



Network Against Gender
Based Violence

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Socio-cultural Perceptions of Female Genital Mutilation and Consequences on Labour in The Gambia: A Qualitative Study



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A Report written for the Network against Gender Based Violence and ActionAid The Gambia



Funded by **AMPLIFYCHANGE**

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Executive Summary

Female Genital Mutilation (FGM) has been at the forefront of women's rights and human rights struggles in The Gambia. Despite efforts to reduce the number of girls subjected to this harmful traditional practice, including a law introduced in 2016, FGM still persists in the country. An estimated 75% of Gambian women and girls ages 15-49 had undergone some form of FGM between 2004-2015 and 56% of girls 0-14 had undergone FGM between 2010-2015 (UNICEF, 2016).

Reliable data on FGM in The Gambia is limited but some recent studies have been published on the negative consequences of FGM on female sexual and reproductive health (e.g. Kaplan *et al*, 2011, 2013a, 2016) who found that FGM types II and III have more adverse effects on health than those who have no FGM or Type I. Studies have also revealed the general inclination of medical professionals to oppose the practice (Kaplan *et al*, 2013c, 2016).

However, more knowledge of sociocultural perceptions of childbirth, FGM and health are needed in order to improve clinical services and development projects targeted at the elimination of FGM. Recently, some qualitative studies of FGM in Senegal and The Gambia including Shell-Duncan *et al* (2010, 2011) and O'Neill (2012) have described the complex settings of social norms and beliefs that frame women's decision-making process surrounding FGM. In particular, the social capital, the religious values and the site of the female body in a political struggle have been drawn out.

This study fills a gap in research on FGM in The Gambia by gathering information on sociocultural perceptions alongside health outcomes in childbirth and delivery. The primary objective of this is to provide an understanding of women's perceptions of FGM and how it affects childbirth and sexual and reproductive health and rights. Underlying this objective is the broader aim of understanding women's own attitudes towards FGM.

FGM and Social Norms

This report frames FGM within the concept of a social norm and also explores the concept of agency and freedom in decision-making, choice and adaptive preference from Amartya Sen's (1999, 2009) capabilities approach. As a social norm, FGM remains an action that persists due to community or social expectations for them (Mackie *et al*, 2015).

Methodology

This study was conducted in November-December 2016 by an international consultant and two Gambian researchers in tandem with a wider quantitative study on the effects of FGM on childbirth. This ancillary study aims to understand women's own perceptions of the effects of FGM on childbirth as well as their attitudes towards their own health and their beliefs on the FGM ban, focusing on feelings and perceptions related to childbirth and delivery, FGM and the recent FGM ban in The Gambia. 17

women from the quantitative study were sampled from Edward Francis Small Teaching Hospital, Jammeh Foundation Hospital, Bansang Hospital and Brikama Hospital.

Key Findings

Key findings of the study are divided into three areas: Women's Knowledge of FGM and Sexual and Reproductive Health, Social Norms Surrounding the Practice and Attitudes towards the FGM Ban. These include the following:

- Women describe FGM as an activity that occurs with a high degree of ritualization, including blessing, charms, white clothes and sometimes dancing. This indicates its enduring cultural status in many areas and differs from recent studies that suggest such rituals have been abandoned as communities take a more religious or medicalized stance on FGM.
- Women hesitate to express pain related to childbirth and to FGM, noting that open discussion of sexual and reproductive health is hindered by norms related to privacy and projecting strength.
- Primary justifications of the practice related to cleanliness, respect of elders and of tradition and the prevention of premarital sex or female promiscuity. Some women who were aware of negative impacts on sexual and reproductive health still felt that these cultural justifications outweighed potential risks.
- Women do not feel that they are the primary decision maker on matters concerning their own sexual and reproductive health. Some who opposed FGM felt that husbands or family members would override their preference.
- Women do not receive adequate information on their own health and on FGM and female reproductive and sexual health more broadly. Many women had experienced complications in their recent childbirth that were likely due to FGM yet most reported that doctors did not explicitly tell women of the cause of their complications.
- Regarding the recent FGM ban in The Gambia, women remained divided. 6 women opposed the ban, 9 women were in favour of the ban and another 2 did not express an opinion. Those who opposed the ban felt that people should have freedom of choice.

The article concludes that some women are experiencing what Sen (1999) calls adaptive preference, or that they make poor quality choices that could negatively impact their wellbeing but believe sincerely that they are making a high quality choice. However, this belief relates to a constriction of rights more broadly. Other women recognise that they have or will make a low-quality choice but feel that they lack the agency due to social norms and pressures from families, particularly in-laws and elders.

The study recommends that:

- 1) Nurses should be a key point of contact for training and awareness and should be trained to recognise and discuss possible risks associated with FGM on sexual and reproductive health.
- 2) Awareness raising at a community level about the FGM ban as well as continued policy and advocacy work to ensure that the ban remains a priority of the new government should occur.
- 3) Further qualitative and quantitative research on women's perceptions of health as well as men's perceptions on FGM will enhance evidence-based policy.
- 4) Women's empowerment on a societal level, including economic independence, should be promoted to encourage a higher level of freedom in decision making processes.
- 5) Programmes seeking to end the practice of FGM should consider how to work within communities and create spaces for open deliberation on the topic, which can assist in moving forward commonly held beliefs and norms.
- 6) Communications about research findings should be shared not only with communities but also with organisations working on similar topics to create unified, strengthened approaches to advocacy against gender-based violence.

1. Introduction

1.1 Background

Across sub-Saharan Africa, the abandonment of female genital mutilation (FGM) remains critical to assuring women's rights and health. FGM is classified as a harmful traditional practice and physical and mental health risks associated with the practice are well documented. The World Health Organisation (WHO) estimates that over 200 million women and girls alive today have undergone some form of FGM, in spite of recent bans and campaigns to end the practice.

Social norms and cultural practices are often identified as barriers to abandoning FGM (Mackie and LeJeune, 2009; Shell-Duncan et al, 2010, UNFPA/UNICEF, 2016) In some places, religion is identified as a primary reason for continuation of FGM, though scholars dispute this justification with some advocating that Islam does not promote this practice (Daffeh et al, 1999; Abusharaf, 2006); in many contexts FGM plays a central role in girls' initiation and marriage rituals and contributes to norms about womanhood and femininity (Shell-Duncan et al, 2010). Often, norms surrounding FGM are transmitted through religious channels, interacting to create pressures on women and families. Research on the values and beliefs that support or defy the practice are needed to create policies and programmes that can support communities in shifting norms related to FGM.

The Republic of The Gambia (hereon referred to as The Gambia) is an ideal context in which to explore such shifting norms. The Gambia has relatively high rates of FGM: an estimated 75% of Gambian women and girls ages 15-49 had undergone some form of FGM between 2004-2015 and 56% of girls 0-14 had undergone FGM between 2010-2015 (UNICEF, 2016). In 2015, The Gambia ratified legislation banning FGM and, prior to this, campaigns led by UNICEF, Tostan, GAMCOTRAP, ActionAid International The Gambia (AAITG), Network against Gender Based Violence (NGBV), Wassu Gambia Kafo, Bafrow and others have invested resources to educate and encouraged communities and youth to abandon or reduce the practice.

Reliable data on FGM in The Gambia is limited but has expanded in recent years, primarily related to medical outcomes and practice (Kaplan et al, 2011, 2016; MRC, 2001), though some emerging qualitative research also exists (Dibba and Barrow, 2016). Studies on perceptions and practices of women at a community level (Shell-Duncan et al, 2010) by men (Kaplan et al, 2013b) and by medical professionals (Kaplan et al, 2013c, 2016) enhance understandings of social norms and practices of FGM.

In The Gambia, NGBV and AAITG recently led a quantitative study on the medical implications of FGM on women during and after childbirth. In addition, 17 women were sampled to gather more information on women's own experiences with childbirth, delivery and their beliefs on FGM. This report presents findings from the accompanying qualitative

study that unveils women's general knowledge of the practices and beliefs as to why it still occurs or why it should not. Knowledge of and opinions on the recent FGM ban are also exposed. This data is critical for women's sexual and reproductive health in The Gambia.

This report discusses the research questions and aims; literature review of FGM in Africa and in The Gambia; and frame the concept of FGM as a social norm. Then Methodologies will be discussed before research findings are presented.

1.2 Research Aims and Questions

The primary objective of this is to provide an understanding of women's perceptions of FGM and how it affects childbirth and sexual and reproductive health and rights. Underlying this objective is the broader aim of understanding women's own attitudes towards FGM.

The questions framing this research are:

- 1) What are the socio-cultural perceptions regarding FGM, including perceived advantages and disadvantages of the practice?
- 2) How do women perceive complications during their births and what resources are available to address complications?
- 3) What are women's attitudes towards the abandonment of FGM?

1.3 Rationale

Both globally and in The Gambia, research on women's perceptions of FGM and their medical experiences remains limited. Such information plays a critical role in working to shift social norms and practices towards abandoning the practice. More information is also needed on women's own knowledge of FGM and health practices. By conducting this research as an ancillary study to a broader, quantitative medical study, it provides an opportunity to compare women's actual medical outcomes alongside their own perceptions.

2. Literature Review

This section will frame the concept of FGM within international contexts as well as in The Gambia. Also, the concept of social norms will be explored as a lens for understanding FGM practices in The Gambia and beyond.

2.1 Defining and Locating FGM in International Discourses

FGM is defined as 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or other non-medical reasons' (UNFPA, 2014). This report chooses to use the term FGM as a rights-based approach, in line with UNFPA, WHO and UNICEF. In accordance with WHO and other international organizations, this study abides by classification of FGM as Type I-IV:

- I. *Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).*
- II. *Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).*
- III. *Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).*
- IV. *All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.*¹

In multiple international charters and declarations, FGM has been declared a violation of women's and children's rights, including the Universal Declaration of Human Rights, The Convention on the Rights of the Child and the African Charter on Human and People's Rights (the Maputo Protocol). In the 2015 Sustainable Development Goals, FGM is located under Target 5.3 to 'eliminate all harmful practices, such as child, early and forced marriage and female genital mutilations.' This target supports Goal 5 for gender equality and women and girls' empowerment.

Some maintain that campaigns against FGM are Western or neo-colonial and are thus invalid. However, many activists from Africa are vocal that the practice causes physical and emotional harm and must be stopped. Furthermore, cultural arguments are weakened within viewpoints that promote culture as dynamic and changing as opposed to static.

2.1 Qualitative Studies on FGM

While qualitative data is limited on FGM, some surveys have been taken across Africa and in diaspora communities. In Nigeria, Ahanonu and Victor (2014) conducted a survey on mother's perceptions of FGM and found that mothers with a tertiary level of education were less likely to believe that excision reduced a woman's promiscuity. They also found that women held 'ambivalent perceptions' of FGM, with 56.8% reporting that they do not believe the practice is beneficial to females and 44.2% believing that uncircumcised females become promiscuous. Thus in spite of knowledge of harms and risks, social norms relating to chastity and sexuality prevail.

An ethnography of the Futanke community in Northeastern Senegal reveals more about why communities resist bans on the practice. For example, O'Neill (2011) found that upholding FGM could be understood as resistance to neo-colonialism and asserting local power in the face of overwhelming globalisation and even dominance from mainstream Senegalese urban culture. In Sierra Leone, members of the Bondo, a secret female society, resisted international campaigns by promulgating

¹ For more on this, see: <http://www.who.int/reproductivehealth/topics/fgm/overview/en/>

the tradition and through this practice also gained political power (Bosire, 2012).

A large body of research on FGM in diaspora communities also exists, primarily in the UK and Scandinavian countries. Findings have shown in Sweden that women from Somalia and other FGM practising countries abandon FGM once living in a heterogeneous community and having contact with Arabs or Muslims who do not practice as well as feeling pressured by laws of the country (Johnsdotter and Essén, 2016). However Hussein (2010) found among Somali and Sudanese woman in the UK that women with FGM felt ashamed and uncomfortable seeking medical help in the country and also did not feel that the FGM Law would prevent their community from continuing the practice.

In Senegal, Cislaghi, Gillespie and Mackie (2016) studied the impacts of a community-level human rights education project

2.2 FGM as a Social Norm

Abandonment of FGM is a complex process partly because of its socio-culturally engrained nature. Human actions do not occur in isolation and are often ruled by broader societal structures. Mackie et al (2015, p. 7) define a social norm as 'the interdependence of expectation and action'. In other words, an individual's actions are not always determined by personal opinion or rational thought but by the expectation and norms of the surrounding community.

The practice of FGM can be understood as a social norm in which the practice continues in large part because many other processes and beliefs of the community, or reference group (Johnsdotter and Essén, 2016). In many groups, FGM fulfils social norms relating to gender including a woman's ability to participate in marriage and be accepted in the community. In communities where women remain socioeconomically dependent on marriage, these are even more important.

However, social norms should not be understood as static but rather as dynamic and shifting. Education and awareness can have an impact on encouraging people to change behaviours or opinions, as well as contact with other cultural groups. Shell-Duncan et al (2010) argue that FGM must be viewed within shifting cultural norms. For example, in a rural African community, women require certain qualities to succeed socially and economically, and this includes fulfilling gender norms and marriage that may involve FGM. The authors argue that as community values shift, the importance of FGM can also evolve or diminish.

Cislaghi, Gillespie and Mackie (2016) also argue that providing new opportunities for community members to take on new roles that diverge from traditional gender roles in the community also allows for changes to occur gradually within a community. Furthermore, individuals' self-conceptions need to shift at the same time that beliefs and practices in order for social norms change to occur.

For example, Johndotter and Essén (2016) argue that FGM is indeed a norm that can be shifted, having found that Somali immigrants in Sweden began abandoning the practice after encounters with other Muslims of nationalities that do not practice FGM, health care systems and diminished fears about marriageability of daughters. Thus different contexts can lead to deliberation and creation of new norms related to femininity and health.

Social norms could also be understood within 'capabilities approach,' a theoretical framework which argues that development is the attainment of freedom and well-being and should be measured at the individual level – in the ways in which human beings are able to live well through the selection and achievement of high quality choices. Often, the 'capability sets,' or set of preferred choices are determined by community and social norms (Sen, 2009) and this can lead to what has been called 'adaptive preference' wherein oppressed people with limited choices believe that they actually are making quality choices. In the case of FGM, the prevalence of the practice as a social norm could make it an adaptive preference, as women connect the choice to marriage, family and economic stability.

O'Neill (2012, p. 22) also points out that beyond being a locally based social norm, 'FGC is the nexus at which tensions between the global and the local, secular and religious, human rights and community law, NGO policies and sectarianism, new elites and inter-caste relations all come together and cross over, intersecting at various levels.' In this case, argument to both continue and abandonment of FGM drawn from a range of competing and overlapping sources and are often at a struggle between globalisation and local authority over autonomy of self and community, including the body. It is important to note that the female body becomes politicised and compounds the inability of women to make autonomous choices about sexuality, personal health and well-being.

2.3 FGM in The Gambia

The availability of data on FGM in the Gambia has increased in the past three decades. An increase in projects, symposia and funding for FGM began in the mid-1990s following global public health, human rights and development trends (Hernlund, 2000). The Gambia Committee on Traditional Practices Affecting the Health of Women and Children (GAMCOTRAP) has advocated for the abandonment of FGM since 1984 in an often hostile political and social environment.

Health Impacts of FGM

One of the first quantitative, community-based surveys on health impacts of FGM was led by the Medical Research Council Unit The Gambia (Morison et al, 2001) and entitled 'Long-term reproductive health consequences of female genital cutting in rural Gambia'. The study included 1,348 women of which 1,156 underwent a gynecological examination and found that 58% had been subjected to FGM, with over 90% being type II. The same study also showed that women had higher rates of bacterial vaginosis and herpes.

Kaplan et al (2011) conducted a study from December 2008 to March 2009 of 871 women in all six regions of the Gambia. The study, commissioned by the Gambian government, found that 66.2% of women had undergone Type I, 26.3% had Type II and 7.5% had Type III. Long term and immediate complications associated with FGM included haemorrhage, acute anaemia, infections, scarring and pain during sexual intercourse. Type II and III had most prevalence of such complications: 55.0% of women with both Type II and III FGM patients had experienced either immediate or late complications and 23.7% of women with Type I experienced similar complications. This study confirms that FGM can increase the risk of poor outcomes, even in its less severe forms.

Kaplan et al (2013a) found that FGM had significant impact on women's health. Women with no FGM had no cases of fibrosis, keloids, synechia and clitoral neuroma whereas women with type I ranged from 2.5% to 15.8% and from type II 19.4% to 54.4%. Women with type II FGM experienced increased rates of episiotomy, perianal tear and prolonged labour. 65.9% of women with type II had complications during delivery, as opposed to 39% of women with type I and 11.7% of women with no FGM. Of a sample of 570 women in Western Health division, 139 had no FGM, Type I was 326 and type II 105. Only 2 women presented FGM type III.

Socio-cultural factors surrounding FGM in The Gambia

Some studies on socio-cultural practices and norms have been conducted in the Gambia in the past decades. Reports noted a decreased amount of 'ritual' surrounding the practice, in part due to increasing religious justification for the practice. Also, public discourse against the practice may push families to do FGM when children are younger as to avoid stigmatization or intervention by family or medical providers. Studies have also shown that rural, homogenous settings have higher prevalence (Koroma, 2002).

Daffeh et al (1999) found that different communities cut girls at different ages: at the time of the study, Sarahules who primarily cite FGM as a religious obligation conduct this during infancy whereas those who view FGM as an initiation rite perform the operation near or after puberty. However, recent UNICEF (2016) data seems to show a large number of girls are undergoing FGM after the age of 14, indicating that the practice does not only occur at birth.

Some have also argued that women who traditionally perform the practice have economic incentives to do so (Bafrow, 2000). However other studies have argued that women who perform FGM operations have different motivations, including viewing their work as an important service to the community and thus economic incentives to "*ngansimba*", the Mandinka word for women who perform the operation, may not prevent occurrences of FGM.

Factors influencing decisions surrounding FGM are complex and relate to religion, urban/rural location, socioeconomic status, education, ethnicity and subgroups of ethnicity; some Jola subgroups, such as Jola Casa do not perform FGM whereas other Jola groups do (Koroma, 2002). More so, Shell-Duncan et al (2010) found that in Senegal and The Gambia FGM is not an individual decision; even if parents do not agree with the practice, in-laws, communities, religious leaders and other actors play a central role in deciding whether a girl will undergo FGM. They found that, “the decision of whether, when and how to perform FGM resulted from a constant process of negotiation about how to position oneself in light of shifting social relationships, contexts and experiences, representing ... proximate social experiences and actors - affecting decision making.”

Kaplan et al (2016) in a survey of 1,288 health care professionals found that 76.4% of health care professionals wanted to abandon FGM/C and 71.6% believed that the practice had negative consequences on health and life, showing increased negative attitudes to the practice from an earlier study (Kaplan et al, 2013c). 10.5% of professionals admitted to performing FGM/C within their professional practice. However, 24.4% still intended to cut their own daughters. Kaplan (2016) also found that among health workers, main motivations for the practice had dropped from religion to tradition from a similar study in 2010-11. Kaplan found that HCP are more knowledgeable than in 2016 in being able to identify FGM and also to understand.

Data on the abandonment of FGM in the country up to the time of the legislation is variable. Data from MICS (2010) shows that only 33% of Gambian women are in favour of abandoning the practice (UNICEF, 2016). In 2013, GAMCOTRAP reported that 683 communities had agreed to ‘drop the knife’. More quantitative studies are required to know the extent to which the practice will be reduced following the 2015 law.

Advocacy and Policy

A public discourse on the abandonment of FGM has existed for many years. Since 2009, The Gambia has been part of UNICEF/UNFPA joint project to end FGM, which has in part contributed to advocacy and research. Prior to this, the NGO Tostan has worked with Community Management Committees to empower communities to ban the practice (Gillespie and Melching, 2010). In addition, organisations such as AAITG, NGBV, GAMCOTRAP and Wassu Gambia Kafo have participated in campaigns and or research on the subject.

3. Methodology and Research Methods

This section addresses the epistemological and ontological foundation of the study as well as the methods taken to collect and analyse data. This research is rooted in a subjectivist approach to knowledge that validates the presence of individual knowledges and truths. In a study of a subject

as complex and culturally rooted as FGM it is necessary to take this approach to knowledge.

For this reason, a qualitative approach to research is desirable as it gives the ability to gather information on values, beliefs and lived experiences (Lincoln and Denzin, 2008).

3.1 Field of Study and Research Design

Data collection occurred during three weeks in November 2016 and was conducted by the research team consisting of: Dr Marika Tsolakis, Ms. Sarjo Camara and Ms. Abbie Barrow. Together, and with inputs from NGBV and AAITG staff, the team formulated the interview schedule (see Appendix 1) and tested it and considered translation issues in Wolof and Mandinka.

The research team was also trained on conducting qualitative research at an academic level, including obtaining informed consent, protecting data and other ethical issues. See Appendix 2 for training documents and guidance for interviews.

Sarjo and Abbie conducted all of the interviews for this study. Dr Tsolakis did not attend the interviews as her presence as a white, European woman was felt to have potential impacts on open responses of the participants regarding FGM, especially pertaining to the recent ban.

3.2 Sampling and Interviews

The study includes interview data from 17 women from the larger clinical study led by Dr Patrick Idoko in four hospitals in the Gambia: Jammeh Foundation Hospital, Brikama Hospital, Edward Francis Small Teaching Hospital and Bansang Hospital. NGBV provided lists of potential participants who had given consent to be contacted for follow-up questions from the quantitative study. Women were sampled using the convenient method. The original lists included: 7 participants from Brikama, from which only 3 women were found and available for an interview; 5 names from Edward Francis, of which 4 were available; 10 from Jammeh Foundation of which 5 were interviewed; 12 from Bansang of which 5 were interviewed. Of all the women who were interviewed, only 3 had not undergone FGM. This gave multiple perspectives on the practice from those not partaking in the procedure. As such

The sample represents urban, peri-urban and rural communities. Ages ranged from 19 to 38 and women had between 1 and 7 children, although the average woman had 2. Of 17 participants, 8 reported themselves as Mandinka, 3 as Wolof, 2 as Jola, 2 as Fula, 1 as Jahanka² and 1 as Fula/Mandinka. As the study sampled participants in Banjul, Kanifing Municipality, West Coast and Central River Regions, this may have

² While the Gambian Bureau of Statistics (GBoS) regard Jahanka as a subcategory of the Mandinka ethnicity, this study has maintained the ethnic categories that women used to describe themselves.

influenced population distributions and groups who practice FGM are not included, such as Sarahule. All three Wolof women did not have FGM.

Participants were offered to do the interview at the location of their choice. If participants chose to do the interview at a health centre, a small amount of money for transportation was given which only occurred in Bansang. In all other cases, the research team met the women at whatever location was convenient, including homes, businesses and hospitals.

This study did not include focus group discussions for various reasons. For one, the sensitive nature of the topic and concerns about confidentiality may have hindered quality of data or put participants at risk. Furthermore the aims of the research on individual perceptions and experiences did not necessitate focus groups as emphasis of this study was on depth of information from female participants.

In this report, all women have been assigned pseudonyms and any information that could reveal their identity has not been disclosed. See Appendix 4 for table of participants.

3.3 Translation and Analysis

The field researchers transcribed the interviews directly into English from the original Wolof or Mandinka recordings. Dr. Tsolakis read through the interviews and clarified any language ambiguities. Any terms in local languages that were deemed relevant were left in local language by the researcher. The data was analyzed using NVivo to code themes. These initial themes were made into a list of super-ordinate themes with subcategories. These sub-categories are used in the analysis in Section 4. A preliminary verification meeting with the research team was conducted at the end of data collection in December and analysis, prior to final writing up of the report. Members of NGBV and AAITG also subjected the report to a final reviewing January 2017.

3.4 Ethics

The Gambia Government/Medical Research Council Joint Ethics Committee approved this study. All participants were both orally informed and given a written information sheet explaining the purpose of the research and emphasizing the voluntary nature of their participation and the confidentiality of the data. See Appendix 3 for Information Sheet and Consent Form. Privacy of the participants' identities was upheld at all times and participant's identities were coded and kept separate from any transcriptions or recordings. The data obtained as a result of this research is guarded against any unauthorized use.

Women gave verbal informed consent that was audio recorded. All women except one agreed to have the interview recorded. In this case, signed consent was given and notes were taken during the interview. As all the participants were part of a larger study, they all had a baseline

understanding of the study's aims that facilitated the consent and also decreased suspicions about any ulterior political motives.

Anonymity was only breached in one instance at the request of a participant herself who sought further medical advice and requested help from the researchers. However, other details of her interview were not disclosed to the medical doctor. The research team discussed any issues of maternal or infant health that arose and assessed any ethical concerns. For example, in one case a mother was in the hospital with her baby who was unwell but in the case as medical treatment was undertaken, the research team did not choose to take any actions.

Due to the sensitive nature of FGM in The Gambia, the researchers took particular care to remind participants that they could stop the interview at any time and were not obliged to answer any questions, limiting any potential harm or discomfort. For this reason, the anonymity and confidential procedures detailed above were also essential in guarding the participants from any potential harm.

The 2016 presidential elections also created potential risk or exposure to violence during the campaign period for both participants and researchers. For this reason, protection of the researchers, as well as the participants was a main goal of the study and was mitigated through transporting the participants with an NGBV driver and conducting most interviews in pairs. Participants were not asked to travel except in the case of Bansang and researchers did not conduct interviews in the week preceding the elections and three additional interviews took place after the elections. Also, the emphasis on anonymity and confidentiality in order to ensure that participants' views could not be traced back to them was a priority of the research team.

3.5 Generalizability

While qualitative research is not generally concerned with 'validity' in the same way as quantitative research, steps have been taken in this research to ensure data quality and also generalizability to other cases (Lincoln and Denzin, 2008). In this sense, generalizability does refer to statistical regressions but rather to making 'logical generalizations to a theoretical understanding of a similar class of phenomena rather than probabilistic generalizations to a population' (Popay et al, 1998 in Horsburgh, 2003, p. 12). Through rigorous documentation and data management, as well as transparency about the research process and findings, as well as selection of a representative sample, this research has findings that could be transferred to other settings.

3.6 Limitations of Research Design and Mitigating Factors

Constraining factors included the presidential elections that took place on December 1, 2016 having an anti-FGM activist as a potential presidential candidate, making the question of FGM more politicized. This acted as a potential limitation in women's ability to speak out on FGM in the tense political climate. In addition, the recent law banning FGM may have

discouraged women from talking freely about the subject for fear of punishment. This limitation was mitigated through the consistent discussion of FGM as a development, health and human rights issue and also by drawing links to the women's initial participation in the quantitative portion of the research.

Another limitation is that it is difficult to collect qualitative data on FGM because it is a 'retrospective self report' (Riesel and Creighton, 2015, p. 49). However this has not impacted on the quality of the findings, as it is the participants' own perceptions and feelings, as opposed to fact-based events, that are analysed. Any information relating to health backgrounds and FGM could also be triangulated with the study.

A final limitation to the research was having a non-Gambian lead researcher who does not speak Mandinka and only intermediate Wolof. This was mitigated by the recruitment of two Gambian researchers who assisted in data collection and translation. This also helped in establishing rapport with participants as many Gambian women may assume that foreign women have an anti-FGM stance.

3.7 Positionality

This research was funded by AmplifyChange through AAITG and NGBV. All of these organizations take an anti-FGM stance and work to eliminate the practice in The Gambia as part of their strategic plans. The research team of Dr Tsolakis and Ms. Camara and Ms. Barrow also acknowledged their own positions on the topic when designing the interview schedule and took necessary measures to erase leading questions or bias. The researchers remained flexible and open to the opinions of women and care was taken in the process of informed consent and throughout the interviews to not place blame or judgment on women who had undergone the practice or who believed in it.

As many Gambians perceive foreign and Western people to be against the practice, Dr. Tsolakis did not conduct the interviews. The researchers also tried to make women comfortable by sharing their own identity and experiences as Gambian women when they felt it could open a more conducive interview setting.

4. Findings: Women's Knowledge of FGM and Sexual and Reproductive Health

The following three sections discuss findings from the 17 interviews. These are grouped into the major categories of findings: women's knowledge of FGM and sexual and reproductive health, social norms related to the practice and attitudes towards the FGM ban. These sections also respond to the primary research questions in Section 1.

4.1 Limited Knowledge of FGM among Women

A main finding of this study is that women lack detailed knowledge of processes of FGM that were conducted on themselves or more broadly. Women were asked what, in their opinion is FGM, and if they knew of any different types. In most cases, women could only identify it as cutting of female genitalia, like Amie, 32-year old Mandinka mother of 7 from Brikama hospital who responded: 'The only types I know is cutting.' Ngoneh,³ a 32-year-old Mandinka woman from Bansang, went on to elaborate that 'some cut small, some cut all' without further details.

Some women, however, elaborated more on the actual process of cutting. Fanta gave the following description:

"FGM means taking women to initiation, to our cultures and teach them discipline. Okay the procedure they take is that they use a razor blade, bring the girl child spread her legs apart and cut a part of her genital. I know only one type where they take the woman and cut her genital."

Only Jainaba, a nurse, and Adama noted that there were different degrees of cutting. For example, Adama gives more details, explaining Type III infibulation:

"Well FGM they said is not good that is what I know. They lay you down and cut you, and then later make you sit in hot water. And my people they normally also seal their girl child after circumcision but I was not sealed anyway. Only 1 type that is they cut you and then seal you."

Women may not know about procedures and processes of FGM because they do not remember their own experience. Yama stated:

"I don't know what FGM is, when I was taken I was a baby and I have never asked what they usually do there. I agreed that I am a Mandinka and FGM is a big practice in my community but I don't know what it is or what they do so as I said If I don't know what it is I cannot possibly know how many types."

Ambiguities of describing the process may relate to terminology in local languages. The researchers used 'polite' forms in both Wolof and Mandinka: *wulokonata* in Mandinka and *dem leul* in Wolof both mean 'to go to the bush' and infer a type of initiation; participants preferred these polite terms.⁴ In cases where women did not understand the polite form, *nyakata* in Mandinka and *harafal* in Wolof, which both equate to 'cutting,' were used. Researchers noted that many women experienced profound discomfort in talking about their own genitalia as this was not culturally accepted and could be viewed as improper or impolite.

³Not her real name. All names in this section are pseudonyms. See Appendix 4 for table of participants.

⁴ These terms are not used for male circumcision.

However, some women could recount complications they or other women had experienced. Anta, a 30-year-old Mandinka woman who gave birth in Banjul at Edward Francis Teaching Hospital did remark that she experienced 'excessive bleeding, dizziness, and fell ill and also see other children suffer from heavy bleeding.' She was personally against the practice of FGM. However, Oly who experienced the same type of side effects and also reported difficulty walking afterwards strongly believed that FGM was a beneficial practice for disciplining a child.

4.2 Limited Knowledge of Personal Sexual and Reproductive Health

Several women experienced complications during childbirth. 6 out of 17 participants reported undergoing an episiotomy during childbirth related to this study and 1 reported a previous episiotomy. Women also experienced prolonged labour and delivery, pain during and after delivery, dizziness and continued wetness and bleeding. However, doctors and nurses did not always communicate to the women the reasons for the procedure or for other complications. Kadija reported an episiotomy and the doctor never told her why. Amie, a Mandinka 32 year old and mother of seven children who gave birth at Brikama, reported other complications that the doctor did not explain to her. Many women also said that they did not follow up with a doctor after the delivery though some women did report this, especially when stitches from an episiotomy caused discomfort.

Awa a 24 year old of Fula and Mandinka parentage had experienced Type III FGM and had their outer genitalia sealed. However, Adama said that while the doctor told her she had an episiotomy because she was very tight and suggested that the episiotomy was related to FGM.

Oly also noted that, 'During childbirth I was increased to make my delivery possible. But the doctor did not say why I was increased, but he did enquire if I had sex with a man before labour and I told him I did not have any intercourse.'

Only Fatu, who gave birth at Jammeh Foundation Hospital, said that after her delivery, the doctor told her that she 'suffered a great deal of pain...as a result of FGM.' Tisbeh, who gave birth at Brikama Hospital, also explained, while deliberating the positives and negatives of FGM:

".... I don't see any positives of FGM, also I don't know of any negative impact although after I gave birth the doctor there told me that my labour was painful as a result of circumcision, he told me female circumcision is not good. He confirmed to me that I was circumcised that was why."

Here it seems that had the doctor not informed her of the complications related to FGM in her recent labor, she may not have expressed any negative results. This may have also influenced her answer on supporting the FGM ban although, as discussed in later sections, she would not guarantee that her daughter would not be cut.

Thus, good communication between medical professionals and female patients can have lasting impacts on perceptions of FGM. A barrier to open communication could be that some women think that it is inappropriate to discuss FGM with men (e.g. Oly) and thus if doctors are males, it may create a constrained environment. Women also noted that nurses were most helpful in recovery, more than doctors, and that in-laws and husbands were key members of their recovery process. Therefore, communications with family members, including husbands, can have potential benefits on health.

However, as the findings from the accompanying study show, doctors and nurses should also be sensitized in how they communicate such potential risks of FGM on reproductive health. As existing evidence does not show a causal relationship but rather an associated risk, these must be considered within women's own personal medical history.

5. Findings: Social Norms Surrounding the Practice of FGM: Promiscuity cleanliness and respect

Social norms related to the practice of FGM seemed to focus on three key issues: promiscuity, cleanliness and respect. Of the 14 women who had undergone FGM, all of them located the practice as a custom within their community and as a tradition. Amie seemed to describe FGM as a social norm as per the definition in Section 2: 'Because other tribe members are doing it, then they also do it to be at the same level.'

However, most women went beyond calling it a tradition and also mentioned other aspects of the practice that were deemed of value within the community: in particular religious values and promiscuity. For example, Mariama who had recently given birth at Jammeh Foundation Hospital said that, 'Well I do hear that if you are not circumcised you like men too much, also it is said to be a religious obligation.' She felt that circumcision served a dual purpose.

Awa notes that, 'It's a tradition, also it is done to stop young girls from following men at a young age.' Fanta goes deeper into the topic, adding that:

"Well I do hear that circumcision is like a school, this is the place children are taught how to sit among elders, how to eat with elders, how to behave and respond to elders, basically everything about discipline. They also say that if a girl is not circumcised she like men too much so it is another reason they do it."

Thus the process of circumcision and any rites surrounding it relates to broader social norms about how to behave and act correctly as a girl and a woman, especially in relation to elders. However, it also seems to curb sexual appetite so that girls do not 'follow' or 'like men too much.'

Astou, a 38 year old mother of 5 who had given birth at Edward Francis Teaching Hospital, tied together the concept of tradition and also added an idea of both cleanliness and respect:

“Because it has been in practiced from one generation to another, so is a tradition. To remove bad smell and to give you good upbringing. If you don’t do it you are called a *solima* (someone who does not know anything in regard how to deal with her elders or impolite).”

Her use of the word *solima* is significant as it is a pejorative term for women who do not respect tradition or community elders. Thus a mother who refused her daughter’s FGM, as well as a girl who did not undergo FGM could be viewed as not following cultural and traditional norms. Astou also relates this to cleanliness and not having a bad odour. Also the concept of a ‘good upbringing’ meaning that this is part of the necessary education or socialisation of a child which can also infer that a well-brought up child will be modest and follow other norms such as abstaining from intercourse before marriage. This also suggests that cultural initiation may be a factor in FGM in initiating women in to proper social categories and roles.

Tisbeh who commented that ‘Ah FGM, they do say if someone is not circumcised they don’t have respect’ also echoes this idea. Respect here also meant to obey norms such as not engaging in sexual intercourse before marriage. For example, many people who supported the practice acknowledged that FGM prevented pregnancy. Shell-Duncan et al (2011) found similar rationales for continued practice of FGM in Senegal and The Gambia, arguing that FGM acts as a signal to other women, especially elders in the community, that a woman is deserving of inclusion and is not only a social norm but also a form of social capital.

The ways in which women express these norms are complex and interrelated, as described in social norm theory. These norms play a role in how women are perceived and treated and thus can contribute to continuing the practice.

5.1 Social Norms: FGM as a religious and cultural practice

As discussed in Section 2, some literature in The Gambia had suggested that FGM was being done earlier in girls’ lives and without any type of ‘initiation’ ceremony as to be purely religious in its justification. However, participants’ responses reveal that ceremony and not strictly Islamic processes accompany FGM.

Many women described FGM as happening within a set of cultural rites. For example, Aminata explained:

“The mothers decide about FGM processes. And the main preparations include, first seeking spiritual guidance and protection, then charms will be prepared for the child to tie around her waist. And charms are also made for general protection against all evil throughout the process. After the

initiation there is usually a big event for the circumcised girls.”

Here, she describes that non-religious ceremonial processes take place, which was present in the narratives of 12 out of the 14 participants who had undergone FGM. Most women mentioned a ritual bath, charms or ‘juju’, seeking marabout’s advice, wearing white clothing or purchasing new clothing and dancing or celebrating afterwards. As noted above, this also suggests the relationship between FGM and cultural initiation.

Only four of 14 women who had experienced FGM identified it as a religious obligation, though other cultural norms mentioned above could also intertwine with religious obligations,

5.2 Social Norms: Community-Based Decision Making

As is brought out in Section 2, studies have found that mothers are not the primary decision makers in regards to performing FGM on a girl child. This has also proven true in The Gambia. Women consistently described the role of elders, relatives and husbands in deciding whether and when a girl would undergo FGM. For example, Kineh, a Wolof woman, did not have FGM performed on her. However, she married a Fula man whose community practices FGM ‘and that makes my children Fula by birth but still their father is against it and therefore they will not be circumcised.’ This finding suggests the importance of integrating men into awareness and community decision-making initiatives on the subject.

Many other women echoed the same sentiments. Ngoneh, a 32-year old Mandinka woman from Bansang with 3 children, stated, *‘Is the old women who decide the process.’*

Tisbeh, who had just given birth to her first child at Brikama Hospital and was herself subjected to FGM in the Mandinka tradition, said that she was against the practice herself. However, at the end of the interview, when asked whether she would circumcise her own daughter, she responded:

“The question if I will circumcise my daughter, that I cannot answer because the child does not belong to only me. If I have good intention that my daughter will not be cut, maybe my in-law or husbands sisters don't feel the same way so I cannot protect that child. You are aware how they steal your child away and only to inform you after already circumcising her.”

While at this point, the researchers used the opportunity to empower Tisbeh, a 21-year old Mandinka woman who gave birth to her first child at Brikama Hospital, to know her rights regarding her own child.

Interestingly, Oly, a Jola woman who gave birth at Jammeh Foundation Hospital also conveyed a feeling of powerless and inability to form an opinion or decision:

“Well they said it is a good thing, and that it helps to discipline the child. Well if they said it is not good then that is what I am also replying about. What I think does not matter because this is not a decision I make.”

In her response, ‘they’ is unclear – it could mean the community or her family circle, but in either case, she felt that whatever the wider group believed was also what she should believe. More so, her own thoughts are not important because she was not a decision maker. However, Oly did note that she opposed the FGM ban because ‘children need discipline.’ Therefore, the prevalence of the community or family, which are often interlinked, eliminated her individual agency. Sen (1999) and Nussbaum (2000) view this restricted agency as a contributing to ‘adaptive preference’ or when individuals accept and value low-quality choices and decreased well-being because other choices are unknown or not available.

5.4 Social Norms: Expressing Pain

Ideas were varying about whether it was a taboo to express pain both after childbirth and after FGM. However most women agreed that pain in these circumstances could only be discussed with women who had similar experiences.

For example, Fatu, a 19-year old Mandinka woman who gave birth at Jammeh Foundation Hospital, explained:

“It is a taboo to express pain during childbirth, you cannot share with people especially those who have never experience childbirth about the pains of childbirth. For circumcision, I don't think it is a taboo, but still people don't talk much about it.”

So in terms of FGM, while she may not view it as forbidden culturally, it may not be a common or accepted practice. Adama supports this idea:

“For me I don't think it is a taboo, because for me I do tell people how my birth was so painful and how tired I became during childbirth. It is not a taboo too to express pain after circumcision but people are cautious not to discuss it publicly but I think that is a personal choice not like a taboo against it.”

Fanta, a Mandinka woman reiterates similar ideas but feels more strongly that expressing pain after FGM may be a taboo:

“It's a taboo expressing pain after childbirth to someone who has never experience childbirth. Its a taboo to express pain after FGM to anyone who has never been circumcised, in fact anyone not circumcised is not allowed to visit and come to the circumcision event.”

These ingrained beliefs about restricting the expression of pain may explain why some women in the study do not seek medical advice after childbirth.

However, Ngoneh, a 32-year-old mother of 6 who gave birth in Bansang did not feel that expressing pain after both childbirth and FGM were taboo.

Bintou, a 22-year old Wolof woman who delivered in Bansang who did not undergo FGM felt that expressing pain after childbirth was not taboo because, 'because expressing it mean sharing knowledge and experience.' Therefore, while discussing pain surrounding both childbirth and FGM are not considered taboo topics, women feel more comfortable to discuss such issues with other women who have undergone similar experiences. However, it is unclear to what extent such hesitations might limit their seeking out of medical help in instances of pain.

6. Findings: Attitudes towards the FGM Ban

As this research took place within the context of a newly enacted law against FGM in The Gambia, participants were also asked about their opinions on the law. All women were informed of the ban to some extent and only Oly questioned its existence, referring to the ban as 'rumours'. 6 women opposed the ban, 9 women were in favour of the ban and another 2 said they did not want to express their opinion or had nothing to say. Of these two, 1 was Wolof without FGM, the other Mandinka with FGM.

Aminata, a Jahanka woman who gave birth at Brikama hospital, felt that FGM had become harder to do, at least in her more peri-urban area:

"The FGM ban is a good thing in my opinion. And I think even if you want to circumcise your child it is not easy anymore since the circumcisers are now afraid."

However other women did not mention a reduction in the practice as a result of the ban.

Some women who had experienced pain in both childbirth or as a result of FGM were more likely to consider FGM as a negative practice and to subsequently support the ban. For example, Awa, a Fula/Mandinka woman who had given birth to her first child at the Banjul Hospital gives the most compelling example. Awa had a difficult childbirth and the doctor performed an episiotomy because she was 'tight.' Her child had been unwell since birth and the interview took place at the Banjul clinic. However, apart from her difficult labour, which she later alludes to as a result of her FGM, Awa also describes the negative implications of FGM on her well-being in adulthood:

"The negative thing is the sealing they do after being circumcised, it makes sex very painful when you are taken to your husband, it makes it impossible for the husband to penetrate and I was a victim of that. I was sealed after being circumcised, when I was taken to my husband for the first night he tried everything, it was so painful, and he could not go inside. The following day my mother took me

back to the circumciser and she used a razor blade to remove the sealing, it was a very painful procedure I experienced as an adult over again, and that same day I was made to have sexual intercourse with my husband. I don't know any positive reason for FGM."

Her experience had a negative impact and she felt no hesitation to express her pain having relived the FGM process as an adult with the added difficulties of fulfilling her duty to sleep with her husband on the same day. In addition to this negative experience, Awa continued on to say that 'The Law is a good thing because FGM causes difficulty for women when giving birth' implying that she understood that FGM was at the root of her own delivery complications as well. Thus, while she may not have experienced or remember negative experiences in her childhood, the late complications related to FGM helped to form her anti-FGM opinion.

Jainaba, a qualified nurse, was Fula and had 1 daughter. Of the participants, she was the one with most medical or scientific knowledge of FGM and could speak in English about the process as well as her own childbirth and experience. Jainaba explains:

"I am aware of the FGM ban but I don't think it is right to ban the practice. They should have propose that they will teach the circumcisers to cut very small part of the clitoris and avoid sealing the women after the procedure but not to condemn it completely."

The interviewers then probed her about whether she would circumcise her own daughter, to which she responded that her daughter would not but this did not indicate that the practice should be abolished. Jainaba was probably the most educated of women and the only one working in the medical profession. Although Kaplan et al (2013c) work shows that Jainaba is in the minority of medical professionals in The Gambia, her response was striking. Especially considering that she had been infibulated and re-cut so had personally experienced pain and difficulties resulting from FGM. More so, she could list complications from FGM such as pain during intercourse and difficult delivery. However, she believed that 'And the positive aspect is that when a woman is circumcised it prevents her clitoris from growing like a penis and becoming big and long, so cutting part of it is necessary.'

What is interesting to note is the difference between Awa and Jainaba who had both undergone similar painful experiences in both sexual intercourse and childbirth yet one woman had felt strongly against the practice afterwards and the other didn't. These may relate to more rapidly changing cultural norms in a more diverse and urban area where 12 was living as opposed to the rural and more homogenous contexts of Jainaba.

However, for many women in favour of the practice, they often reiterated the same cultural norms such as discipline or cleanliness. For others,

articulating a justification was more difficult. For example, Fatu, a 19-year old Mandinka woman who gave birth at Jammeh Foundation, replied:

“I am aware of the ban, and I do listen to the radio and TV where they talk about the practice and say it is not good. But I don't believe it should be banned and I cannot give reasons why I said that. I just believe it.”

This unwavering belief can also illuminate the existence of FGM within a set of complex and unquestioned social norms.

7. Conclusions

Decision-making processes related to FGM occur within a complex and constrained field of social norms related to culture, religion. The constrained settings in which women make choices related to their sexual health could be explained by the concept of ‘adaptive preference’ (Sen, 1999; Nussbaum, 2000). Adaptive preference describes how in oppressive settings, people become conditioned to accept poor choices and outcomes because no other options are available. Some women believed that FGM was a high quality choice that they should be able to make. Indeed, in their constrained settings, maintained by social norms, FGM may have seemed like a quality choice as opposed to being considered a ‘solima,’ disrespectful, promiscuous, unclean or without prospects of a suitable marriage.

However, adaptive preference does not entirely describe the rationale for women choosing FGM. While some women may still believe that FGM is a good choice to make, others are aware that it is a low-quality choice yet lack the power and freedom to make such decisions. This derives from a lack of agency in decision making related to their own sexual and reproductive health due to community and familial norms that rely upon elders and men. Agency is also weakened by a lack of information about general health and FGM. For example, if doctors do not communicate that FGM creates potential or actual complications, then women’s decision-making processes also remain restricted.

However, ‘choice’ was often how women who opposed the FGM ban justified their decision. Many felt that women should have a choice to continue the practice. In this case we can use this understanding of adaptive preference to understand that this is a false or low-quality choice in terms of actual human development and well being. Nussbaum (2015) also argues that decision-making processes are not strictly rational but also rely heavily on emotional processes, also applicable here. However for women to deliberate and engage in a critical thinking process will require better communication and information. As Shell-Duncan et al (2010) also argue, social beliefs about what a ‘good’ girl is must also change.

Sen (2009, p. 284-5) argues that a complication in evaluating health ‘arises from the fact that the person’s own understanding of their health may be limited by lack of medical knowledge and by inadequate familiarity

with comparative information.’ More so, he notes that a distinction can exist between ‘the “internal” views of health based on the patient’s own perception, and “external” views based on observations and examinations by trained doctors or pathologists.’

In the case of FGM, what is considered to be a good, clean and healthy body by the patient may differ from doctors’ understanding of health. Also, what may seem like serious complications to a patient may not bear the same gravity to women who have developed ‘adaptive preference’ to certain states of well-being or who view no other choice.

In the case of Jainaba, described in Section 6, who was a nurse and mother to one daughter in Bansang and could understand the medical detriments of FGM but still carried cultural concepts of health and bodily integrity that outweighed these potential complications. When asked about the positive and negative aspects of the practice, she responded:

“The negative aspect include the sealing, when you are sealed it makes sexual experience for the first time very painful. Also during labour it causes difficulty when giving birth. And the positive aspect is that when a woman is circumcised it prevents her clitoris from growing like a penis and becoming big and long, so cutting part of it is necessary.”

Even when women have an idea about potential medical complications related to the practice, other beliefs and social norms contribute to complex decision making processes. Women have to negotiate these competing benefits and detracting factors and choose pathways that seem most beneficial in their social, cultural and economic milieu.

Sen (2009, p. 246) acknowledges the challenges of balancing community and individual well-being and agency. Ultimately, however, he argues that the individual well-being should be prioritized. It is individual valuation on which we would have to draw, while recognizing the profound interdependence of the valuations of individuals who interact with each other. The valuation involved would tend to be based on the importance that people attach to being able to do certain things in collaboration with others.

Complications of FGM are not being communicated to women in relation to childbirth and sexual health. Even some women who described basic knowledge of complications related to FGM still did not express FGM as the cause of their own childbirth and labour outcomes. However, findings show that these ideas must also be communicated with community leaders and men as well, and in particular the elder women who often decide when FGM procedures happen in a certain community.

8. Recommendations

Based on this study, recommendations can be drawn for policy, programmes and further research on FGM in The Gambia.

- 1) Nurses should be a key point of contact for training and awareness and should be trained to recognise and discuss possible risks associated with FGM on sexual and reproductive health.
- 2) Awareness raising at a community level about the FGM ban as well as continued policy and advocacy work to ensure that the ban remains a priority of the new government should occur.
- 3) Further qualitative and quantitative research on women's perceptions of health as well as men's perceptions on FGM will enhance evidence-based policy.
- 4) Women's empowerment on a societal level, including economic independence, should be promoted to encourage a higher level of freedom in decision making processes.
- 5) Programmes seeking to end the practice of FGM should consider how to work within communities and create spaces for open deliberation on the topic, which can assist in moving forward commonly held beliefs and norms.
- 6) Communications about research findings should be shared not only with communities but also with organisations working on similar topics to create unified, consistent approaches to advocacy against gender based violence.

References

- Abusharaf, R. M. (Ed). (2006). *Female Circumcision: Multicultural Perspectives*. Philadelphia: University of Pennsylvania Press.
- Bosire, O. (2012) *The Bondo secret society: female circumcision and the Sierra Leonean state*. PhD Thesis. University of Glasgow. Available at: <http://theses.gla.ac.uk/3506/1/2012BosirePhD.pdf>
- Cislaghi, B., Gillespie, D., Mackie, G. (2016). *Values Deliberation and Collective Action: Community Empowerment in Rural Senegal*. New York: PalgraveMacmillan.
- Daffeh, J., Dumbuya, S. et al (1999). *Listening to the Voice of the People. A situation analysis of Female Genital Mutilation in The Gambia*. WHO and UNICEF; The Gambia.
- Dibba, S. and Barrow, (2016) *A. Deeper than Cut: FGM/C after decades of advocacy in The Gambia. A Docudrama*. Unpublished Bachelor of Science Thesis. Diaconia University of Applied Sciences.
- Gillespie, D. and Melching, M. (2010). 'The transformative power of democracy and human rights in nonformal education: the case of Tostan'. *Adult Education Quarterly* 60(5), 477-498.
- Hernlund, Y. (2000). 'Cutting without ritual and ritual without cutting: female 'circumcision' and the re-ritualization of initiation in The Gambia.' In: Shell-Duncan, B. and Hernlund., Y. (Eds), *Female Circumcision in Africa: Culture, Controversy and Change*. Lynne Reiner: Boulder and London. p. 235-252.
- Horsburgh, D. (2003). 'Evaluation of qualitative research'. *Journal of Clinical Nursing* 12, 307 – 312.
- Hussein, E. (2010). 'Women's experiences, perceptions and attitudes of female genital mutilation.' The Bristol PEER Study. Available at: <http://www.forwarduk.org.uk/wp-content/uploads/2014/12/Womens-Experiences-Perceptions-and-Attitudes-of-Female-Genital-Mutilation-The-Bristol-PEER-Study.pdf>
- Johnsdotter, S. and Essén, B. (2016). 'Cultural change after migration: circumcision of girls in Western migrant communities'. *Best Practice & Research Clinical Obstetrics & Gynaecology* 32 , 15 – 25
- Kaplan, A., Hechavarría, S., Martín, M., Bonhoure, I. (2011) Health consequences of female genital mutilation in The Gambia, evidence into action. *Reproductive Health* 8(26), Available online at: <http://reproductive-health-journal.biomedcentral.com/articles/10.1186/1742-4755-8-26>

Kaplan, A., Forbes, M., Bonhoure, I., Utzet, M. et al (2013a). Female genital mutilation/cutting in The Gambia: long-term health consequences and complications during delivery and for the newborn. *International Journal of Women's Health* 5, 323-331.

Kaplan, A., Cham, B., Njie, L.A., Seixas, S., Blanco, S., Utzet, M. (2013b). 'Female genital mutilation/cutting: the secret world of women as seen by men'. *Obstetrics and Gynecology International*, 1-11.

Kaplan, A., Hechevarría, S., Bernal, M., and Bonhoure, I. (2013c). Knowledge, attitudes and practices of female genital mutilation among health care professionals in The Gambia: a multi-ethnic analysis. *BMC Public Health*, 13, 851. Available online at: <http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-851>

Kaplan Marcusan, A. Riba Singla, L., Laye, M., Secka, DM., Utzet, M., and Le Charles, MA. (2016). Female genital mutilation/cutting: changes and trends in knowledge, attitudes, and practices among health care professionals in The Gambia. *International Journal of Women's Health* (8). 103-117.

Koroma, J.M. (2002). 'Female Genital Mutilation in The Gambia: A Desk Review'. *National Women's Bureau*. Available online at: https://www.unicef.org/wcaro/wcaro_gambia_FGM_Desk_Review.pdf

Mackie, G. and J. LeJeune (2009). Social Dynamics of Abandonment of Harmful Practices: A New Look at the Theory. Special Series on Norms and Harmful Practices. Innocenti Working Paper No. 200906. Florence, UNICEF Innocenti Research Center.

Mackie, G., Moneti, F., Shakya, H. and Denny, E. (2015). 'What are social norms? How are they measured?'. UNICEF/ University of California, San Diego Center on Global Justice. UNICEF. Available online at: https://www.unicef.org/protection/files/4_09_30_Whole_What_are_Social_Norms.pdf .

Morison, L., Scherf, C., Ekpo, G., Paine, K., West, B., Coleman, R., Walraven, G. (2001). 'The long-term reproductive health consequences of female genital cutting in rural Gambia: a community-based survey'. *Tropical Medicine and International Health*, 6(8), 643-653.

Nussbaum, M. C. (2000). *Women and Human Development: The Capabilities Approach*. Cambridge: Cambridge University Press.

Nussbaum, M. C. (2015). *Political Emotions: Why Love Matters for Justice*. Cambridge, MA: Belknap Press.

O'Neill, S. (2012). Defying the Law, Negotiating Change: The Futanke's Opposition to the National Ban in Senegal. Doctoral thesis, Goldsmiths, University of London. Available online at: <http://research.gold.ac.uk/8852>

Reisel, D. and Creighton, S. (2015). 'Long term health consequences of Female Genital Mutilation (FGM)'. *Maturitas* 80, 48-51.

Sen, A. (1999). *Development as Freedom*. Oxford:Oxford University Press.

Sen, A. (2009). *The Idea of Justice*. Cambridge: Harvard University.

Shell-Duncan, B., Herlund, Y., Wander, K., and Moreau, A. (2010). *Contingency and Change in the Practice of Female Genital Cutting: Dynamics of Decision Making in Senegambia: Summary Report.* University of Washington. Available online at: <https://csde.washington.edu/~bsd/FGC/Contingency%20and%20Change%20in%20the%20Practice%20of%20Female%20Genital%20Cutting.pdf>

Shell-Duncan, B., Wander, K., Herlund, Y., and Moreau, A. (2011). 'Dynamics of change in the practice of female genital cutting in Senegambia: testing predictions of social convention theory'. *Social Science & Medicine* 73(8), 1275-1283.

UNICEF. (2010). Multiple Indicator Cluster Surevy (MICS). Available online at: <http://mics.unicef.org/surveys>

UNICEF, 2016. 'UNICEF's data work on FGM/C.' Available online at: https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf.

UNFPA, UNICEF. (2016). *Manual on Social Norms Change*. UNFPA. Available online at: <http://www.unfpa.org/publications/manual-social-norms-and-change>

UNFPA. (2016b). 'Frequently Asked Questions: FGM. Available online at: <http://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions#sthash.WC4SC0KY.dpuf>

Appendices

Appendix 1

Interview Schedule

- 1) Tell me about your recent childbirth? Where did it take place?
- 2) During and after childbirth, how was your experience? Did you have any complications? What did the doctor say was the cause of the complication?
- 3) Who supported you in your recovery after childbirth? Your husband? Your midwife/doctor? Your mother/mother-in-law? Your community?
- 4) In your opinion, what is FGM? Do you know about different types?
- 5) In your community, who decides about FGM processes? What preparations are needed?
- 6) Do you know someone or have you experienced any complications related to FGM?
- 7) Are there any taboos in expressing pain following childbirth? Why or why not? Is this the same for FGM?
- 8) Why do you think that people practice FGM?
- 9) Having experienced FGM, what are the positive and negative aspects of the practice?
- 10) Are you aware of the FGM ban in The Gambia? What do you think about it?

Appendix 2

This was the interview protocol given to the researchers as part of training for qualitative interviews. First part goes through steps of obtaining verbal and signed informed consent. The second is a form to take notes during the interview.

Interview Protocol

Before Interview: Check that you have your recorder, a copy of the information sheet and two copies of the signed consent form (in cases where someone does not want to be recorded). Also 1 copy of the note form to record some basic information

- 1) **Introduction** – NGBV, follow up on previous research they were already involved, a bit of information on yourself and why you are interested in the study etc. *warming up*
- 2) **Ask introductory questions** –record this on the note form
- 3) **Informed consent – read the sheet** (see Example 1)
- 4) **Attain informed consent** (see Example 2)
- 5) **Record interview**
- 6) **Final Notes** as soon as you have finished, write down any thoughts or notes that might be important for me to understand the context at the end of the note sheet
- 7) **Load data onto computer or encrypted USB. Keep this in a secure place. Try not to move around town with multiple interviews on the recorder when possible.**
- 8) **Transcribe into English**
- 9) **Do not save any files with participant name – once we have finalised participants for each site I will give you a code for each one.**
- 10) **Inform Marika when each transcription is done and arrange for hand-over of data. Do not email unless document is encrypted.**

Example 1 – Explaining the study

So as I said before, my name is _____ and I work for Network against Gender Based Violence. We are doing a study now to better understand the link between FGM and reproductive health, especially following child birth. The goal of the study is to improve women’s health outcomes and also better understand your opinions about FGM.

This interview is a follow-up to previous medical exam and questions that you had at _____ Health Centre.

I am going to ask you some questions primarily about your recent childbirth experience as well as your health in the past. I will also ask some questions about FGM – your experiences or people you know experiences and opinions. It should take about 30 minutes.

I understand that some of these things may be difficult to talk about. You do not have to answer every question and we can also stop at anytime. It’s my priority that you feel safe.

The information you will be providing us with will be kept strictly confidential and your name will be not be known to people outside the study team. Any information that could also reveal your identity will be

concealed. Details of who you are and what you think will not be passed on to the government, the police or health centers under any circumstances. I would only share information if I felt that you were in danger.

Participating in the study will help me and the research team to improve women's health in the Gambia through better knowledge of women's life experiences.

I will give you this information sheet that also explains what I have said and also has the contact details of my supervisor in case you have any questions later.

Do you have any questions?

Do you agree for me to record the interview? Ok, I will turn on the recorder and ask you again if you give permission for me to record.

Example 2 – Getting verbal, recorded informed consent

*****turn on the recorder and begin recording *****

Interviewer: So, did I explain the nature of the study to you?

Interviewee: Yes

Interviewer: Do you understand that you can decide to stop the interview and any moment and you don't need to answer anything that you don't want to?

Interviewee: Yes

Interviewer: And that your identity will be anonymous? No one will know your name.

Interviewee: Can you explain that again?

Interviewer: Of course. So like I was saying before, I am the only person that will know your name in relation to the email. We will change your name for the study and any of the documents associated with it.

Everything will be kept in a safe place and encrypted.

Interviewee: Ok...

Interviewer: So do you give me permission to record this?

Interviewee: Yes, I give permission.

Participant # _____

| | |
|--|--|
| Interview location and time | |
| Initial perceptions <i>What are the surroundings like? Did she come alone? Is she hesitant to participate?</i> | |

| | |
|-------------------------------------|--|
| Age | |
| Marital status | |
| # of children | |
| Ethnicity/ preferred language | |
| Language used in interview | |
| Notes during interview | |
| Closing notes: | |

Appendix 3

Information Sheet and Signed consent form

PARTICIPANT INFORMATION SHEET

Socio-cultural perceptions of female genital cutting and its consequences on labour in The Gambia - A study by the Network against Gender Based Violence (NGBV)

Goals and context of the study

In the Gambia, female genital cutting is a very common practice that many women have undergone for cultural reasons. Researchers are working on identifying the risks of the practice on women's reproductive health. This study wants to find out more about women's experiences of childbirth and female genital cutting, the reasons for practicing and attitudes towards abandoning the practice.

Procedure

We will ask you some questions about the practice of female circumcision in your community, such why it is practiced and what people think about it. There will also be questions on childbirth and reproductive health

problems. *Recordings may take thirty to forty-five minutes and may be audio recorded with your permission.*

Risks and Inconveniences

The risks of participation in this study are minimal. You may feel uncomfortable speaking about some intimate issues but you are free to withdraw from the study at any time and do not have to respond to questions you feel uncomfortable with. The information you will be providing us with will be kept strictly confidential and your name will be not be known to people outside the study team. Details of who you are and what you think will not be passed on to the government, the police or health centers under any circumstances.

Benefits

There are no immediate direct benefits, however, by participating in the study you provide us with important information to contribute to the body of knowledge needed to educate people on childbirth, FGM and other health issues. If you wish, you can also receive more information about female genital cutting. We will also publish the information and you will be able to have access to the findings.

Rights of research participants

Participation is voluntary. If you agree to participate, you can stop the interview at any moment or decline any questions. Your name is not recorded and all information you provide will be kept completely anonymous.

Contact

If you have any questions or concerns you can call Dr. Patrick Idoko (3543545) or Haddy Mbodge Barrow (3701119). For more information on NGBV, see: [www. networkgbv.org](http://www.networkgbv.org)

Thank you very much for your time.

DOCUMENTATION OF CONSENT BY RESEARCHER

Socio-cultural perceptions of female genital cutting and its consequences on labour in The Gambia.

Hereby, I confirm that the information sheet has been read and explained to the respondent. It was clear that the person could freely choose to participate in the study. The respondent had the opportunity to ask questions and discuss the study. If the respondent had some questions, the interviewer gave a good and clear answer to the questions.

I confirm that it was explained to the respondent that he/she did not have to answer on the questions when he/she did not want to and that the respondent could stop the interview at any moment. Furthermore, it was explained to the respondent that their name is not recorded and that the information provided will be kept completely anonymous.

Name of researcher
dd/mm/yyyy

Date

Signature of researcher

Participant Consent (when Verbal Recorded Consent is Not Given)

I confirm that I was given the information on this study and that it was explained to me that I did not have to answer all the questions, could stop at any moment and that all details would be kept confidential and anonymous.

I have given my consent for the interview.

Name of Participant
dd/mm/yyyy

Date

Signature of Participant

Appendix 4

Table of Partipants

| # | Pseudonym | Hospital of Recent Childbirth | Marital Status | Age | FGM? | Ethnicity | Language of interview | # of Children |
|----|-----------|-------------------------------|----------------|-----|------|--------------------|-----------------------|---------------|
| 1 | Aminata | Brikama | Married | 19 | Yes | Jahanka (Mandinka) | Mandinka | 1 |
| 2 | Oly | Jammeh Foundation | Single | 24 | Yes | Jola | Jola/ Mandinka | 1 |
| 3 | Mariama | Jammeh Foundation | Married | 24 | Yes | Mandinka | Mandinka | |
| 4 | Fatu | Jammeh Foundation | Married | 19 | Yes | Mandinka | Mandinka | 1 |
| 5 | Kine | Jammeh Foundation | Married | 31 | No | Wolof | Wolof | 3 |
| 6 | Kadija | Jammeh Foundation | Married | - | No | Wolof | Wolof | 3 |
| 7 | Ngone | Bansang | Married | 32 | Yes | Mandinka | Mandinka | 3 |
| 8 | Bintou | Bansang | Married | 22 | No | Wolof | Wolof | 4 |
| 9 | Amie | Brikama | Married | 32 | Yes | Mandinka | Mandinka | 7 (4 girls) |
| 10 | Astou | Edward Francis | Married | 38 | Yes | Jola | Wolof | 5 |
| 11 | Anta | Edward Francis | Married | 25 | Yes | Mandinka | Mandinka | 2 girls |
| 12 | Awa | Edward Francis | Married | 24 | Yes | Fula/ Mandinka | Mandinka | |
| 13 | Sohna | Edward Francis | Married | 26 | Yes | Mandinka | Mandinka | 2 |
| 14 | Fanta | Bansang | Married | 26 | Yes | Mandinka | Mandinka | 2 |
| 15 | Adama | Bansang | Married | 20 | Yes | Fula | Mandinka | 2 |
| 16 | Jainaba | Bansang | Married | 24 | Yes | Fula | English and Wolof | 1 |
| 17 | Tisbeh | Brikama | Married | 21 | Yes | Mandinka | Mandinka | 1 |