include meeting ethnic groups living in the areas between Senegal and its neighbouring countries to discuss FGM. Save the Children works alongside community and traditional leaders to develop appropriate interventions and reinforce advocacy work in the country.

Tostan

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

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

Since 2005, Tostan reports that thousands of villages have joined the movement for the abandonment of FGM in Senegal, and in 2014 there were 175 communities actively engaged in the CEP across ten regions, including Kolda, Kaolack, Sédhiou, Matam, Saint Louis, Bakel and Thiés. 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 begins 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, communities are supported through a community-led microcredit scheme.



***Facilitator and Participants at a
CEP session, Kaolack Region
(Used with permission; © Tostan Senegal)***

Facilitators fluent in the local language use oral traditions and visual tools to guide the sessions, which are designed to encourage reflection on social norms such as FGM and early/forced marriage. FGM is addressed within a human-rights framework, but spoken about specifically during the Kobi sessions on health and hygiene.

The CEP also uses a model of organised diffusion, which encourages participants to reach out to communities and individuals not involved, to share ideas, learning and new information. Community Management Committees are set up and trained in the management skills necessary to implement development projects.

In 2006, Tostan set up the Empowered Communities Network in Senegal to help communities partner with other organisations. Tostan has also been involved with the Zero Fistula Project and the organisation of repair-surgery camps providing consultations, repair surgery and support for local women in the regions of Kolda-Sédhiou and Tambacounda-Kédougou in Southern Senegal.

UNICEF/The UNFPA

Strategies: HR / CDP / HTP / R / M

www.unicef.org

www.unfpa.org

Senegal was one of the first 15 countries forming part of the UNJP on its inception in 2008. At the national level, the UNJP has contributed to the development of the second National Action Plan in Senegal to accelerate the abandonment of FGM/C 2010–2015 and the establishment of the National Technical Committee in charge of monitoring and coordination.

At the local level, the UNJP has been part of the movement led by Tostan and the implementation of its CEP. UNICEF also supports a wide range of grassroots NGOs using different strategies to effect the abandonment of FGM. It has, for example, supported the engagement of religious (in particular Muslim) leaders in the movement to abandon FGM, the involvement of local media and the production of information materials on FGM in local languages.

World Vision

Strategies: CDP / E / H / HTP

www.worldvision.org

World Vision has been working in Senegal since the drought crisis of 1983–1984. As part of its work to address FGM, it uses various strategies in several African countries, including raising awareness in communities, advocacy, alternative rites of passage, and education and training for ex-cutters.

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

National and Local Organisations

Association pour la Promotion de la Femme Sénégalaise (APROFES)

Strategies: HR / H / E / HTP / SG

Since 1987 APROFES has been working to raise awareness of women's rights in Senegal. Its projects aim to increase the social, political and economic role played by women by improving access to resources, including health services, empowering them in decision-making and economic independence, and by reducing violence against women. APROFES works both at the national level, through its coalition work, and at the local level, with female leaders, entrepreneurs and women's groups, to run awareness-raising campaigns and provide counselling, support and legal assistance to victims of Gender Based Violence (GBV). Partners in Senegal include Réseau Siggil Jigéen and Crossroads International.

Collectif des Femmes pour la Défense de l'Enfant et de la Famille (COFDEF)

Strategies: H / HTP / HR / L

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

Conseil Sénégalais des Femmes (COSEF)

Strategies: HR / E

Women's rights, in the context of human rights, underpin the work of COSEF. Since 1995 COSEF has undertaken education, consultation, and monitoring and evaluation work on women's issues throughout Senegal. These issues include: access to politics, the relationship with men in society, the promotion and development of gender issues, and preserving the physical integrity and dignity of all women. COSEF aims to create a framework for information-sharing, study, research, training and consultation on all issues affecting women in Senegal. Activities have included participation in the World Conference on Women (Beijing, 1995), being a founding member of the Committee Against Violence Towards Women and supporting other organisations engaged in similar issues.



A musical display at an event organised on 6 February 2015 to mark Zero Tolerance Day (Used with permission; @COSEPRAT)

Comité Sénégalais sur les Pratiques Traditionnelles (COSEPRAT)

Strategies: HTP / EX / H

Based in Dakar, COSEPRAT is the national committee member of the IAC. It aims to raise awareness of HTPs, including FGM, and contributes internationally by attending conferences and summits and at a national level by holding seminars, training medical staff and traditional birth attendants and initiating alternative sources of income for excisors.

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

Groupe de Recherche sur les Femmes et les Lois au Sénégal (GREFELS)

Strategies: HR / H / SG / M

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

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

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

Réseau Siggil Jigéen (RSJ)

Strategies: HR / H / E / HTP

siggiljigéen.org

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

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Challenges Faced by Anti-FGM Initiatives

There are numerous challenges to the work of campaigners that are related to infrastructure. The lack of passable roads and electricity in rural communities, which means limited or no access to computers/internet, makes communication and coordination difficult.

Other, more direct, challenges to initiatives are:

- providing continued support to communities that have started the abandonment process;
- a lack of sustainable funding for projects that work with communities over prolonged periods of time;
- a lack of support for abandoning FGM by some religious leaders, even though it is illegal;
- care for women who have already undergone FGM, which is linked to poor healthcare infrastructure;
- non-enforcement of the law against FGM and little provision in the law or society for women who want to protect their children from FGM;
- a lack of medical studies in the country on the problems caused by FGM, or gynaecological observation to support the self-reported numbers of FGM prevalence; and
- difficulties in gathering accurate data on FGM prevalence and abandonment, given the pressures of the known illegality of the procedure – making the legitimacy of ‘truthful reporting’ questionable and pushing the practice underground.



Villagers in the rural area of Keur Simbara (© Jessie Boucher)

Conclusions

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

Adopting Culturally Relevant Programmes

Communities in Senegal have different practices when it comes to FGM and also express different reasons for practising it. Programmes to tackle FGM need to be aware of these differences and deploy strategies to address the issues within each community and to build support to stop FGM. The GMP's Girls' Holistic Development recognises and uses the influential role of older women to act as champions for change, and Tostan works with and empowers communities. Both these organisations encourage and support change from within communities.

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 the 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. The prevention of FGM is connected to the eradication of extreme poverty and hunger, the achievement of universal primary education and gender equality, the reduction of child mortality, the improvement of maternal health and the fight against 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 57th session focused on violence against women and girls, including FGM. We hope that this momentum is continued and that violence against women, and FGM, are reflected in the post-MDGs agenda and at the Beijing +20 platform to be held in September 2015.

FGM and Education

Education is a central issue in the elimination of FGM. The lack of basic education is a root cause for the perpetuation of social stigmas surrounding FGM as it relates to health, sexuality and

women's rights. FGM hinders girls' ability to obtain basic education and often prevents them from pursuing higher education and employment opportunities. This lack of education directly relates to issues surrounding child marriage. We recommend that organisations continue to provide education programming for boys and girls and that the Government make efforts to comprehensively report on education conditions.

FGM, Medical Care and Health Education

More resources and education are needed across the health systems in Senegal, and better access to healthcare, especially in rural areas, is crucial. With regards to FGM, health providers need to be better trained on the complications resulting from FGM and provided with resources to support girls and women who have undergone it, addressing both their physical and psychological issues.

FGM, Advocacy and Lobbying

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

FGM and The Law

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

FGM in The Media

The 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 through the 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. In Senegal, a significant number of those who practise FGM believe it to be a religious requirement. Therefore, it is essential that religious leaders speak out against the practice and encourage its abandonment.

Communication and Collaborative Projects

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

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

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

Further Research

- Complementary methodologies and more complete data on what is working and changing in FGM programming would be beneficial.
- Consistency in both the order of questions in surveys and the age cohorts of daughters would allow for analyses of trends between datasets.
- It would be extremely beneficial to determine how to collect reliable data on an illegal practice, which needs to be addressed at global and grassroots levels.
- Given the significant work being done to end FGM in Senegal, there is a lack of medical reports on the impact of FGM and how the situation may be changing. This needs to be addressed.
- Further research on the involvement and impact of religious leaders in the work to end FGM could be beneficial to programming.
- Monitoring girls' enrolment and attendance at school, and discouraging early marriage in favour of completing education, could be influential in changing beliefs and the practice of FGM. Similarly, educating boys on the harm of FGM is important, as is encouraging them to marry uncut girls.
- It would be worthwhile to investigate the use of social media and mobile phone technology as a strategy to advocate and educate on the issue of FGM, and to support girls at risk and survivors of FGM.

Appendix I

List of International and National Organisations Contributing to Development Goals and Women's and Children's Rights in Senegal

Action Aid

The African Movement of Working Children and Youth (*AMWCY*)

African Network for the Prevention and Protection against Child Abuse and Neglect (*ANPPCAN*)

Amnesty International

Association of European Parliamentarians with Africa (*AWEPA*)

Association des Femmes Juristes du Sénégal

Association pour le Développement des Femmes et de l'Enfant au Sénégal (*ADFES*)

Association pour la Promotion de la Femme Sénégalaise (*APROFES*)

Association Sénégalaise pour le Bien-être Familial (*ASBEF*)

Association Sénégalaise pour la Promotion de la Famille (*ASPF*)

Association Sénégalaise de Protection et de Promotion des Droits de l'Enfant et de la Femme (*ASPRODEF*)

Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa (*CARMMA*)

Centre Africain pour l'Education aux Droits Humains et a la Paix

Child Fund International

Children of the World

Christian Aid

Christian Children's Fund

Coalition Nationale de Associations et ONG en Faveur de l'Enfance au Sénégal (*CONAFE*)

Collectif Des Femmes pour la Défense de la Famille (*COFDEF*)

Comite D'Etudes sur les Femmes, la Famille et l'Environnement en Afrique (*CEFFEVA*)

Comité Sénégalais sur les Pratiques Traditionnelles (*COSEPRAT*)

Conseil Sénégalais des Femmes (*COSEF*)

Child Rights International Network (*CRIN*)

Crossroads International

Defence for Children International (*DCI*) – Senegal

Economic Community of West African States (*ECOWAS*)

ENDA Graf Sahel

Environmental Development Action in the Third World (*ENDA*)

Forum for Women Educationalists (*FAWE*)

Global Fund for Children

Grandmother Project (*GMP*)

Groupe pour l'Abolition des Mutilations Sexuelles (*GAMS*)

Groupe pour l'Etude et l'Enseignement de la Population (*GEEP*)

Groupe de Recherche sur les Femmes et les Lois au Sénégal (*GREFELS*)

(I)NTACT International Action Against FGM

Inter-African Committee on Traditional Practices (*IAC*) – Senegal

Médicos del Mundo

Orchid Project

Organisation pour la Formation et l'Appui au Développement (*OFAD NAFOORE*)

Open Society Initiative for West Africa (*OSIWA*)

Plan International – Senegal

Rencontre Africaine pour la Défense des Droits de l'Homme (*RADDHO*)

Réseau Africain pour le Développement Intégré (*RADI*)

Réseau Siggil Jigéen (*RSJ*)

Save the Children – Senegal

Sister Fa

SOS Children's Villages

Tostan

Union des Coalitions Ouest Africaines pour l'Enfance (*UCOA*)

UN Women

United Nations Children's Fund (*UNICEF*)

United Nations Development Programme (*UNDP*)

United Nations Population Fund (*UNFPA*)

USAID

Women Living Under Muslim Laws (*WLUML*)

World Health Organization (*WHO*)

World Vision

