Risk Factors and Impacts of Female Genital Mutilation Practice in Senegal

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RISK FACTORS AND IMPACTS OF FEMALE GENITAL MUTILATION PRACTICE IN SENEGAL

by

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Abstract

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INTRODUCTION: Female Genital Mutilation (FGM) has significant negative physical complications on girls and women and its persistence is linked to lack of education, poverty and other socio-demographic characteristics such as region, type of place of residence, religion, and ethnicity. FGM is extremely dangerous. Even though FGM carries cultural marks, its primary objectives are social, sexual, and economic control of female sexuality. Despite the global effort to eradicate the practice and the evidence of its detrimental health consequences, FGM is still prevalent in Senegalese practicing communities.

OBJECTIVE: The purpose of this study is to investigate the risk factors associated with the practice of FGM and its impact on women. Additionally, this study aims at determining FGM relationships with poverty and education using a representative sample of the Senegalese population.

METHODS: Data (n=18,363) from the Senegal Demographic Health Survey of 2005 is used for this study. T-test is used to examine the effect of FGM practice on physical complications. Moreover, Chi square test is used to examine the association between FGM practice, and certain socio-demographic characteristics, including education, poverty level, region, place of residence, religion, and ethnicity.

RESULTS: The results showed FGM had a significant effect on physical complications and that education, poverty, region, type of place of residence, religion, and ethnicity were all risk factors of FGM practice.

Keywords: FGM, traditional practice, physical complications, socio-demographic characteristics, Senegal
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CHAPTER 1
Introduction

Female Genital Mutilation (FGM) refers to the cutting, removal or alteration of the female genitalia for social rather than medical reasons (Rahman & Toubia, 2000; Sarkis, 2003). Its primary objective is the promotion of social, sexual, and economic control of females (Rigmor & Denison, 2012) while reflecting normality, and identity in a patriarchal setting (Almroth et al., 2001). FGM creates significant negative physical complications for women and girls (Utz-Billing & Kentenich, 2008; Rigmor & Denison, 2012) and is linked to lack of education (SDHS, 2005), poverty and other socio-demographic risk factors such as region, type of place of residence, religion, and ethnicity (karmaker, Kandala, Chung, & Clarke, 2011). The practice has long and short term consequences for as many as 140 million girls and women worldwide (WHO 2011; Thiam 1978). Research clearly indicates that FGM causes permanent damage to the female victims (Utz-Billing & Kentenich, 2008). As Vissandjee argues, FGM is part of a continuum of terror-inducing acts against women that range from mutilation to torture (Vissandjee et al. 2003).

While there is no definitive evidence that indicates when and where FGM originated or how and why the practice spread, various scholars have drawn some conclusions. Momoh (2005) states that evidence of FGM is found among the Hittites, Ethiopians and Egyptians and in these latter ancient communities traces of infibulations were found on Egyptian mummies. Greek historians as well as other scholars trace the practice to the second century with vague description of different types of FGM (Johnsdotter, 2012). There is the diffusion theory which identifies the origin of the
practice with a starting point located in either Egypt where it is believed that mummies were excised or the Middle East where FGM was performed on female slaves to protect them from rape (Little 2003). The simultaneous invention theory links the origin of FGM to the fact that people from different parts of the world thought simultaneously of solving female genital related issues by inventing a practice that would control female sexual behavior (Johnsdotter, 2012). These two theories are weak in the sense that they are solely based on assumptions (Boddy, 1982). There is documented western history that shows the practice of FGM in Europe and in the United States (Thiam, 1978).

Clitorihypertrophy, an abnormal increase in the size of the clitoris causes it to grow larger. Western doctors and scientists treated it as a disease that can be cured through clitoridectomy which is the ablation of the clitoris (Johnsdotter, 2012). Thus, FGM was undeniably performed in Europe and the United States. While the practice is widespread, this research focuses on Senegal which is one of the West African countries where FGM is practiced among several ethnic groups. It is estimated that 26% of Senegalese women have undergone the procedure (Senegal DHS, 2010-2011).

**Theoretical Considerations**

Feminist theory is one of the most important frameworks for analyzing the status of women and men in society while trying to bring a change to women’s subordination caused and reinforced by gender inequalities in patriarchal societies. Patriarchy is defined as a structure that oppresses women for the benefit of men (Van Rossem & Gage, 2009; Thiam, 1978) and keeps women from advancing in society. In the FGM context, western feminists argue that the practice reinforces men’s domination over women. They also assert that FGM is practiced to control female sexuality as the procedure main
outcome is to weaken women sexual desires (Rigmore & Denison, 2012) and to assure fidelity after marriage.

Symbolic interactionism, a term coined by Blumer (Nelson, 1998) refers to three fundamental assumptions that guide people’s learning and behaviors which are: 1) meaning is a central element of human behavior, 2) people have a sense of self, and 3) Individuals are influenced by societies’ cultural norms and values (Smith & Hamon, 2005). The proponents of FGM used the symbolic interactionism theory to explain the reasons why FGM is still prevalent despite 50 years of global fight for its abolition. They argue that in African cultures, the socially constructed symbols of “circumcised” women are deeply enmeshed in local traditional beliefs and are attached to positive qualities that would identify a “real” woman. Socially learned meanings associated with female circumcision would identify a circumcised female as pure, fertile, beautiful, capable of enduring pain, and above all as being a virgin whose sexual appetite is under control. Thus, as females learn the meanings attached to FGM symbols through interaction with society, they develop a sense of themselves based on social standards set for them. One can assert that there is a continuous support of FGM if you belong to either a practicing community or a particular ethnic group. Additionally; there is a major difference in terms of prevalence between rural and urban areas. The most reasons given for FGM were social standing and the urge to preserve virginity (Weir, 2000). Even educated women are often challenged with FGM dilemma (Igwegbe & Egbuono, 2000). Women in areas with high prevalence support the practice of FGM because it makes all girls marriageable.
**Purpose of the Current Study**

The purpose of the current study was to gain further insight into the relationships between Female genital mutilation (FGM) and its physical consequences. Specifically, this study aimed to provide further information about how FGM may be associated with poverty, education, belonging to specific regions, living in urban or rural areas, religion, and ethnicity through secondary data analysis of the 2005 Senegal Demographic health survey. Though there was a more recent data set dated from 2010-2011; this latest data was not utilized because of the omission of key questions related to FGM.

Further, this study expands on literature that examines FGM and certain risk factors that are very likely to encourage the continuation of the practice. As previous research has been limited by measuring FGM through health indicators such as physical and mental consequences, the current study add a deeper look at possible FGM risk factors. Finally, this study aimed at determining possible relationships between FGM, poverty, education and other socio-demographic characteristics. By providing further information on which types of indicators are more strongly related to FGM, and identifying the mechanisms by which risk factors are likely to be linked to problematic outcomes; activists, feminists, and concerned international and local organizations can gain further insights in better comprehending the harmful traditional practice and in finding better ways leading to the eradicate of FGM worldwide. Without a doubt, this information will facilitate early prevention and intervention efforts.
CHAPTER 2

Literature Review

Definitions

**FGM.** According to World Health Organization (WHO) Female Genital Mutilation “comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons” (WHO, 2000). There are many variations of FGM and the WHO classified them into four groups:

- **Clitoridectomy (Type I):** partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

- **Excision (Type II):** partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).

- **Infibulation (Type III):** narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

- **Other (Type IV):** refers to all other harmful procedures to the female genitalia for purposes such as pricking, piercing, incising, scraping and cauterizing the genital area.

**Parallel between clitoris and penis' alterations.** The terminology attached to the discussion of this issue has been key to the perception of the importance of this issue to the wellbeing of women and girls. Labeling FGM as female circumcision is exceedingly
misleading as it does not render justice to the procedure, the health, psychological, and/or sexual short and long-term complications resulting from it (Thiam, 1978). Female genital mutilation is seen to be fundamentally more damaging to health (Bell, 2005) than male circumcision because as Fran Hosken’s research states in her report “the excision of the penis which is the equivalent of the excision of the clitoris is instantly recognized as a severe physical genital mutilation with permanent consequences and is a criminal offense.” (Hosken, 1994) The same idea is reiterated by Rahman and Toubia as they equate clitoridectomy to the amputation of most of the male penis. If in using the term circumcision, a parallel is drawn between the female clitoris and the male penis implying that both have the same meaning, and that the circumcision procedure is the same for females and males, then the cutting off the part or the entire clitoris would imply the cut off part or the whole male penis (Rahman & Toubia, 2000), which is not the case in male circumcision. It is evident here that the consequences are totally different as we can assert that male circumcision is less likely to impair male sexuality (Bell, 2005) whereas FGM is more likely to impairs female sexuality (Rigmore & Denison, 2012). However, certain scholars reject the assumption that FGM destroys female sexual response (Gruenbaum, 2001).

The strongest justification of FGM for practicing societies is to control female sexuality. Whether in the western world where clitoridectomy was used as a means to control masturbation (Johnsdotter, 2012) or in African, Asian, or Arab cultures in which FGM is performed to control female sexuality before and after marriage, genital alterations are seen as the cure for all matter of female sexual ailments. Thomas Laqueur (1999) talked about the importance of the tip of the clitoris as it was the central organ for
female sexual pleasure. As such, the clitoris was seen as a threat for males’ manhood and therefore was reduced to an insignificant state (Moore & Clarke, 1995). However, in the 1970’s thanks to feminist activists in their quest for female sexual liberation, the clitoris was restored back to its glory with the Hite report (1976) which reported that most women reach orgasm through clitoral stimulation instead of vaginal stimulation. Koedt, (1973), argues that “it is the clitoris which is the center of sexual sensitivity and which is the female equivalent of the penis. It is argued that the erectile tissue of the clitoris functions the same as the penis (Moore & Clarke, 1995). It is in that vein that the World Health Organization (WHO) condemns FGM, as it involves the removal of part of or the entire clitoris which is the key female sexual organ equivalent in its anatomy and physiology to the penis (WHO, 1998).

Cultural Contexts

According to Momoh (2005), certain beliefs, rites, cultural norms, social hierarchies and religions are among cultural factors that encourage the perpetuation of FGM. Culture was defined as shared characteristics typical of certain ways of living of a particular group of people. It is regarded as a congregation of shared customs and concepts and is handed down to next generations (Haralambos & Holborn, 2000). FGM is considered to be a rite of passage from childhood to adulthood. From the numerous practicing ethnic groups, FGM is perceived as a rite of passage and an identity marker. Thus FGM symbolizes the passage from youth to womanhood making it a necessary step to be taken in order to gain social promotion. To avoid social pressure from peers and rejection from the community, families conform to constructed societal norms. Specific ideas about “cleanliness”, “beauty”, and “femininity” were avowed as cultural beliefs that
support the continuation of FGM. In certain cultures, the clitoris is removed in order to maintain femininity because many believe that it could grow and resemble the penis. Others believe that the look of the clitoris is ugly and it is better to have the genital area smooth which reflects the idea of beauty. Some other cultures believe that during childbirth if the baby’s head touches the clitoris the baby would die. For many communities practicing FGM, family honor depends on the daughter’s virginity. This is the case of certain particular ethnic groups in Senegal where FGM is perceived as a way to preserve virginity and prevent premarital sex (Mackie, 2000). Some other cultures use FGM as a birth control method which allows them to control the population growth.

Since advocates of universal women’s rights brought the issue of FGM to the international community, there has been an unexpected resistance to change and the reasons are numerous (Gruenbaum, 2005). As mentioned earlier, FGM is deeply rooted in certain cultures and indigenous people do believe in the positive aspects and benefits of FGM (Little, 2003). In these particular settings it is a common belief that FGM is associated with gender identity markers and that the symbolic aspect of FGM support the essences of beauty as opposed to the masculine look of the clitoris that is considered ugly (Gruenbaum, 2005). Additionally, it is a common belief that FGM is necessary to preserve virginity before marriage and to preserve the family honor through the protection of females’ morality (Thiam, 1978). For infibulating societies, two factors are considered primordial (Thiam, 1978). They refer to the marriageability factor and the economic factor which will determine the chances a girl has to live or not to live a decent life under the dependence of a husband (Gruenbaum, 2005). Therefore, the conditions
for a daughter’s future marriage are to be taken seriously (Jaeger, Caflisch, & Hodlfield, 2007).

Several theories have been put forth to bring a rational explanation of the reasons why FGM should be banned worldwide. The Western Feminist perspective condemned FGM as a violation of women’s rights that must be handled as universal women’s rights and claimed that the practice must be outlawed. However, the new wave of feminism marked by the “Feminism of Color” refutes the emphasis on the Universality of women’s rights claiming that women are culturally different and therefore these cultural differences must be taken into consideration (Kalev, 2004). However, others argue that taking culture into consideration could give FGM a positive connotation as the reasons for the practice become associated with the rite of passage into womanhood, bravery, beauty, cleanliness, and self-control (Utz-Billing & Kentenich, 2008). Kalev affirms that group rights as claimed by proponents of FGM do not hold ground to allow these communities to practice FGM in western countries because there is a limitation to their rights. There is a tolerance of cultural practices; however, group rights cannot surpass the rights of the individual. Little (2003) argues that FGM is a violation of the individual right to choose especially in the case of children who cannot provide an informed consent, while undergoing this harmful practice that will affect their entire life.

**FGM as human rights issue**

FGM is seen as a harmful traditional practice that infringes girls’ and women’s human rights. USAID (2004) reports that FGM was first acknowledged in the agenda of the United Nations in 1948 within the framework of the universal declaration of human rights. Dorkeeno, (1994), states that FGM is a strong demonstration of gender-based
violence. Its primary motive is to control women’s sexuality and autonomy. In the
global arena, the practice is recognized as a form of torture and violence against women
and girls. Among numerous transnational agencies that believe FGM is a violation of
human rights are: WHO, United Nation Children Education Fund (UNICEF). For
example, in 1996, WHO made a firm stance in the fight against FGM. Not only did
WHO officially reject the practice, it categorized it a pure violation of human rights.
Additionally, the United Nations supported the use of the contentious terminology of
“Female Genital Mutilation” to describe all FGM related practices especially
clitoridectomy, excision, infibulation, and other genital alterations and to advocate for its
eradication.

FGM is classified as violence against women and children and any issues relating
to it falls under international rights law (Kalev, 2004). The human rights model adopted
by most feminists encompasses four human rights subdivisions such as the rights of the
child, the rights of the women, the right to freedom from torture and, the right to health
and bodily integrity (Shell-Duncan, 2008). Rahman and Toubia (2000) have listed the
following as human rights violation.

- *The right to be free from all forms of discrimination:* FGM is a form of
discrimination against women as stipulated in Article 1 of CEDAW. The practice
engenders horrendous effects on the physical, mental, and sexual health of
affected girls and women. FGM is a violation of the girls and women’s human
rights.

- *The right to life and the right to physical integrity:* FGM is a life threatening
practice as death could be the extreme consequence resulting from it. Every girl
and woman is entitled to an absolute right over the integrity of their body. Any act or procedure that is potential threat to their physical security is a violation of their right. Usually, girls are subjected to FGM at an age in which they cannot make an informed decision. Practicing communities believe that the female body needs alterations because it is not pure and that the natural genital look is ugly. FGM irreversibility compromises the physical integrity of girls and women as the damage caused pose serious risk to women’s health and well-being. FGM may violate a girl’s or woman’s right to life in cases when death occur from victims’ over bleeding or infection afterward. Researchers posit that FGM may be a contributing or causal factor in maternal death, however, the accurate mortality rate of FGM girls and women is not well documented and deaths due to FGM are hardly ever reported as such (Crowes & Melching, 2005).

- **The right of the child:** Researchers argue that FGM violates children’s rights as the important decision that will affect their whole life is taken by their parents and without the child full understanding of the health consequences associated with FGM. The age at which FGM is performed on girl children varies from one country to another, from one ethnic group to another. Age ranges from a few days after birth to adolescent and just before marriage or after first pregnancy.

- **Right to health:** FGM is associated with detrimental health consequences that could seriously impair girls and women’s health. Therefore subjecting females to genital mutilation for non-therapeutic reasons is a violation of their rights as individuals are entitled to enjoy fully the highest attainable standards of physical and mental health.
The issue of informed consent: Informed consent is a vital part of any agreement as it shows that approval is given based on educated information that allows the individual to reach an informed decision about whether or not to approve or disapprove an action to be performed on her/him. The consent must be given freely without coercion with a clear understanding of what the action entails. According to Fran Hosken (1979), any violation of the physical nature of the human individual, for any reasons of any kind, without the informed consent of the person involved, is a violation of human rights. FGM is mostly performed on children who are too young to give a valid consent (Mackie, 2003) as they are not aware of the irreversible act of FGM. Additionally, Hernlund & Shell-Duncan (2007) presented an interdisciplinary approach to the understanding of decision-making process vis-à-vis circumcising or not circumcising daughters in the Gambia and Senegal area. The authors introduced the concept of contingency facilitated by theoretical discussion of proximate social experience and the influence on social construction of opinions that affect decision making in regard to FGM. It results from their assumptions that the concept of contingency mirrors an on-going and fluctuating positioning of one’s opinion in regard to FGM based on needs and realities (Hernlund & Shell-Duncan, 2008). In their analysis, societies plagued by poverty, daughters’ eligibility to be part of the marriageable pool becomes a survival issue of a great concern for parents. In this particular matter, parents do believe that the consent given on behalf of their children is in their best interest as it is to give their daughters a chance to have a husband and a provider.
The United Nations, along with other non-governmental agencies, embraced the human rights framework and required governments around the world to take a stand to eliminate FGM. It is in that vein that the United States created a law in 1996 forbidding the practice of FGM on females under the age of 18 years old. FGM became a punishable crime (CEDAW). The human rights model worked better in the eradication campaign because governments around the world who are signatories and members of the United Nations are all invited to comply with the legal recommendations and to enact local laws forbidding the harmful practice. At the very least, there is now a legal international and regional foundation to fight FGM. Legislations guided by human rights concepts have the particular duty of protecting every individual whether male or female. The harmful traditional practice of FGM deserves full investigation under human rights ethics. FGM is cruel, harmful, painful and unnecessary. It affects the health of women and girls. The practice is not only deemed a violation of human rights, but it is also considered a criminal offence in western countries as well as in many African countries that banned FGM.

Both the children rights and women rights have certain limitations. From the standpoint of children's rights, children cannot provide informed consent and all decisions are left to the parents who may think that assuring their daughter's marriageability and social acceptance should be through FGM and therefore is the best interest of their child. There are also limitations on the women's rights stance because of exemption of certain traditional customs through United Nations treaties. Additionally, FGM is claimed to be a decision by women and for women and the implication does not give much room to invoke gender discrimination (Simister, 2010). The freedom from
torture aspect is critical because it can be viewed as an attack on culture and could ultimately cause resistance. As for the right to health and bodily integrity even though it is less judgmental, it opens the alternative route to medicalization of FGM (Shell-Duncan, 2008). Since FGM is sanctioned as a violation of women’s human rights, proponents are trying to reframe it through a certain medicalization as to make it banal.

**Issues in the Eradication Effort**

**Cross cultural activism.** Activists in the movement to eradicate FGM have met with a number of obstacles. One such obstacle involves the clash of worldviews/cultural contexts between the activists and those for whom they wish to act. Many scholars and feminists use Western, Eurocentric lens to explain, critique and denounce the practice of FGM (Nnamuchi, 2012). They argue that FGM is a phenomenon created solely to control women’s sexuality and to reinforce patriarchal ideologies and social structures. In doing this, they failed to acknowledge the cultural justification for the practice of FGM. This allowed proponents of FGM to use a cultural determinism argument as a weapon to curtail the enormous work accomplished thus far in the quest for the eradication of FGM.

The proponents of FGM argue that every society has a right to practice its own culture (cultural determinism). Schweder (2004) argues that opponents of FGM are in fact waging a cultural eradication campaign with the intention of accusing African mothers as torturers or mutilators. By the same token, Shell-Duncan (2008) defends the idea that African women do not view the human rights claim as universal because the concept is fundamentally Eurocentric and promotes western ideals of what it means to be civilized. Harsh criticism and insensitivity to cultural self-determination prompted a backlash among African women. They argue that “cultural imperialism” and “intellectual
colonialism” cannot be imposed on other nations that have different standards of living (Schweder, 2004). They argue that there is not just “one” universal morality but a multitude of cultural moralities. The Association of African Women for Research and Development stated: “In trying to reach their own public, the new crusaders have fallen back on sensationalism, and have become insensitive to the dignity of the very women they want to "save". They are totally unconscious of the latent racism which such a campaign evokes in countries where ethnocentric prejudice is deeply rooted” (AAWORD, 1983). As an opponent of FGM, Shell-Duncan tackles a poignant issue while warning other scholars that eradication cannot happen without the participation of indigenous people.

**FGM Legislation.** One strategy to address the issue of FGM has involved the enactment of National and International legislation. This legislation has been predicated on the framing of FGM as violence against women and girls (Lax, 2000; Hosken, 1979, Thiam, 1978). While violence against women remains one of the most obstinate of the challenges to human rights, the Violence Against Women Acts of 1994 brought a tremendous change to female victims. A number of countries have laws which make FGM illegal but enforcement is an ongoing issues. Legislation alone may not bring a significant change in social behavior and as argued by Hosken, (1979) international legislation is less likely to affect traditional norms than cooperation and collaboration. One of the heated debates is how to balance legislation with a widespread social practice that has ties with cultural norms and beliefs especially in African countries.

**FGM and gender discrimination.** Gender based discrimination is clearly relevant to the discussion of FGM. FGM is performed on female subjects to control
women’s sexuality (Rigmore & Denison, 2012; Van Rossem & Gage, 2009) while enhancing males’ sexual enjoyment (Thiam, 1978). The implication is that it implicitly endorses the strong message of the subordinate role of women in society (Obermeyer, 1999). In most patriarchal societies, women’s role is very limited and these typical societies promote her submission to male power. In this context, FGM is perceived as an attempt to suppress women’s sexuality, emphasize on her subjugation, and an effort to control her reproductive capacity (Thiam, 1978). The validation of FGM as gender discrimination is reinforced by the fact that CEDAW (Committee on the Elimination of Discrimination Against Women) issued a specific recommendation that FGM be regarded as is because it clearly shows discrimination against women in favor of men. United Nations Signatories of these treaties are highly encouraged to incorporate in their laws the principles of human rights. From laws and policies, actions are taken on the global level to bring awareness of the practice and to support women’s rights to freedom from FGM. States governments are encouraged to enact policies that will deal adequately with the practice of FGM.

Physical Complications

The issue of the mutilation of healthy genital organs. One valid argument as to why FGM should be banned worldwide is that healthy female genital organs are damaged for non-therapeutic reasons. The initial stage of the global campaign to end FGM framed the practice as a health problem to be considered an obstacle to human healthy development. It was viewed as a disease that can be cured by eradication (Hosken, 1982) and attempts were made to address the issue using the health model.
The health model’s logical reasoning was that if people were made aware of the destructive health risks of FGM, they would be driven to abandon the practice. The health approach at the forefront in the global fight against FGM did not bring a large scale change as it was intended originally however, the reason it did not work well was that the emphasis was on an exaggeration of the risks which ultimately affected its credibility (Schewder, 2000). Proponents of FGM were able to discern this particular weakness and built their case from it while questioning the absence of scientific evidence of the medical risks claims. They argued that the literature related to the harmful effects of the practice was not reliable and the few studies were done with samples that were so insignificant that they could not be representative of the 130 million females affected by it. Therefore, the health model failed to provide the strong support FGM opponents needed in order to wage a successful battle to eradicate the harmful practice. Not only did the health model fail, but it also promoted the conceptualization of FGM as a health issue that can be dealt through medicalization (Shell-Duncan, 2008).

The medicalization of FGM which allows doctors to perform the excision as a surgical procedure would absolutely undermine the idea of eradication. Certain scholars argue that the medicalization should be temporary and used just as an alternate means and as harm reduction (Shell-Duncan, 2001). However, the WHO bans all forms of FGM in hospitals to avoid medicalization of the practice (Jaeger, Caflisch, & Hodlfeld, 2007). Scholars argues that medicalization of FGM is unacceptable, unethical, and must be stopped as it denies women and girls the right of bodily integrity (Utz-Billing & Kentenich, 2008). While medicalization may remove the postulation of physical health
risks like infection, it does not address the many other potential harm and risks, such as the irreversibility of the practice and its destructive repercussions.

In the traditional setting, local practitioners may use so-called “tools” from pieces of broken glasses or broken bottles to perform the FGM act. As the operation is performed customarily without anesthetic, the immediate consequence felt by the victim is the excruciating and agonizing pain as the razor blade or knife slices either part or the whole genital organ (Johnson & Okon, 2012). The female reaction to the unbearable pain is to try to get out of the grip that pins her on the floor and this wrestling can lead to some fractures in certain parts of the body as well as a deeper cutting that can cause a permanent damage to adjacent organs (McKenna, 2002). Bleeding often leads to anemia and in some extreme cases of over bleeding can result in death.

**Short-term and long-term health risks.** World Health Organization (WHO 2008) documented some of the implications of FGM on the health of women and girls. Research indicates that FGM is associated with short-term risks concomitant to heavy bleeding, urinary tract infection, swelling, injury to the urethra, difficulty healing, as well as other health related problems (Utz-Biling & Kentenich, 2008). Additionally, FGM is associated with long-term physical health consequences such as chronic anemia, incontinence, infertility, dermoid cyst, scars (Conroy, 2006) as well as mental trauma (fear, depression, high risk of psychiatric disease) and sexual consequences (loss of sexual desire, no ability to have orgasm (Rigmore & Denison, 2012). Other effects include urine retention, injury to neighboring organs, severe bleeding, painful sexual intercourse, painful periods, and complications in labor (WHO, 2006).
The severe damage resulting from the unhygienic instruments used is infection to the genital area that can culminate in the long run to damage the reproductive system leading to infertility (Almroth et al., 2005). In a study of female genital mutilation undertaken by WHO (2008), the victims of female genital mutilation indicated that in addition to the immediate health complications endured, they experience also other problems such as higher likelihood of caesarean sections and post-partum hemorrhage especially among women with type III (infibulation). From this study, the authors argue that the association between FGM and primary infertility is significant. Another study conducted in the Gambia found that some infections are significantly more frequent among circumcised women (Morison et al., 2001). Infections resulting from the operation could turn into the invasion of the genital areas by pathogenic agents leading to some damage and the likelihood of various irremediable diseases.

Childbirth and neonatal issues have also been linked to FGM. A study by the World Health Organization related to female genital cutting and obstetrical complications has shown that women who had FGM when compared to non FGM women are significantly more likely to experience difficulties during childbirth and that their babies are more likely to die as the result of the practice (WHO, 2006b). This notion of physical complications was also explored by Rosenthal (2006) who argues that genital cutting raises by 50% likelihood mothers or their new born will die. Here, infibulation which is type three was studied and the results suggested that women with infibulation have a higher risk of 1.3 for both caesarean section and infant resuscitations in addition to a higher risk of 1.6 for still birth and early neonatal death than non FGM women. Furthermore the WHO acknowledges some of the dire physical complications of FGM
through the substantiation of women's experience of adverse health short-term and life-long complications. Severe complications especially a continuous leakage of urine and feces can be detrimental to women's life and turn them into social outcasts (Ukpai, 2007). Additionally, the excision of the glans clitoris as it damages nerve endings located in the genital area, also eliminates the sensitivity and sensation of the external portion of the clitoris resulting in frigidity of the victims (Fernandez-Aguilar & Noel, 2003). It is accounted that the detrimental repercussion of FGM on girls and women vary largely from mild to more severe complications depending on the type of FGM performed (Shell-Duncan, ).

**Socio-Demographic Risk factors**

Research has found that certain socio-demographic dynamics are determining factors of influence in the perpetration and perpetuation of FGM (UNICEF, 2005). Although all these risk factors are associated with the continuity or discontinuity of the traditional practice of FGM, they are closely related to the traditional culture of practicing communities. Gruenbaum (2005) argues that education, autonomy, and economic security would give women the free will to decide whether or not to excise their daughters by lessening the fear that lack of genital mutilation would threaten their marriageability, means of support, integrity and social security. Therefore, it is very likely to have high or low rates of FGM prevalence due to females' level of education, their level of poverty / wealth, the region they live in, their urban or rural residency, their religion, or their belonging to specific ethnic groups (DHS, 2005). There is substantial support in the works of scholars for the importance of increasing education as a predictor (Williams & Sobieszczyk, 1997). Assad (1980) suggests that the practice may change
and decrease when communities are exposed to education and other aspects of socio-economic development. Furthermore, it is believed that education along with public health drives can be contributory in decreasing FGM practice (DHS, 2005; Hosken, 1982). Mackie (1996) proposes a technique similar to the one used to end foot-binding in China. The method includes education, public health intervention as well as organization / gathering of parents who will pledge to neither mutilate their daughters nor let their sons marry FGM women. Education is a powerful tool that can liberate women from ignorance and dependency. Education can surely give women the choice to continue or stop the harmful practice. However, there is a growing uncertainty that education alone whether formal or informal is consistent with evidence that it can decrease FGM prevalence. For example, the Poular ethnic group is among the most educated group in Senegal; somehow, they have high rates of FGM practice (SDHS, 2005). Nonetheless, there is quite a general consensus that education can be effective at reducing FGM (Hicks, 1993) and that higher education may be a protective factor for women (Karmaker, Kandala, Chung, & Clarke, 2011). Therefore, it is expected to have high rates of FGM among less educated women and low rates of FGM among educated women.

Mackie (1996) posits that the less advantaged or the less fortunate adopt FGM in order to give their daughters a chance to be eligible for marriage. Lack of economic resources reinforces women's vulnerability and difficulty in finding other means to become independent (Simister, 2010). In less prosperous societies, women find themselves trapped in poverty and dependency and are forced to accept and comply with FGM. Krishnan (2005) claims that access to economic and social resources are the root
of women’s ability to resist violence such as FGM and that one such resource is education. Research has found that regions as well as place of residence in terms of urban and rural setting are significantly related to FGM (Karmaker, Kandala, Chung, & Clarke, 2011). In popular beliefs, FGM is thought to be prescribed by certain religions and reinforced by certain religious leaders. In Senegal, it is an erroneous belief that FGM is mandated by Islam (Gruenbaum, 2005; Toubia, 1994; Thiam, 1978) however, it is the primary reason why FGM is practiced largely among Muslim practicing communities. Hicks (1993) argues that of all factors influencing the perpetuation of FGM, Islam has probably been the single most important one. In a study conducted in Java and Madura, FGM is associated with Muslim identity. The study found that FGM is more likely to be practiced in Madura where there is a much high number of Muslim (Darwin et al., 2002)

FGM is predominant in particular ethnic groups whereas it is inexistnet in some others. Ethnicity is known to be one of the most determining factors of influence in the continuation and maintenance of FGM in Senegal. Diverse reasons given include beliefs that FGM promotes purity and chastity, enhances fertility, increases marriage opportunities and prevents stillbirths (Sipsma, Chen, Ofori-Atta, Ilozumba, Karfo & Bradley, 2012). Research shows that education, poverty, regions, rural or urban settings, religion, ethnicity, along with other socio demographic and socio-economic are all risks factors that are significantly related with FGM (Karmaker, Kandala, Chung, & Clarke, 2011).
Chapter 3

Senegal: Demographic, Cultural and Sexuality Contexts

Demographic Context

Geography. Senegal is located on the coast of Western Africa. Senegal is bounded to the north by the Republic of Mauritania, on the east by Mali, on the south by Guinea and Guinea Bissau and to the west by the Atlantic Ocean. Senegal is a flat country and it is crossed by the Gambia which is an enclave of land between the Senegalese regions of Kaolack and Ziguinchor, and the lower river of the same name. Covering an area of 196,722 square miles, Senegal has a large opening on the Atlantic Ocean with its 700 kilometers of coastline.

At the administrative level, the territory currently consists of 14 administrative regions (SDHS, 2010-2011) as three new regions were created and the latest being that of Matam (created in 2002). The regions are subdivided into 34 departments, 66 municipalities (similar to urban areas), 94 districts and 320 rural communities.

Map (Figure 1).
**Population.** In 2004, Senegalese population reached 10,564,300. The average population density was 43 inhabitants per square miles. However, the population was unevenly distributed among the 11 original administrative regions of the country. Dakar, the capital city and also the smallest region, occupies 0.3% of the national land area and is home to nearly 23% of the total population and 75% of the urban population (SDHS, 2005). The largest region, Tambacounda, houses only about 6% of the population.

Population growth remains high (2.4%). The rapid growth rate of the population is mainly due to the high fertility rate (6.7 in 1997). Senegal's population is very young. Half of the population is less than 20 years old. The literacy rate is strongly correlated with the degree of urbanization. To a national average of 65% illiterate, Dakar has the lowest rate of illiteracy with (35%); and Ziguinchor follows with 43%. In other areas,
outside of St. Louis and Thies, illiteracy is over 75%. Although Senegal has more than 20 ethnic groups, more than 90% of the population belongs to five dominant ethnic groups: Wolof (43%), Poular (24%), Serer (15%), Diola (5%) and Mandingo (4%). Senegal's population is predominantly Muslim (94%). There are also Christians (4%), Animism and other religions make up 2% of the population (SDHS, 2005).

**Economy.** Senegal is a small country with very limited natural resources. It is classified as one of the Least Developed Countries (LDCs) and is labeled also as a Highly Indebted Poor Country (HIPC). The phenomenon of poverty has emerged and intensified in the 1990s with a steady deterioration in the living conditions of households. Even though poverty indicators calculated from data collected from the Senegalese Household Survey (ESAM I, 1994/1995 and ESAM II, 2001/2002) (SDHS, 2005) confirm the downward trend in poverty from 61% to 49%, poverty is still widespread in Senegal. According to these two sources, nearly 49% of households still live below the poverty line.

**Religion.** FGM is practiced across religious faiths in Senegal. It is more widely performed by the Muslim groups in practicing communities; however, it is very common to see Christian or Animist communities performing FGM on girls and women (WHO, 2008). The strongest reason given by parents is that they believe that FGM is mandated by their religion especially in areas in which the population is predominantly Muslim (Thiam, 1978). It is to be acknowledged that FGM pre-dates all the three main religions known as Judaism, Christianity, and Islam. Even though the practice of FGM is mostly associated with the Muslim faith, there is no mention of it in the Koran (Thiam, 1978, Dirie, 1999). This would imply that the source or origin is not from Islam. In fact, most
erudite Imams who are the Islamic leaders reject FGM practice as it is seen as altering God’s creation. Although, FGM is not mandated by Islam, some followers refer to it as they claim that it was dealt with by some “Hadiths” which are the sayings of the Prophet Mohamed. Since there is no written evidence supporting FGM in the major religions such as Judaism, Christianity, and Islam, one can say that religions do not support the practice of FGM and that people mistakenly refer to it as their basis for continuing the practice (Nnamuchi, 2012).

**Cultural Context**

According to Greif (1994), cultural beliefs refer to the ideas and thoughts, common to a group of individuals, which govern their daily interactions. Scholars consider each societal setting to be a reflection of its own culture and carrying its particular beliefs that are known through socialization process by which culture is unified, maintained, and communicated (Grief, 1994). Cultural beliefs give meaning, logic, and understanding to human existence, experience, and relationships to both other human beings and to the world (Lewis, 1996).

In FGM practicing communities in Senegal, cultural norms as well as religious and other traditional beliefs translate into a conditional support of FGM to acknowledge rites of passage from childhood to womanhood, and also to acknowledge the accession to female higher ranks or secret societies. In these particular FGM practicing communities, it is a common belief that the cutting of the clitoris and/or the creation of a genital shield through infibulation is a pre-requisite to womanhood and a ticket to the marriageable pool (Shell-Duncan, 2008). It is also believed that FGM is necessary for female “cleanliness” and “beauty” while others see it as identity markers in differentiating male
and female subjects by removing the clitoris that many believe that if left on a female subject will grow to be the size of a penis which will become fatal at the contact with either the husband or the head of a newborn male. Therefore, there is always a rationale behind FGM practice if put in rightful context, however, agreeing or disagreeing with the practice is a different matter.

The meaning of womanhood in Senegal. The Senegalese society is hierarchically structured upon dichotomous entities in which males and females are classified along with their characteristics, tasks, roles, qualities, and opportunities (Thiam, 1978). Gender is one of the defining markers that determine the degree to which individuals behave within the cultural and social values conferred to them from generation to generation and are deeply seated in patriarchal ideologies. Gender covers all aspects of what it means to be a woman or a man. It also refers to the socio-cultural distinctions between women and men. Another important component is the notion of femaleness which is the meaning of sex as defined in the Senegalese culture. Sex refers to the biological attribution of female or male physical characteristics (Thiam, 1978). Sex is the anatomical differentiation between female and male bodies.

In Senegal, under the patriarchal system, the maintenance of a normative masculine hegemony implies structures, practices, and constructions that determine to whom value and power are attributed. The social organization based on female and male identities mostly has resulted in males' total privilege over females. The patriarchal social order is viewed as problematic by African and western feminists who forcefully decry this unequal, oppressive, and unjust system (Shell-Duncan, 2008). This typical Senegalese patriarchal social order reduces women to their reproductive capacities
(Thiam, 1978) with no right to sexual self-determination and quite contrary, it is all in the hand of men who detain the power over women and control their sexuality and sexual behavior.

**Implications of being a female in an African traditional patriarchal system.**

Feminist movements across cultures made a significant contribution in bringing to light the issues and challenges faced by West African women. They accurately showed how these issues especially the practice of female genital mutilation affect millions of women and girl-children who had been subjected to the harmful practice. The first and foremost of their concerns was the gender inequality that prevail in Senegal. Whether African or Western feminists, they all came to the conclusion that such inequalities lived and experienced by both females and males are not “natural” as patriarchy would want to present it but rather are the fruit of the Senegalese social construction of gender endorsed and fed by a rigid traditional patriarchal system (Thiam, 1978).

Women’s subordination is a daily lived experience of Senegalese women. First of all, they are deprived of education opportunity as they are kept in the home and away from any public prospects. For example in Senegal, 74% of women are illiterate (SDHS, 2005). Most young girls go through informal education initiated at home by the mother, the grandmother, the aunts, or the sisters (Thiam, 1978). They learn at a very early age that “real women” are the stay-at-home mothers. This traditional system inculcate in them that a woman should be a “super-woman”; for example that they should be able to lift a hot pan from the fire and not feel the burn; they should endure stoically the beating and the harshness of a husband if they want to have successful children in life; they
should worship the male figures in their lives, and everything they may possess belong to their husband who can dispose of it as he wishes (Thiam, 1978).

Senegalese women are taught at a very early age that their body, mind, and soul belong to their husband. They are taught to believe that they are responsible for their husband’s happiness which should be ultimately their primary concern (Thiam, 1978). Regardless of a whole day of work in the fields, cultivating, home domestic labor is exclusively hers as she cooks every day to feed the whole family. They care for the husband, the children, the in-laws, and any elder relatives in the nearby. As one can notice, woman is not part of the equation as they even forget about themselves and their well-being (Thiam, 1978). They are taught to take care of everybody but themselves. Their lives and experiences reveal the marks of patriarchy ideology.

Economically, uneducated Senegalese women are not viable on their own as they are totally dependent on their families and later on, on their husband providers. This imposed status makes women vulnerable and prone to be objects of violence with devastating physical, mental, and psychological repercussions.

**Female Sexuality Context**

**Female sexuality in Senegal.** Female sexuality describes the sexual aspects of a woman’s reproductive capacities, behaviors and identities attributed by the patriarchal social order. Female sexuality is never referred to as the opposite of male sexuality but “she” is the “object reserved for males’ sexual needs and to carry their offspring (Thiam, 1978). The messages about female sexuality received and perceived by members of society are that women are dangerous, and the female body is imperfect and dirty which implies that it needs to be fixed and controlled for the betterment of the group.
Therefore, the female body becomes a social body and is regulated and controlled (Thiam, 1978). The methods of control vary from culture to culture and from ethnic group to ethnic group throughout Senegal. As the methods vary, so does the violence inherent of each particular method (Simister, 2010). Therefore, women’s ability to control her body is illusory even though the right to bodily integrity is a right to which every woman is entitled.

Female Genital Mutilation and female sexuality. FGM aims at controlling female sexuality and ensures that women adhere to the social construction of gender roles prescribed by the traditional social system (Kaplan, Hechavarría, Martín, & Bonhoure, 2011; Thiam, 1978). FGM is one of the most common means to ensure women remain “in their place” and will always be subordinated to men (Almroth, & Elmusharaf, 2007). Violence against women could carry particular sexual behaviors and beliefs that would keep women subordinate to men. Violating the bodily integrity of women (Karim, 1993) is part of a continuum of patriarchal repression of female sexuality. These constructions of female sexuality not only contribute to women’s oppression, but also deny them the possibility of expression of both the body and sexuality (Thiam, 1978).

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Female Genital Mutilation and female sexual life. The highly cultural and politicized ritual usually marks the change of social status from childhood to womanhood and is generally accompanied by a ceremony (Maligaye, 2007). The socially constructed symbols of circumcised women are deeply enmeshed in each local traditional belief and are attached to positive qualities that would identify a “real” woman. Socially learned meanings associated with female circumcision would identify any female as pure, fertile, beautiful, capable of enduring pain, and above all as being a virgin whose sexual appetite
is under control. Women who undergo FGM procedure develop a sense of entitlement (Williams, 2005) as they are given a preferential treatment whereas women who have not undergone genital cutting perceive themselves as unworthy, unclean, and not marriageable in their particular context. The uncircumcised women learn about the negative connotations which spark in them the urge to conform to socially constructed symbols in order to fit in. In cases where a woman who belongs to a community that does not practice FGM marries a man from a community that does, her future in-laws may demand that she undergoes FGM in accordance with the traditions of her future husband’s community (Caldwell, Orubuloye, & Caldwell 2000). The preservation of virginity before marriage is extremely important to both the individual and family identity. Thus either a barrier is created as in the case of infibulation in which the girl is stitched closed or in the case of excision or clitoridectomy in which parts of the sexual organ are cut off to reduce female sexual sensitivity or desire.

The Senegalese cultures have not given much room for young girls or women to be involved in discussing issues about sex and sexuality (Thiam, 1978). The common belief in African traditional societies is that once young children are exposed to discussing sex, they would be tempted or curious to try it at an early age. This perception has nurtured the culture of complete silence on sex and sexuality issues in Africa. This has caused many female genital mutilation practices at a very early age as a counter measure (Thiam, 1978). Since parents in general deny the young the right to fully know and understand sex issues, the result is that many teenagers grow up confused and shocked about certain body changes or events such as first menstruation. Sex is taboo. It is never part of any family discussion. Mystery and awe are wrapped around sex (Jaeger,
Caflisch, & Hodlfeld, 2007). It is absolutely forbidden to have sex before marriage and if a woman does, she is punished by being ostracized.

The research findings disclosed that in case of the removal of the clitoris, which is the sexual stimulant in women many did not experience a lot of satisfaction when having sex with their husbands (Rigmor & Denison, 2012). Many found sex painful because of the virginal hole being too small and a lack of sexual desire. Utz-Billing & Kentenich (2008) stated that FGM causes physical, sexual, and mental health consequences to those who undergo the procedure.

**FGM law in Senegal**

In 1999 the Senegalese government adopted the Article 299 of the Penal Code, which imposes a maximum penalty of five years imprisonment on parents or guardian who subject a minor to FGM. Additionally, the Ministry of Family Affairs adopted an Action Plan 2000-2005 according to which FGM is to be eradicated in Senegal by 2015. How is this working? Are they about to succeed or are they failing? Senegal is among one of many African countries that has ratified several international conventions that condemn FGM. Among those international ratifications are the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the UN Convention on the Rights of the Child (CRC), the African Charter on the Rights and Welfare of the Child and the Maputo Protocol (to the African Charter on Human and Peoples’ Rights) on the Rights of Women in Africa.

Since the purpose of the government is to reach a complete eradication in 2015 (SDHS, 2005), efforts to improve networking and coordination among all players are made in order to stop the practice in a very efficient way. Efforts to educate the
population in a formal and non-formal education are planned. According to the
evaluation of the Action Plan conducted in 2008, 3,300 of the 5,000 villages identified
with FGM practice disavowed the practice in official public declarations. This means
that more than half of the practicing communities and population stopped the practice.
Unfortunately, these numbers does not translate accurately with the most recent Senegal
DHS of 2010-2011 which shows only a 2% decrease of the practice in Senegal between
2005 and 2010. How come villages are renouncing publically to FGM yet the practice is
still high. Is the practice driven under grown? Are these pledges not taken seriously?
Chapter 4
Study Context

Hypothesis

1. FGM is associated with physical complications.

2. FGM is associated with certain demographic characteristics specifically education, poverty, region, type of place of residence, religion, and ethnicity.

Methods

Participants. A total of 14,602 women (15-49) and 3,761 men (15-54), and a representative sample of 7,412 households participated in this study. The sample for the survey covered the population residing in households in 11 administrative regions of Senegal with all ethnicities, education level, poverty level, place of residence, and religion included. There were three questionnaires involved such as: the women questionnaire, about daughters’ questionnaire, and the men questionnaire.

Procedure. Data for this study is obtained from the 2005 Senegal Demographic Health Survey (SDHS) which is the second to the latest in a series of national level population and health surveys to be carried out in Senegal. DHS are cross sectional health surveys organized and sponsored by the United States Agency for International Development (USAID). The 2005 SDHS data is intended to bring light into the prevalence of FGM in the population variations and the possible health complications associated with it. The SDHS survey was conducted by the use of structured interviews with relevant questions tailored from the Demographic Health survey to suit Senegal’s own characteristics and realities. The SDHS has a particular module on the practice of FGM with pertinent questions on the practice and participant feelings about it as it covers most issues concerning FGM. It is intended to assist policy makers and program
regulators in their attempt to design new strategies for demographic, social, and health policies. The survey collected data on demographic, social and health issues from a sample of women and from men. From these surveys, prevalence of FGM was shown to range from 2% with the Wolof ethnic group to 79% among Soninke women (SDHS, 2005). This quantitative analysis will help set comparative aspects of risk factors such as education, poverty, region, type of place of residence, religion, and ethnicity and their consequences. For the purpose of this study, data collected from the women questionnaires will be used.

**Senegal Demographic Health Survey - SDHS**

The 2005 Senegal Demographic and Health Survey (SDHS) is the fourth of its kind after the 1986, 1992-1993 and 1997. The SDHS-IV was conducted by the Research Center for Human Development (HRDC) with technical assistance from Macro International, the U.S. agency in charge of international program (DHS-Demographic and Health Surveys DHS). For the implementation of the survey, the Ministry of Health and Medical Prevention of Senegal, a research sponsor, has set up a steering committee to monitor and support the technical team of the EDS-IV. The Government of Senegal has benefited from financial support from the World Bank, USAID, UNICEF and UNFPA. The SDHS 2005 was carried out from February to May 2005 and provides estimates at the national and regional level.

The data is intended to furnish program managers and policymakers with comprehensive information on levels and trends in fertility preferences, awareness and use of family planning methods, infants and young children feeding practices, nutritional status of mothers and young children, fertility, sexual activity, early childhood mortality
and maternal mortality, maternal and child health; awareness and behavior regarding HIV/AIDS and other sexually transmitted infections. Additionally, the 2005 SDHS collected information on malaria prevention and treatment, neglected tropical diseases, domestic violence, fistulae, and female genital cutting (FGC).

**Measures**

*Female Genital Mutilation.* FGM is assessed by asking a single question to participants: “were you circumcised”? Answers are coded as follow: (No = 1; Yes = 2). If we have a yes to this question we will deduce that the participant was subjected to FGM.

*Physical complications.* Physical complications were assessed by asking to participants a single question that generates different effects of the practice: “At the time when the genitals are cut or afterwards, did you have any of the following:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Excessive bleeding,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Difficulty passing urine / Urine retention,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Swelling of the genital area,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Infection in the genital area/ improper healing,</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

A yes to any of these sub-questions will implicate some physical health risks resulting from the operation.

*Education.* Education is assessed by a single question on the SDHS and MICS questionnaires asking participants: “What is your highest education level”? The scoring involves four categories (No education, primary, secondary, higher). Participant will circle a number under these categories.
**Wealth index / poverty.** SDHS computed several items to measure household ownership of goods / possessions such as television, car, bicycle, electricity, and other goods to represent household wealth as there are no direct questions on family income or revenue. This variable is to determine if there is an association between FGM and poverty levels. The variable is coded as “poorest”, “poorer”, “middle”, “richer”, and “richest”.

**Region.** Respondents’ region of residence comprised of the 11 administrative regions of Senegal which include: Dakar, Diourbel, Fatick, Kaolack, Kolda, Louga, Matam, Saint-Louis, Tambacounda, Thies, and Ziguinchor.

**Type of place of residence.** Place of residence is measured in terms of “rural” and “urban”.

**Religion.** Religion was measured in terms of Muslims, Christians, and Animists.

**Ethnicity.** Participants were asked to select which of the six major ethnic groups they belong to. Among the selections are: “Wolof”, “Poular”, “Serer”, “Mandingue”, “Diola”, and “Soninke”. Those participants who do not belong to a specific Senegalese group are assigned to “Not Senegalese” or “Other”.

**Statistical Analysis**

SPSS version was used to analyze the DHS data. An independent sample t-test is conducted to evaluate the effect that FGM has on individuals’ physical complications. Chi square was used to test the association between FGM and certain demographic characteristics, specifically education, household economic status, region, type of place of residence, religion, and ethnicity.
Results

The results from the t-test showed that there was a significant difference on physical complications between those practicing FGM (M = .31, SE = .71 and those who did not (M = .30, SE = .61, p < .001.

Chi square tests were performed on education, wealth index / poverty, type of place of residence, region, religion, and ethnicity. Chi square test was used to test whether two categorical variables are associated (Field, 2009). Weights were put on before running the analyses. The results show that there were significant associations between whether or not participants were circumcised and their highest education level; between whether or not participants were circumcised and their poverty level; between whether or not participants were circumcised and which regions they were from; between whether or not participants were circumcised and the type of place of residence they live in (rural / urban); between whether or not participants were circumcised and their religion; and between whether or not participants were circumcised and their ethnicity.

<table>
<thead>
<tr>
<th>Education level (%)</th>
<th>FGM No</th>
<th>FGM Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No education</td>
<td>65.50</td>
<td>34.5</td>
</tr>
<tr>
<td>Primary</td>
<td>73.3</td>
<td>26.7</td>
</tr>
<tr>
<td>Secondary</td>
<td>80.7</td>
<td>19.3</td>
</tr>
<tr>
<td>Higher</td>
<td>79.6</td>
<td>20.4</td>
</tr>
</tbody>
</table>

Note: p < .001
Table 1 shows a significant association between whether or not participants were circumcised and their highest education level, $X^2 (3) = 211.3$, $p < .001$. As expected, a clear pattern shows that the more educated the women were, the less association with FGM.

**Table 2. Poverty level and FGM**

<table>
<thead>
<tr>
<th>Poverty Level (%)</th>
<th>FGM No</th>
<th>FGM Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorest</td>
<td>56.2</td>
<td>43.8</td>
</tr>
<tr>
<td>Poorer</td>
<td>54.6</td>
<td>45.4</td>
</tr>
<tr>
<td>Middle</td>
<td>65.4</td>
<td>34.6</td>
</tr>
<tr>
<td>Richer</td>
<td>76.6</td>
<td>23.4</td>
</tr>
<tr>
<td>Richest</td>
<td>86.6</td>
<td>13.4</td>
</tr>
</tbody>
</table>

Note: $p < .001$

Table 2 shows a significant association between whether or not participants were circumcised and their poverty level, $X^2 (4) = 1012$, $p < .001$, with the poorest and poorer wealth categories having the highest percentage circumcised (43.8 and 45.4%). The pattern reflects the expectation that the poorer the women get, the more their association with FGM.
<table>
<thead>
<tr>
<th>Region (%)</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dakar</td>
<td>82</td>
<td>18</td>
</tr>
<tr>
<td>Diourbel</td>
<td>98</td>
<td>2</td>
</tr>
<tr>
<td>Fatick</td>
<td>93.8</td>
<td>6.2</td>
</tr>
<tr>
<td>Kaolack</td>
<td>87.5</td>
<td>12.5</td>
</tr>
<tr>
<td>Kolda</td>
<td>5.7</td>
<td>94.3</td>
</tr>
<tr>
<td>Louga</td>
<td>94.9</td>
<td>5.1</td>
</tr>
<tr>
<td>Matam</td>
<td>5.2</td>
<td>94.8</td>
</tr>
<tr>
<td>Saint-Louis</td>
<td>53.1</td>
<td>46.9</td>
</tr>
<tr>
<td>Tambacounda</td>
<td>12.5</td>
<td>87.5</td>
</tr>
<tr>
<td>Thies</td>
<td>92.7</td>
<td>7.3</td>
</tr>
<tr>
<td>Ziguinchor</td>
<td>30.2</td>
<td>69.8</td>
</tr>
</tbody>
</table>

Note: p < .001

Table 3 shows that there is a significant association between whether or not participants were circumcised and the region they live in, $X^2 (10) = 6803$, $p < .001$, with the Matam region being the highest at 94.8% and the Diourbel region being the lowest at 2%.
**TABLE 4. Place of residence an FGM**

<table>
<thead>
<tr>
<th>Type of place of residence (%)</th>
<th>FGM No</th>
<th>FGM Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>77.5</td>
<td>22.5</td>
</tr>
<tr>
<td>Rural</td>
<td>62.3</td>
<td>37.7</td>
</tr>
</tbody>
</table>

Note: All p < .001

Table 4 shows a significant association between whether or not participants were circumcised and the type of place of residence, $X^2 (1) = 3784$, p < .001, with rural having a higher percent circumcised (37.7) as compared to urban (22.5%).

**TABLE 5. Religion and FGM**

<table>
<thead>
<tr>
<th>Religion (%)</th>
<th>FGM No</th>
<th>FGM Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muslim</td>
<td>69</td>
<td>31</td>
</tr>
<tr>
<td>Christian</td>
<td>88.8</td>
<td>11.2</td>
</tr>
<tr>
<td>Animist</td>
<td>83.6</td>
<td>16.4</td>
</tr>
</tbody>
</table>

Note: p < .001

Table 5 shows a significant association between whether or not participants were circumcised and their religion, $X^2 (3) = 1114$, p < .001, with Muslim having the highest percentage at 31%, Animist at 16.4% and Christian having the lowest percentage at 11.2%.
Table 6 illustrates a significant association between whether or not participants were circumcised and their ethnicity, $X^2 (7) = 6405, p < .001$, with Soninke having the highest percentage at 78.7% and Wolof the lowest at 1.7%. There is a high prevalence FGM practice among the not-Senegalese population residing in Senegal.

**Discussion**

**Physical Complications.** Efforts to eradicate female genital mutilation (FGM) have often been ineffective because practicing communities have always denied its correlation with women’s physical health impairments. The international global interventions brought an adverse reaction as most traditional communities continue the practice of genital mutilation as retaliation against what they perceived to be a neo-colonial immersion or purely an act of cultural imperialism. In the meantime, young girls and women hijacked in this controversial debate undergo pain and destructive health complications that carry negative repercussions during the course of their lives.
Consistent with previous research findings (WHO, 2008; Utz-Billing & Kentenich, 2008), this study found that FGM practice had impact on physical complications. FGM engenders physical consequences which degrees of complications depending on the type of FGM performed, the hygienic conditions of the procedure, the medical knowledge of the circumciser, and many other factors (Utz-Billing & Kentenich, 2008). It suggests that as a result of FGM, girls and women who have undergone the procedure suffer from a wide range of health complications that could be severely incapacitating (WHO, 2000). The ablation of healthy genital tissues inflicted upon infants, toddlers, young girls or women can generate heavy bleeding thus causing chronic anemia or death in extreme cases (Hosken, 1982). FGM is associated with short term risks such as infections, swelling, injury to the urethra, extreme pain, urine retention, difficulty to sit, failure to heal properly (WHO, 2008) as well as long term physical health complications such as chronic anemia, incontinence, infertility, dermoid cyst, keloid scar, abscess on the vulva, difficulty of menstrual flow, calculus formation in the vagina, and other destructive health risks. Because of the cutting off their genital organs and the tightness of the vagina, female sexual life is very difficult as they suffer from Dyspareunia and may experience extreme pain during sexual intercourse (Rigmore & Denison, 2012).

The type of FGM performed may contribute from mild to more severe health complications relating to obstetrical problems. During childbirth, women with FGM and especially those who are subjected to infibulation which is the narrowing of the vagina incur more complications as the obstruction of the birth canal leads to a longer labor with higher risks of still birth and higher risk of injuries to the perineum (Utz-Billing &
Infibulated women have an infertility rate of 25 – 30% (Almroth et al., 2005) making their trials and tribulations a daily stress.

Though clitoridectomy and excision have different consequences than infibulation, all these types of FGM alter females' health and sexuality and constitute a physical health hazard that violates the bodily integrity of girls and women (UNICEF, 2005; WHO, 2008). Due to its negative and irreversible health consequences, FGM can result in the reduction of quality of life among suffering women, therefore, even its mildest form is unacceptable to the global community. The fact that about 30% of Senegalese women are actually excised is an indication that the eradication campaign and programs fighting against FGM are not fully successful in Senegal contrary to what politicians and proponents of FGM want us to believe (Thiam, 1978). It is absolutely crucial to initiate a critical review of anti FGM programs in Senegal and implement them rigorously so that Senegal may achieve its FGM eradication goals while improving the health and quality of life of girls and women.

**Socio-demographic risk factors.** After more than four decades of anti-FGM campaigns in Senegal, this study's findings provide important background information on the prospects for intervention for the eradication of FGM practice. This study, further shows that FGM is significantly associated with socio-demographic risk factors especially education, poverty, region, type of place of residence, religion, and ethnicity. All these are considered risk factors because lack of education, hardship, living in certain regions and in particular areas, belonging to certain ethnic groups or religious affiliation would make women prone or more likely to go through FGM (Karmaker, Kandala, Chung, & Clarke, 2011). The result shows that, as expected, the no education group has
the highest percent of excised women whereas the educated group of women has the lowest rate of FGM at 20.4% with higher degrees and 19.3% for women with secondary education. This finding is similar to the findings of a study conducted in Nigeria (Abubakar et al., 2004) on the assessment of knowledge, attitude, and practice of female genital cutting. In alignment with (WHO, 2008), the more education women get, the less likely they undergo the procedure, and the less likely they perpetuate the practice. With secondary and higher education, about 80% of women have not been excised whereas only 20% have been excised. One can see a clear pattern that as the education level increases the chances for women to go through FGM decrease. Obviously, education plays a significant role in determining the perpetuation of FGM, thus reinforcing the argument that with increasing level of education women will be less likely associated with FGM (Simister, 2010). These results are consistent with those of prior studies that examined the impact of women’s education level and their acceptance or practice of FGM (Williams & Sobieszczyk, 1997). It appears that education influence FGM decision-making, as it is a key factor in the understanding of the harmfulness and the irreversibility of the damage caused by the practice.

Another interesting finding worth highlighting is the fact that poverty increases risk and vulnerability to undergo the harmful practice as it encourages and reinforces FGM practice. This study revealed that as women get richer, they are less likely to go through FGM. About 44% of the poorest women were excised, whereas only 13% of the richest of the women were excised. This finding is consistent with prior research (Gruenbaum, 2005) as this indicates that the primary grounds for the practice of FGM is that parents believe that their daughters are worse off without excision as in most
practicing communities, it is a pre-requisite for marriage which is considered to be the ultimate economic support for women (Gele, Johansen, & Sundby, 2012). Therefore, the plausible reason forwarded is the connection between FGM and women’s economics, as Gruenbaum (2001) argues that the continuation of FGM practice is directly connected to culture as well as the economics.

Senegal is a poor developing country and in many of its communities, women have to undergo FGM to be considered eligible for marriage. Women in these communities are at great economic disadvantages and are totally dependent on men for their survival. In practicing communities, FGM provides a higher status for young girls and women who are then given greater chances to be in the marriageable pool and a guarantee for economic security. Poor families may therefore subject their daughters to FGM thinking that this is the best decision for them as far as economic security is concerned.

In Senegal some of its regions have high prevalence of FGM whereas in other regions the practice is almost inexistent. This is primarily due to the distribution and variation of diverse ethnic groups, their location in specific regions, and their beliefs in regard to FGM practice. Matam region has the highest rate of FGM with 95% of women excised. This finding is expected because Matam is inhabited by most Poular which is an ethnic group that has high FGM prevalence (WHO, 2008) and they are mostly Muslims. Another factor is that Matam borders Mauritania which is a country with high rates of FGM (SDHS, 2010-2011). Kolda (94%) and Ziguinchor (70%) in the south of Senegal have also high rates of FGM as at least one third (1/3) to nearly the whole female population have undergone the procedure of FGM. These results were anticipated in
these two south regions inhabited by the Diolas who practice FGM. Additionally, Kolda and Ziguinchor Border the countries of Guinea-Bissau and Guinea which have high FGM prevalence rates (WHO, 2008; SDHS, 2005). Dakar, the capital city has about 18%, Kaolack (12.5%), Thies (7.3%), Fatick (6.2%), Louga (5.1%), and Diourbel (2%) as these are regions mostly inhabited by the Wolofs and Serer who are composed of two ethnic groups known for not practicing FGM. The unexpected finding was the quite high rate of FGM in Saint-Louis (47%) which is about half of the female population excised. This is a surprise because this city was the first capital city of Senegal before its transfer to Dakar and was and is still a reference for women’s elegance and stature. Saint-Louis is also known for having a big bi-racial population because of the French establishment in the city in addition to its rich tangible and intangible heritage as a former capital status during colonial time (Sow, 2008). Saint-Louis benefited of a great influence as a French dominion in terms of education, culture, and trade. That is the reason of the surprise, as the high rate of FGM does not render justice the historical prestige of Saint-Louis.

As an effort to determine FGM prevalence in urban/rural setting, this study aimed to bring evidence that there is a higher risk of FGM in rural areas than in urban areas. About 40% of rural women were excised whereas about 20% of women in urban areas went through FGM. As expected, the results from the findings show that FGM is significantly associated with respondents’ place of residence. The result of this study is consistent with a prior study carried out among women in Senegal and the Gambia (Shell-Duncan & Hernlund, 2006) which showed that rural women are more predisposed to go through FGM practice than their urban counterparts. Therefore, urban residency reduces somehow the occurrence of FGM.
The findings of this study also showed that there is a significant association between respondents' religion and the practice of FGM. This finding is consistent with the study conducted by the World Health Organization (WHO, 2008) which found that FGM is commonly associated with Islam; however, the harmful practice is performed on a wide continuum. In our study, most women who have been excised affiliate themselves with the Muslim group (31%) as opposed to Animists (15%) and Christians (10%). Even though FGM is associated with Islam, there is not a unanimous practice among all Muslims. Nonetheless, a great portion of women mistakenly believe that FGM is required by their religion and that it has positive benefits as it is additionally understood to be a cleansing and purification ritual (Garcia, 2010). This perception reinforces that idea of innate female physical and moral impurity that need to be cleansed to ensure that women will not engage in immoral and sinful acts (Thiam, 1978). Previous studies have shown that FGM is practiced across religions (Gruenbaum, 2001). Surprisingly, the percentage of Muslim women who had undergone the practice of FGM in Senegal is quite low (31%) as it does not reach half of all girls and women. However, although the practice of FGM is low among Muslims, our study shows that in fact the Muslim group has the highest FGM rate among religious groups as compared to Animist and Christian. While there has been great number of researches that have produced significant proof to support the credible evidence of the influence of religion on the practice of FGM, most opponents of FGM consider that this is about an erroneous belief (Dorkeeno, 1995) and that is the reason why the practice is not universal among common faith.

The World Health Organization (WHO, 2008) stated that FGM prevalence within a country varies dramatically by ethnic group. FGM is deeply embedded in practicing
settings as it is considered to strengthen the cohesion of communities. FGM is understood to be an identity marker, a rite of passage into womanhood (Gruenbaum, 2001; Shell-Duncan & Hernlund, 2000). FGM may be seen as a demarcation ritual as it serves as a characteristic that distinguishes an ethnic group from another. Therefore, FGM varies more by ethnicity than any other socio-demographic variable (SDHS, 2005).

Our study shows that there is a significant association between whether or not participants were circumcised and their ethnicity with the Soninke having the highest percentage at about 79% and the Wolof with the lowest rate at about 2%. This result was expected and the only two surprises were the Diolas and the not Senegalese group with respectively 61% and 71%. It is obvious that in Senegal, girls growing in the Soninke, Mandingue, Poular, and Diola groups are at higher risk for being excised than girls growing in the Wolof and Serer groups who are at little risk of FGM. The second surprise is the not Senegalese group which has a high rate of FGM with 71.3%.

However, looking back at the composition of the Senegalese population, Senegal has about 20 ethnic groups (SDHS, 2005) even though only six ethnic groups have a population big enough to represent an official ethnic group. The not Senegalese group is certainly the combination of other small group such as the Malinke, Sosse, immigrants from Mali and Guinea, Jakhanke, Manjack, Mankanya, and others minor groups known for their high practice of FGM. Ethnicity is a key factor that would show FGM prevalence / distribution in a country. Therefore understanding the role ethnicity plays is of primary importance (Gruenbaum, 2001) in planning efficient means to help stop FGM.

Overall our findings suggest unequivocally that these demographic variables, specifically education, poverty level, region, type of place of residence, religion and
ethnicity are risk factors for the practice of female genital mutilation among women of reproductive ages (19-45) in Senegal. Clearly, these risk factors contribute greatly to the perpetuation and the spread of FGM in Senegal and they need to be addressed deliberately within practicing community for a successful campaign for a complete FGM eradication.

**Strengths and Limitations**

A certain number of strengths and limitations in regard to the study and the data set used need to be taken into consideration. The strength of this work is that it is based on a national large scale survey from the Demographic Health Survey (DHS) tailored for specific issues relevant to Senegalese societal concerns. Populations, including even those from very remote regions, were accounted, thus making the study more representative of the whole nation.

A very important fact is that the study is based on women’s self-reports which could spark questions regarding reliability and validity (Karmaker, Kandala, Chung, & Clarke, 2011). In practicing communities, women tend to over-report FGM as it is expected that they conform to social norms. To avoid social pressure, and excommunication, not excised women are more likely to report being part of the FGM group. Thus, the fear of social disapproval may increase considerably the report of FGM numbers resulting in an inaccurate estimate and over-representation of FGM. On the flip side, FGM women located in non-practicing communities may hide their condition as to blend with the common belief of the area. In this instance, women tend to under-report FGM especially in areas where FGM is considered illegal and laws enforced. Therefore, there is always a potential lack of reliable figures on FGM prevalence.
The Senegal Demographic Health Survey (2005) was cross-sectional thus allowing only examining association between variables. This type of survey does not permit to determine causal relationship between FGM and other risk factors.

Another limitation is that the SDHS (2005) did not measure household income in terms of salary. A wealth index was used as a proxy that compiled household ownerships such as bicycle, car, radio, and other choices of assets and certain amenities such as electricity. This makes it very difficult to compare accurately wealth index scores from one region to another. For example the wealthier households in the capital city do not necessarily correspond to the wealthier household in a remote village because the levels of wealth distribution differ considerably. Senegal is a developing country and it seems difficult to collect reliable data on income.

Finally, the study is limited is the lack of data on questions pertaining to female sexuality after FGM as well as an absence of data on psychological consequences. These are areas with a paucity of research and data is absolutely necessary in order to demonstrate the harmful effects of FGM and its consequences or repercussion on women sexual life and psyche (Obermeyer, 1999).

Implications for policy, practice, and research

Implication for research. As oppose to other social science topics with numerous studies, FGM is absolutely under studied (Rigmore & Denison, 2012). With its sexuality component, FGM is taboo in practicing communities making it very difficult for people to talk about its negative sexual repercussions (Thiam, 1978). Women are very reluctant to partake in studies or just participate in awareness sessions at local communities (Amusan & Asekun-Olarinmoye, 2006). Women and men do not feel
comfortable talking about sex and sexuality after FGM (Thiam, 1978). Since sex and sexuality are taboo in FGM practicing communities, there may be a feeling of uneasiness and sometimes even guilt to reveal aspects of intimate life and sexual discomfort that are believed to be lived in secrecy. Therefore, teaching the communities about the normalcy of sex and sexuality would reduce considerably the taboo aspect of it and lift shyness and apprehension to talk about FGM sexual consequences.

Many of the studies that have examined the effects of FGM on women and young girls were not high scale studies, thus making it difficult to prove health, psychological, and sexual consequences claims (Obermeyer, 2006). Consequently, researchers are left with very little guidance, reference, and a paucity of high quality scientific evidence in this complicated and controversial social issue. For example the use of the Senegal Demographic Health Survey of 2010-2011 would have been the best tool in our analysis as it is more recent. However, due to a great amount of missing data and the omission of fundamental questions pertaining to FGM made it impossible to use for our quest of FGM risks factors. Therefore, more in depth and comprehensive studies are necessary. To achieve this goal we need a rigorous scientific research, higher scale longitudinal mixed methods, and a more objective ethnographic research. More intentionality is needed in sample design and data collection for studies examining FGM in local and global contexts. This recommendation is consistent with Obermeyer’s (2006) discussion on the value of scientific evidence that would surely maximize the best indication to prove the harmfulness of FGM and its negative consequences on girls and women’s health. Scientific research on the sexual consequences would be the best proof to support the argument that FGM impairs female sexual functioning (Rigmore & Denison, 2012).
More longitudinal designs are also needed to enable a greater focus on the dynamic relationships between communities and FGM families’ over time. Importantly, more rigorous scientific studies are needed to test the claim of sexual dysfunction resulting from FGM (Rigmor & Denison, 2012). For example, because of conflicting findings, Ahmdu (2000), a first generation African American whose parents are African immigrants, decided to undergo FGM in her adult life came out to state that FGM does not implicate sexual problems. Nevertheless, other researchers found that FGM has detrimental effects on women's health and sexuality after assessing the consequences of FGM by measuring (a) sexual satisfaction, (b) sexual desire, (c) initiated sex, and (d) experience orgasm (Rigmor & Denison, 2012). Based on their research, there is evidence in support of the argument that FGM is associated with female sexual functioning. Therefore, more research on the physiological aspect along with appropriate dissemination of results to practicing communities will help decrease the practice of FGM. For example, in examining how young girls and young women go through the mutilation process, their pain, fear, and health difficulties along youth and adulthood lifespan and capturing what happen with menstruation, sexual life, sexual desire, sex avoidance, sexual sensation, pregnancy, and childbirth would be of the utmost indication of the effects of the practice. This strategy will surely give momentum to the fight for the eradication of FGM, as activists and health professionals would get access to a more comprehensive data that will allow them to reach a more efficient means in favor of the abolition of FGM.

Ethnographic research has also an important place in understanding the practice of FGM, as it can give a powerful voice to women in remote places to express their
feelings and share their experiences so that we can better understand their trials and tribulations associated with the practice. Even though sex and sexuality related issues are taboo in Senegal, conscious and well informed ethnographers can work with these women in practicing communities and bring them to the realization of the normality of women’s body experiences. However, Ahmadu (2000) warns us to be aware of those western activists who do not know much about African cultures and are vested of a civilize mission, to rush into false judgment of African cultures and societies. Nevertheless, ethnography conducted since the late seventies continue to inform the work of researchers in how to approach the topic with regards to its adequate contexts and adequate lens (Nnamuchi, 2012). Contradicting methodologies were also deplored by activists, as they are vehemently criticized by FGM proponents (Kalev, 2004). More research is needed about the modern reasons why women keep on perpetuating FGM, although the negative consequences have been proven. Most of current research on FGM focuses solely on the negative health consequences (Utz-Billing & Kentenich, 2007), thus using a very narrow lens to explain the dynamics of the phenomenon. Research is absolutely needed in all areas encompassing the practice of FGM to know about its true hidden motives and prevalence in certain ethnic groups vs. others that do not endorse the practice, while all these groups live in the same context. A broad range research regardless of FGM taboos or cultural restrictions would advance our understanding of this harmful practice. However, to reach a complete eradication of FGM, research alone does not suffice. It needs to be conducted in conjunction with policy and practice implementation.
Implications for policy and practice. Many African countries, under international pressure, enacted laws forbidding the practice of FGM in the international sphere as well as in traditional local communities. Senegal enacted a law in 1999 criminalizing the act in all administrative regions. However, among the practicing communities, not a single family was brought to justice for excising their daughters. Although the government became tougher in passing a law banning the practice, people’s awareness and understanding of the harms resulting from FGM has yet to translate into considerable changes of attitude of women and men toward the practice and prevalence (Amusan & Asekun-Olarinmoye, 2006). Activists from both sides (western activists and African activists) are still debating and negotiating about the correctness of the terminology to be used to refer to the practice and also about the most effective and adequate strategies that can lead from a decrease to a complete eradication of FGM in one generation (Shweder, 2000). This prolonged debate is one of the primary reasons that FGM eradication did not advance rapidly. Although the government enacted a law criminalizing FGM, it is very relaxed in the implementation phase. Formal and informal knowledge and education about the law are not sufficient alone. Many campaigns geared toward enlightening people with regard to the punitive actions of the law have not been very effective. It is necessary to follow up with the implementation of the enacted laws (Thiam, 1978). For example, governments should be able to prosecute parents or family members who subject any female to FGM. Examples of prosecutions should be made public to make practicing communities aware of the legal sanctions they can incur when they violate of the law. Additionally, the penalty must be tougher as to life in prison if a child bleed to death as a result of FGM complications.
The international focus on the cultural, health, and human rights of affected girls and women must expand to embrace more comprehensive applications typical of the traditional norms of social contexts in which these harmful practices occur (Thiam, 1978, 1986). International activists must be very diligent and thoughtful in their targeting of African traditional practices to avoid adverse reactions as seen in the case of Ahmadu Fuambai and other defenders of African cultures who argue that western interventions in African affairs are of an imperialistic and colonialist nature (Ahmadu, 2000). The lead to resolve FGM issue belongs to African women and foreign supports are welcomed as long as their actions are in concordance with concerned African women affected by FGM and of their own African activists. For example, Senegalese communities will welcome the sponsorship of international agencies in their adoption of a symbolic ritual practice instead of the actual operation so that certain beloved values still survive. Community action programs from an ecological perspective can bring change to societal harmful norms.

Recently, research findings identified strategies that may be effective in producing attitude and behavior change in regard to FGM practice. For example, TOSTAN, an American non-governmental organization (NGO) based in Senegal states that they applied a new model of approaching Senegalese villages, leaders, and the community at large in regard to the abandonment of FGM. Their strategy is to encourage and educate a network system that can energize the whole community around basic understanding and adoption of human rights. The model is also based on the empowerment of women so that they can make their own decision as to stopping or continuing the practice. The weakness of this approach is that poor villages agree to
pledge to stop the practice to get monetary compensation to survive poverty however; the practice is driven underground as they keep perpetuating it in secrecy. Reports are very contradicting because if more than 3,000 villages over the 5,000 in Senegal are pledging not to mutilate their daughters anymore, then the results from the two Demographic Health Survey (DHS) of 2005 and 2010-2011 would have shown a substantial decrease in within five years range. From 2005 to 2010, FGM decreased for only 2% (SDHS, 2005, 2010-2011). Certain international agencies may fail in their mission to help African countries because of their primary wrong approach. International agencies as well as NGO’s must work in partnership with African women pioneers of the fight for the eradication of FGM. These women are passionate, they know the culture, and they know the best approach to deal with culturally sensitive matters. These African activists mostly need financial support so that they can reach out to all practicing communities to vehicle ideas of change through formal or informal education.

Medical doctors have an important role to play in the anti-FGM effort and should not help in maintaining a harmful practice knowing its detrimental consequences could lead to death of most vulnerable infants and young girls (Jaeger, Caflisch, & Hodlfeld, 2007). In order to control the practice, the Senegalese government must mandate health and human services workers to educate practicing population. To do so, doctors should not be allowed to perform the practice in any hospitals, clinics, medical facilities or in any private home setting. Doctors must be trained to understand the important role they play in the eradication process (Jaeger, Caflisch, & Hodlfeld, 2007). They must talk to their patients’ parents about the harmful effects of FGM. Doctors are the main recourse when complications from FGM arise, therefore, they must be the health agents to plead
the case against FGM to parents. To get a control over FGM, the government must have a systematic collaboration with medical doctors and hold them accountable if they fail to acknowledge the harmful practice and if they fail to report cases of FGM especially on children. The government should create an agency like DYFS to monitor cases of children subjected to the practice. This will discourage parents from breaking the law by knowing that there will be a punitive action.

Based on the literature review, there are laws enacted to criminalize FGM, however, it might be useful to provide public formal and informal education to religious leaders as they are entrusted by their communities. If these religious leaders stand against the harmful practice, then chances are that their followers will do the same. Therefore, they must be knowledgeable about FGM health repercussions and also they should be able to preach that FGM has no religious foundation (Leye et al., 2007) but it is just a harmful cultural practice. Research has found that ethnic groups with high degree of FGM practice have low level of education whereas educated ethnic groups tend to raise their children to reject FGM (Simister, 2010; Igwegbe & Egbonnu, 2000).

A course that has not yet been taken is to consider associating, educating, and encouraging both male and female children to be active participants and advocates of the eradication process. Until now, educational attempts are geared toward mothers while children and men are not given information about the harmfulness and the pain associated with this practice. Children can be their best advocate if given the adequate tools. If they know they are at risk to be excised and that they have an agency they can report it to, then it means they are given a tool they can use. It would be the same as children from the United States who know that they can dial 911 if they feel they are threatened. That will
be away to empower children so that they know the law is on their side and that they can
always seek help instead of succumbing to peer or societal pressure.

Given the magnitude of the connection between FGM and marriageability, it is
necessary to involve men at all level of the process. While this goes against the radical
feminist framework, there is no way to get to the eradication without males’ endorsement
of marrying uncut women and also to state that they will not marry any cut women. That
will be a revolutionary mentality that could bring FGM to an end.

Additionally, in regard to theories, it will be of our benefit to consider referring to
the ecological theory that looks at the individual within the context of his/her own
environment. That would be a great way to find out why women are cutting their
daughters and to analyze how their living context support or discourage FGM. The
intersectionality theory is also to be explored in understanding the forces and dynamics
that come together to influence women’s experience.

Conclusion

Female genital mutilation is the worst form of violation against women and
children’s rights. Fifty years after the launch of a global movement to eradicate FGM,
one can realize that many variables such race, culture, rights, and prejudice among others
played major roles in reversing the progress especially in the last 10 years. Despite the
health model that brings up the detrimental health consequences and the human rights
model that place FGM victims under an international legal protection; FGM is still
prevalent in the many places it used to be performed and is still performed. Of course,
there is a great contribution from activists, politicians, social scientists, feminists, and law
makers along with great theories in the quest of understanding the people practicing this
harmful phenomenon and in setting an eradication agenda. FGM is very complex as it is deeply rooted in traditional cultures. Its eradication will require a combination of different perspectives, an international and cross-cultural collaboration, a sturdy government control to implement the laws, educational access to men, women, and children, and above all the empowerment of indigenous women so that they can make their own decision as to stopping completely the practice. Education would be an important component, as Simister (2010) argues that ethnic groups with high degree of FGM practice have low level of education whereas educated ethnic groups tend to raise their children to reject FGM. Therefore, more education is associated with less FGM practice.
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December 20, 2012

Ms. Mame Diop
230 Terrace Ave.
Jersey City, NJ 07307

Re: IRB Number: #001286
Project Title: Female Genital Mutilation in West Africa

Dear Ms. Diop:

After an exempt 4 review, Montclair State University’s Institutional Review Board (IRB) approved this protocol on November 21, 2012.

Although this study is exempt from continuing review, any changes made to this protocol must be submitted as an amendment and approved by the IRB.

When you complete your research project you must submit a Project Completion form. Before requesting amendments or submitting project completion, please reference MSU’s IRB website and download the current forms.

If you have any questions regarding the IRB requirements, please contact me at 973-655-5189, reviewboard@mail.montclair.edu, or the Institutional Review Board.

Sincerely yours,

Dr. Debra Zellner
IRB Chair

cc: Dr. Pearl Stewart, Faculty Sponsor
     Ms. Amy Aiello, Graduate