ISSN: 2230-9926

Available online at http://www.journalijdr.com

IJDR

International Journal of Development Research
Vol. 07, Issue, 12, pp.17493-17502, December, 2017

ORIGINAL RESEARCH ARTICLE OPEN ACCESS

FEMALE CIRCUMCISION: A CONFLICT OF CULTURE, RELIGION VS HEALTH AND RIGHTS OF GIRL CHILD

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ARTICLE INFO

Article History:
Received 17th September, 2017
Received in revised form
09th October, 2017
Accepted 26th November, 2017
Published online 29th December, 2017

Key Words:
Female, Circumcision, Gambia, Religion, Infection
JEL Classification: D63, I14, I18, J13, K32.

ABSTRACT

Female circumcision or female genital mutilation (FGM) as is often called is practiced globally in all continents with over 100 women and girls at risk with the majority in Africa. FGM continues to be practiced in many countries and regions associated with religious, cleanliness, acceptance into adulthood, uphold virginity, controls sexuality, increases fertility, preserving culture and other socio- economic factors. Despite its severe consequences (mental, physical, health and right violation issues) and severe pain, hemorrhage. Shock, death. Infection, urinary infection, ulcers, fever, tetanus, complication at birth, FGM continues to be on the increase in Sub-Saharan Africa. Using random sampling techniques in the suburbs of the Gambia capital, Banjul, 500 respondents were interviewed across different ages, educational background and location, the study assessed the prevalence and importance of FGM. The study found older aged, lower level of education; low socio-economic status and rural settlement have higher FGM prevalence relative to younger aged, higher level of education, higher socio-economic status and urban dwelling. The prevalence is also high mainly due to its deep-rooted cultural practice 64 Before Christ and strong religious belief among many tribes in Sub-Saharan Africa. To control its prevalence, the study found enactment of laws and civic education as appropriate means to control and eradicate FGM in most SSA countries.

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Citation: Dr. Seeku A K Jaabi. 2017. "Female circumcision: A conflict of culture, religion vs health and rights of girl child", *International Journal of Development Research*, 7, (12), 17493-17502.

INTRODUCTION

Despite its dangers to health, abuse of human rights of girl child, Female circumcision or female genital mutilation (FGM) prevalence remains high in Sub-Saharan Africa and other parts of the developing world of the Middle-east, Asia and Latin America. This ancient ritual can be traced back to ancient Egypt under the Pharaohs. Egyptian mummies were found to have been circumcised as far back as 200 BC (Kouba and Muasher, 1985; Brady, 1999). While the practice of FGM has been abandoned in Western countries, it remains popular in many African countries from Senegal to Somalia, in the Middle East, in some parts of South-East Asia and even among immigrant communities in Europe, North America and Australia (WHO, 1997, 2010). Female circumcision is a partial or total removal of the female external genital for cultural or other non-therapeutic reasons (WHO, 2008).

"Female Genital Mutilation" or (FGM) or female circumcision (FC) is a recently coined term for a custom going back to the ancient Egyptians. Although it has been reported as far afield as South America and Malaysia, its main locus is Africa. It involves really two procedures, excision of the clitoris with varying degrees of completeness and infibulation or "Pharaonic circumcision", the sewing together of the labia majora of the vulva with catgut or thorns accompanied by excision (Westley, 1999). The varying forms of these procedures are not considered a health hazard by those who practice them but they have been found to be extremely detrimental to the health of those on whom it is performed, health officials and right activities. Short term effects include ulceration, hemorrhaging, septicemia and tetanus infections exacerbated by the use of crude, unsterilized instruments which can be severe enough to result in death. Long-term effects include retention of urine, disturbances of menstruation, blood clots, edema, obstetrical complications, sterility, psychological trauma and frigidity.

It also helps to spread HIV/AIDS. Like male circumcision, female circumcision was originally an initiation rite though now it is frequently practiced on younger girls, even infants. Female circumcision, recently called Female genital mutilation among right activists, is a significant public health and human right issue. It affects an estimated 100 to 140 million girls and women around the world (Westley, 1999). FGM is practiced in approximately 28 African countries as well as among some immigrant populations in Europe and North America. It is practiced almost universally in some countries (Egypt and Guinea), while in others (Mali, Senegal, Burkina Faso), prevalence rates vary between 5% and 92%. In the countries that are considered to make up the FGM belt (Burkina Faso, Côte d'Ivoire, Djibouti, Egypt, Mali, Niger and Senegal), the practice is fairly widespread. The prevalence rates in different countries are as follows: Burkina Faso 72% in 1999 and 77% in 2003, Egypt 95% in 1999 and 97% in 2000,Somalia 98%, Guinea 97%, Sierra Leone 96%, Eritrea 95% in 1995 and 89% in 2002, Ethiopia 80% in 2002, Mali 94% in 1996 and 92% in 2002 and Yémen 97% in 1997 (WHO, 2010).

justification unlike social and cultural aspects in the African context. In the FGM practicing societies in Africa, uncircumcised women are recognized as unclean and are not allowed to handle food and water in some societies. The perception exists, especially in Africa, that women's un-mutilated genitals are ugly and bulky. Among the Kissi and Kikuyu tribes of Kenya, the uncircumcised one is referred to offensively as the uncut one (Ondiek, 2010).

The Objective of the study includes the following

- Examine the importance of female circumcision
- Assess the prevalence among age groups, level of education and rural/urban areas

This paper is divided into five parts. It started with an introduction and historical background of female circumcision in the first Section. Review of literature followed with theoretical and conceptual frameworks. Methodology followed in Section 3 and data analysis in Section 4.

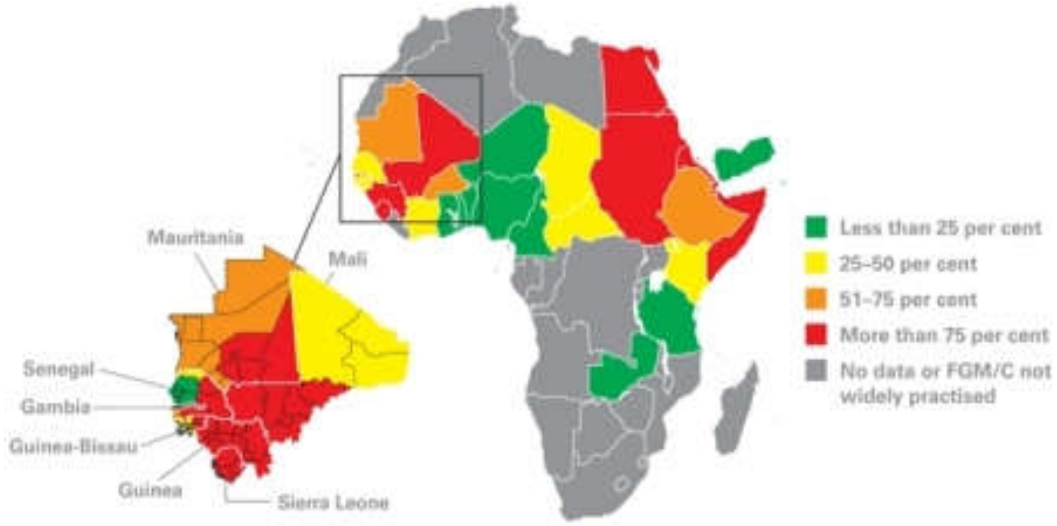


Figure 1. Prevalence of Female Circumcision in Africa

In general, FGM takes place very early in a woman's life: 8 is the average age for women who remember the age at which they were excised. These practices have significant consequences on the lives of women. However, despite their severe consequences (psychological, gynecological and obstetric), and the critical role played by women in development, FGM continues to be practiced extensively in Sub-Saharan Africa overall and, more particularly, in Burkina Faso. Africa has the greatest amount of female circumcision globally with 100 million to 140 million women and girls are at risk of FGM surgery throughout the world and an estimate of 92 million aged over ten living in Africa, (WHO, 2015). The practice is outlawed in most developed countries for example - Britain, Canada, France, Norway, Sweden, Switzerland, and the United States. The following two maps show the percentages of women and girls in Africa from the ages of 15-49 who have undergone a FGM surgery. In Africa especially and in sections of Asia and Latin America, female circumcision is practiced for other reasons than those that border on cultural, traditional and religion. The main reason being the social and cultural significance of the practice as opposed to the medical justification of the practice in Europe and North America in the last two centuries. Advances in Science and medicine could easily disapprove such medical

The paper ends with conclusions and implications of FGM.

Review of Literature

The practice of female circumcision is widespread not only in Africa but also in other continents of the world (Hathout, 1963). Its origin dates well back into history and could have originated as an initiation ceremony of young girls into womanhood (Bella, 1980). A Greek papyrus dated 163 B.C. made specific reference to female circumcision. though female circumcision was said to be prevalent in all continents of the world, the practice was more common among the Phoenicians, Hittites, Ethiopians, Arabians, Syrians, Malaysians, Indonesians, and Africans (Baasher, 1998). Researchers have contended that no single continent was exempt from this custom of female mutilation. Currently, this practice has long been extirpated in many continents except in some of the African countries (Assaad, 1982). Sanderson (1981) gives a conservative estimate of 70 million women in Africa who are affected.

Female genital mutilation: Definition and consequences

FGM is a very longstanding cultural practice. According to Séverine Auffret (1982), excision finds its roots in the

Neolithic period, going back 6000 years BCE. It comprises a number of traditional procedures practiced for cultural or other non-medical reasons. Excision is practiced in 28 African countries, in a few countries of the Arabic Peninsula, and in some immigrant communities originating from practicing countries. Female circumcision is the excision of the little hood that covers the clitoris, but the term is also used to include the partial or complete surgical removal of all or part of the female genitalia (Onad.eko & Adekunle, 1982). Infibulation refers to the removal of the hood, the entire clitoris, the labial minora, and the adjacent medial part of the labial majora. Additionally, the two sides of the vulva are sewn together by catgut sutures, making allowance for a small opening for urine and menstrual flow. There are four major types of female circumcision practiced. Circumcision proper is recognized as type 1. This is the circumferential excision of the hood of the clitoris. This surgical technique is sometimes performed in the United States to redress the failure to attain orgasm by women experiencing frigidity or phimosis of the female prepuce (Rathmann, 1995). The second type involves the excision of the hood of the clitoris and the glans clitoris, or the clitoris completely. The third type is referred to as infibulation or Pharaonic circumcision. As previously described, the entire clitoris, including the whole of the labial minora, and at least the anterior two thirds and often the whole of the medial part of the labial majora, are excised. The two sides of the vulva are then stitched together either with a silk or catgut sutures (in the Sudan), or by thorns in Somalia. This procedure obliterates the vaginal introitus except for a small orifice made posteriorly to allow for the passage of urine and menstrual blood (Cook, 1976). The fourth type, which was practiced by the Pitta-Patta ethnic group of the Australian aborigines, necessitates the enlargement of the vagina orifice at puberty by surgically tearing it downwards or splitting the perineum with a locally fashioned stone knife (Cook, 1992; Melly, 1995). In The Gambia, the practice of female circumcision varies among different ethnic groups and the type of operation depends on the religious and traditional beliefs of the people.

In southern Nigeria, where Christianity and Animism are the predominant faiths, the procedure commonly employed among the Ibos is the surgical removal of the clitoris with or without the labia minora (Agugua & Egwuatu, 1982). Also among the Edo and Yoruba ethnic groups of southern Nigeria, clitoridectomy is the type widely practiced. In northern Nigeria and Eastern Gambia only the partial excision of the clitoris is employed and the same procedure is adopted in the north of Ghana (Ebomoyi, 1995). Few ethnicities in Senegambia region such as Wollofs perform partial removal of clitoris or none at all, particularly in the urban centres. Several medical complications are regularly experienced with infibulation and the fourth type that necessitates the splitting of the perineum with a stone knife. The adverse consequences include septicaemia, partial labial fusion, implantation dermoid, introital stenosis, urinary tract infection, and hemorrhage (Agugua & Egwuatu, 1992; Asuen, 1997; Dareer, 1988; Ebomoyi, 1995). Although the specific procedures vary according to ethnicity or geographic region, according to the World Health Organization (WHO), they can be grouped into four main types:

- **Type I -** excision of the prepuce, with or without excision of part or all of the clitoris;
- **Type II** - excision of the clitoris with partial or total excision of the labia minora;
- **Type III** - excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);
- **Type IV** - pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue;

Types I and II are the most commonly practices forms of female circumcision/FGM. The reasons for female circumcision practice can be grouped into several categories: customs and traditions, control over women's sexuality, religion, social pressure, women's economic dependency, the importance of marriage in the cultures where it is practiced, the low levels of education in these countries, and poverty. FGM supporters maintain that the procedure is a cultural tradition and that circumcised women are more feminine; consequently, the rite is seen as a passage into adulthood (Kissaakye, 2002). The practice is also used as a means to control women's sexuality (Gruenbaum, 1982 and 2002), to protect women's virginity in order to guarantee a successful marriage, and to contain women's sexual desire. Maintaining girls' virginity is key in many cultures as it brings much shame to the family if found not a virgin.

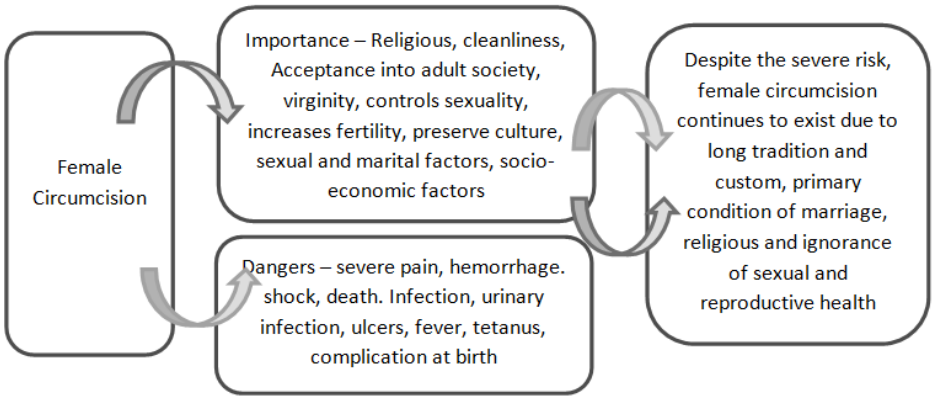
In some communities where lineage is important, it is believed that female circumcision increases fertility. In cultures where FGM predominates, social norms perpetuate the practice. In these societies, an uncircumcised woman is considered unclean and must be purified. In addition to being motivated by society's rejection of uncircumcised girls, parents also face the pressure of social norms, as choosing not to circumcise one's daughter leads to the family's isolation from the community (Rahman and Toubia, 2000). According to Sargent (1991), economic dependency and the importance given to the institution of marriage are also very influential in perpetuating the practice. In these societies, women have very low levels of education and limited opportunities outside of marriage. FGM is also often practiced for religious reasons (Williams and Sobieszcyk, 1987), with the believe that the practice is required by Islam (Kouba and Muasher, 1985). Despite the fact that the practice is currently denounced, it is still being practiced as a well-rooted customs. In effect, as long as the society gives the practice its blessing, there will be social pressure to perform female circumcision/FGM.

In countries where FGM is strongly prevalent, it affects all socioeconomic groups. The resulting complications are considerable. Several studies in medicine, demography, and sociology have found that FGM can lead to adverse health consequences for girls and women. For example, according to Toubia (1995), the health implications vary from pain to death, severe bleeding, urinary track infection and in some cases, the women may die due to tetanus, HIV/AIDS (unsterilised knife/razor) , while in others, they may suffer from pain, acute urinary retention, hemorrhaging, fever, shock, hypersensitivity of genital area, among others. Similarly, Rahman and Toubia (2000) described the harmful psychological consequences of the practice as reported disturbances in eating, sleep, mood, and experience of fear, suppressed feelings of anger, bitterness or betrayal. According to WHO (2006) study carried out in six Saharan African countries (Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan), women who have undergone the

practice have a strong likelihood of having a cesarean delivery (the risk of giving birth by cesarean is 30% higher for circumcised women). In addition, the mortality rate for their children, either before or after the birth, is 55% higher. Moreover, the report adds that these women have a 66% chance of giving birth to a baby who requires intensive care. Despite the fact that FGM procedures are irreversible and have consequences that last a lifetime, and despite the practice is now being denounced, the practice continues

Theoretical and conceptual frameworks

Different justifications have been advanced that maintain the practice of FGM for centuries ranging from region to region and from ethnic group to another.



Source: Author

Figure 2. Conceptual Framework

The most frequently cited justifications include the following:

- Traditions – wishes of ancestors
- Protect the moral behaviour of women in society
- Assure faithfulness of women to their husbands
- Acceptance into adult society - a rite of passage, an initiation to womanhood as the girl approaches puberty and 'becomes a real woman'
- Ensures fidelity during marriage/Control of woman's sexuality – reduce women's sexual appetite or aggression to limit prostitution among women and loyalty to her husband
- Gender identity - may be deemed a beautifying procedure, to remove 'masculine' aspects of a girl's or woman's body
- Increases fertility
- Clitoris is a dangerous organ, can damage husband's organ
- Cleanliness - hygienic and will stop unpleasant genital secretions and odours as the child develops to maturity
- Prevents infants and maternal mortality
- Religious requirement
- Preserves virginity to protect family honour
- Control waywardness of girls
- Prevents pre-marital sex and adultery
- Some communities believe men's sexual pleasure will be enhanced by FGM.
- Fear of baby dying during intercourse or birth if the clitoris is not cut.

This study is based on William Ogburn's (1957; 1964:86-95) "Cultural Lag Theory". The proponent of the theory argues that within society as a whole, when a change takes place in the material culture, the adaptive non-material culture (beliefs, customs and traditional practices) changes extremely slowly in spite of changes elsewhere. The term cultural lag refers to the notion that culture takes time to catch up with technological innovations. In this sense, Ogburn (1957) conceptualizes cultural lag as the failure of ideas, attitudes, and aspects of institutional practices to keep pace with changes in the material culture. There are four primary areas of literature on female circumcision and infibulation: anthropological literature, medical literature, protest literature, and legal literature. Although the earliest reported account of both practices is found in the work of Strabo (64 B.C.-20 A.D.), a Turkish born Greek geographer who discovered the custom while traveling up the Nile, literature on the subject did not really begin until the early twentieth century. It was reported mostly by anthropologists and frequently noted only in passing. The vast literature on the subject began to multiply with the publication of Fran P. Hosken's work in 1979 and 1994 along with her quarterly Women's International Network News. The topic quickly became a heated feminist issue. It was not long before African women, while attempting to end the practice in their own way, began to criticise Western feminists for their writings on the subject. 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.

Western feminists, however, have continued their campaign though occasionally acknowledging African protest. One such article is Natasha M. Gordon's "Tonguing the Body': Placing Female Circumcision Within African Feminist Discourse. "(Issue No.191, 1997:21). In the meantime The Hosken Report has gone into its fourth edition (1994). More significantly, African women have begun to contribute substantially to the literature on the subject. The increased presence of African women in the West has resulted in the proliferation of two relatively new kinds of literature: medical literature and legal literature. The medical literature concentrates on the repercussions of female genital surgeries, while legal discourse has resulted in laws prohibiting it in the U.S., the U.K., Canada, and France. Recent legal actions have been focused on the issue of asylum, involving cases in which African women have pled for asylum in order to escape an operation. A number of these cases have been successful. Brinkman &

Brinkman (1997) prefer the term socio-cultural lag rather than merely cultural lag. They use the term "socio-cultural lags" to indicate deep-rooted FGM practices and the illiteracy of a girl child instead getting the girl ready for marriage than get to school.

Religious Factors

One of the biggest misconception about FGM is that it is sanctioned by religion be it Christianity or Islam. However, there is no possible connection between female circumcision and religion as it precedes both of them. In the FGM risk countries it is practised by followers of all denominations: Christians, Moslems, animists and non-believers and followers of indigenous (traditional) religion. The practice seems to be very extensive among the Muslim population in the FGM practicing countries and as such has acquired a religious dimension. In Ethiopia and Egypt, for example, both the Coptic Christians and the Muslims practice FGM. However, not all Muslims practice FGM, for example in Saudi Arabia, Libya, Jordan, Turkey, Syria, the Maghreb countries of northwest Africa, Morocco, Iran and Iraq. None of the two major religions, Islam and Christianity, impose the practice of FGM. The Quran, Hebrew Scriptures (Old Testament) are Christian scriptures (New Testament) are silent on the FGM subject. Sunna (the words and actions of the prophet Mohammed) contains a number of references to female circumcision (Toubia 1993). The Prophet (Hadith) was quoted to have said "reduce but do not destroy" (AI 1998) and ".if you cut, do not overdo it, because it brings more radiance to the face and it is more pleasant for the husband." However, there are controversies surrounding this Hadith. Religious leaders, except some missionaries, have not until recently recognized it as a harmful practice to discouraged its practice. However, debates among Muslims reveal that FGM is a social custom, not a religious practice In a 1998 symposium of religious leaders agreed that FGM has no religious basis and has nothing to do with Islam (IAC Report). However, they tend to link the moral benefits attributed to FGM (such as purity, virginity, morality) with religion.

Sociological Reasons

One justification of FGM is the sociological aspect which presents the operation as a transition in life stages as an initiation rite to womanhood**.** It was performed at puberty on girls 12 to 14 years old, or just before the onset of menstruation and marriage. FGM as an initiation rite emphasises the transition in age status from girlhood to womanhood and to marriageable age. As an uncircumcised girl has no chance of having a suitor, the operation is a signal for her readiness for marriage and availability. During initiation period, the girls are kept in seclusion for a period of time (at least 2 weeks) and given instructions on morality, tribal law, cultures, social codes, being a good wife, etc. Jomo Kenyatta, the first president of Kenya and a strong supporter of the tradition of FGM, gives a better picture of the importance of FGM in tradition. "The operation is (still) regarded as the very essence of an institution which has enormous educational, social, moral and religious implications, quite apart from the operation itself. For the present, it is impossible for a member of the Kikuyu tribe to imagine an initiation without circumcision. Therefore, the abolition of the surgical element in this custom means to the Kikuyu the abolition of the whole institution." He continues to show the close relation between marriage and female circumcision/FGM, that uncircumcised kikuyu girl cannot marry and is ostracized by the community and tribe. It is a taboo for a Kikuyu man or woman to have sexual relations with someone who has not undergone this operation.

Sexual and Marriage Factors

A frequently cited reasons for FGM is its assumed ability to diminish women's desire for sex. This in reality is the truth. Cutting away of the sensitive part of the genitalia kills the emotion associated with the organ. There is a generally held belief that uncircumcised women and girls are difficult to satisfy sexually, and this implies that women cannot control their sexual emotions. Uncircumcised women are assumed to be over sexy. "Excision is believed to protect a women against her over sexed nature, saving her from temptation of being prostitute, suspicion and disgrace while preserving her chastity" (MRG 1992/3). This is one of the core reasons for the existence of FGM. It is believed that FGM serves as a means to discourage premarital sex and reducing sexual desire of a girl thereby preserving her virginity. The reduced desire even during the marriage is expected to ensure faithfulness of a woman to her husband. This is why it is believed that uncircumcised girls are assumed to run wild into prostitution, or are considered of loose moral bringing shame and disgrace to her parents. For most African women as well as other Third World women, marriage and reproduction are the only guarantee for a women to gain economic security and social status. Marriage ensures a woman with old age pension or security as well as respect in the society. In some African communities a woman without children or an unmarried woman will have a very difficult life and a devastated old age, especially ones without any support from their relatives or community. Marriage is the base for the whole practice of FGM, without which, a woman is denied the right of marriage, in most cases also denial of receiving bride price. In Africa, marriage does not come easily without its sacrifices. Virginity must be maintained at the time of wedding and the lack of it has damaging social consequences to the girl as well as her parents. Virginity is the base for marriageability and it also enforces the prohibitions of sexual relationships outside marriage. Virginity is considered as a base for a family's honour. A girl is expected to bring honour to her family through the preservation of her virginity and this is where FGM comes as a means of ensuring virginity. In Africa, a woman not a virgin on her wedding day will suffer a lot in her life. Many Maasai[1] girls are traditionally considered children until they are circumcised, it is seen as imperative for a Maasai girl to undergo the circumcision rite before she is married. This strongly ingrained cultural belief propels families to go to great lengths to complete the circumcision

Psychological Reasons

Gender Identity: In most societies the clitoris is seen as a "dangerous" organ, hence, requiring its removal. It must be removed as in Mali, Burkina Faso, Senegal, The Gambia and all over West Africa based on the belief that the clitoris of the female makes her a male. In FGM practising countries, the removal of the clitoris is believed to make a woman feminine. In addition, clitoris is considered to be ugly on a girl and must be removed to get the girls clean required for hygiene and

[1] minority tribe in Kenya

religion purposes. With the clitoris representing masculinity in young girls, hence the need to identify their sex clearly becomes of prime importance (Hosken 1993; MRG, 1992/3). This point is best explained by an Egyptian women defending FGM. "We are circumcised and insist on circumcising our daughters so that there is no mixing between male and female.In Egypt and Sudan and Ethiopia, an uncircumcised woman is disgraced by her husband, who calls her 'you with the clitoris'.

Health Factors

The upholders of FGM argue that the removal of the female genitalia contributes to the cleanliness and purity of women. In some communities popular terms for mutilation are synonymous with purification, (Ondeik, 2010, AIC, 1998). It is believed that the removal of the clitoris and labia contribute to the cleanliness and beauty of women. In such societies an uncircumcised woman is considered dirty and polluted. This is one reason why uncircumcised women are ostracized within their own families and communities. They are not part of the social life such as communal feasts. The removal of the clitoris keeps the vagina clean and makes vaginal intercourse more desirable than clitoral stimulation. These misconceptions are based on the fact that secretions produced by the glands in the clitoris, labia minora and majora are bad smelling and unhygienic and so makes the female body unclean.

It is believed that clitoris removal keeps the vagina clean. On the other hand, its presence is believed to damage the baby at delivery and affects the husband's genitals during intercourse. It is also believed to enhance fertility (Leye 1998). Other myths include that female circumcision enhances the husband's sexual desire; prevents maternal and infant mortality. Under normal conditions secretions are odourless and if the secretions are bad smelling, excessive and coloured, then this is an indication of infection or other serious problems, probably requiring medication. In reality female circumcision/FGM can create uncleanliness by closing the vulva and preventing the natural flow of urine and menstrual flow and consequently leading to the retention of urine and menstrual blood causing offensive smell.

Economic Reasons

Economic reasons are important factors that perpetuate the practice of FGM particularly in the rural as well as urban areas. Female circumcision is a prerequisite for marriage and payment of the bride price to the parents of the girl. In communities where the practice of FGM is deeply-rooted an uncircumcised girl is not eligible for marriage and maybe a burden on her parents as no one member of the community will dare to marry her. This enforces parents to have their daughters undergo the FGM operation. Along this line one can always refer to President Kenyata on this issue of circumcision and marriage – *"No proper Kikuyu would dream of marrying a girl who has not been circumcised."* The payment of bride price is part of the marriage institution and can be relative to the degree of the operation (Smith 1995). Bride price holds the key to marriage by enforcing FGM and virginity. The circumcisers also play a big role in promoting and prolonging the practice of FGM particularly in the rural areas. Their trade provides them with a regular income and a social status in the community.

Traditional Factors

The basic question for one to ask is what are the reasons and justifications for its persistence regardless of its psychological, medical and physiological irreversible damages. The reasons forwarded by the practitioners can be divided into two: perceived religious sanctions and traditional factors. The conceptual framework in Figure 2 outlines why the practice continues to persist despite its dangers. Tradition covers all the main existing deeply-rooted myths surrounding the practice of female circumcision. The belief is FGM ranges from country to country and ethnic group to another. At the top of the lists are tradition, culture and social norms passed from generation to generation usually from grandmother to mother to daughter. In poor and illiterate societies the opportunities to access global information and knowledge and the possibilities of challenging the status-quo is minimal and inconceivable. Hence, what comes from elders, local community leaders, political and religious leaders and the protectors of traditional culture is accepted without any challenge. Tradition appears to provide solutions to problems within communities. Even the elites are no exceptions to cultural pressures as any courageous challenge of the existing norm are liable to stigmatization. A couple of recent studies highlighted the importance of culture and customs in female circumcision practice. A survey of female circumcision in Senegal (2003) (regions of Saint Louis, Kolda and Tambacounda) and Sierra Leone (2004) shows the following findings:

Table 1. Reasons for female circumcision

	Senegal	Sierra Leone	Gambia
Tradition	94%	85.6%	92%
Initiation and Education	53%	49%	60%
Purity & Social Identity	52%	35%	56%
Religion	14%	17%	18%
Requirement of marriage	22%	4%	20%
Chastity	21%	3.7%	22%
Hygiene	3.3%	5%	7%

Source: Adapted from Bob (2004)

In similar study in Mali, respondents stated reasons for maintaining the practice as follows: customs 23%, hygiene 32%, marital requirements 43%. In Senegal, a study of 500 interviewees in Mbour region showed 31.7% for purification purposes according to Islamic law, 25.7% for traditional reasons and 32.1% for the reservation of virginity (Diallo, 2008). Many people believe the clitoris to be ugly. Others believe that an uncircumcised girl is incapable of bearing children. Still others believe that infibulation adds pleasure to the husband during intercourse. Excision is said by many to reduce temptation in unmarried girls as is infibulation. Although theories have been proposed, no one knows the origin of genital mutilation. It is clearly found in northern Africa especially in Muslim areas although the Koran and other Muslim literature does not require it. It also occurs among many non- Muslim peoples. In Africa, the practice of female circumcision is found in the countries of Chad, Niger, Nigeria, Togo, Burkina Faso, Ghana, Côte d'Ivoire, Liberia, Sierra Leone, Guinea, Guinea Bissau, Sénégal, The Gambia, Mauritania, Egypt, Sudan, Djibouti, Ethiopia, Somalia, and Mali. Of course, not all of the peoples in these countries follow such practices. Before Maasai girls in Kenya and Tanzania are married, they must undergo circumcision in a ceremony that 99 percent of the time is sponsored by their prospective suitors. Aside from the actual surgical procedure, the rite

includes a ceremony in which the entire community comes together to celebrate the girl's passage to adulthood.

METHODOLOGY

In address the objectives and research questions of the study, we developed questionnaires to reach out to the respondents. The study focuses on the main ethnic groups in The Gambia in the surburbs of the capital, Banjul – Sukuta, Serekunda and Brikama) across different ages, educational background and rural/urban dwelling. The study again focuses on female circumcision being highly topical relative to male circumcision being of lesser controversy. This study focuses on the cities and their suburbs. The research adopted a random sampling of girls aged 15 years and above. In each of the three communities, males and females of childbearing age made up over 72% of the total population. With our sample size, houses were visited and stratified random sampling technique was used to select an equal number of female respondents. A total of 500 respondents were interviewed in the three communities. A field study was conducted during eight-week period between January to Mid-March 2016. Through good preparations before the fieldtrip and a well-established network of contacts, the fieldwork provided a well planned exercise. The case study focuses on the subject of FGM with the aim to examine its cultural importance and prevalence over key indicators of age, education and rural/urban areas. The study is based on questionnaires and interviews in order to collect information that can be put into a broader sense. The respondents gave their perception on FGM on the different experiences and perspectives.

Data Analysis

Among the 500 respondents who participated in the survey, 350 were subjected to circumcision in these three locations. A number of respondents have highlighted the cultural importance of female circumcision ranging from cleanliness, protecting virginity, religious requirement, social reasons, family honour, sexual and marital reasons and initiation into womanhood, among others. Table 1 summarizes the differences among women by their circumcision status. Women who had and those who had not undergone the practice differed significantly with regard to most socio-demographic characteristics. The findings as captured in Table 1 above are in line with the literature regarding age, education, socio-economic status and regional indicators. Age distribution shows different responses with high aged women (35-50 ages) reporting greater number of women circumcised relative to 15-24 and 25-34. With considerable sensitisation nowadays, more and more younger children are not subjected to circumcision compared to decades ago. Low level of education (illiteracy) shows higher incidence of women circumcised at 70% relative to educated ones 30%.

Socio-economic factors also influenced different responses with higher incidence (52%) among lower socio-economic status relative of high status of 48%. Regional levels also reported high incidence among rural dwellers compared to urban settlers as the social cohesion, community pressures and traditional beliefs are higher in rural areas relative to urban areas. Women who were not circumcised were highest among young aged groups 47.7% relative to 32.7% and 19.9% of 25-34 and 35-50 age groups respectively. Uncircumcised women are higher among literate (high education) at 59.7% relative to 41.3% and also high socio-economic status and living in urban areas, as shown in Table 1.

Table 2. Socio-demographic Characteristics of Women Circumcised

Characteristics	Not Circumcised		Yes Circumcised	
	N= 150	30%	N= 350	70%
Age of Respondents				
15-24	71	47.7%	88	25.3%
25-34	49	32.7%	105	30%
35-50	30	19.9%	157	44.8%
Educational Level				
No School	62	41.3%	245	70%
Yes	88	59.7%	105	30%
Socio-economic Status				
Low	67	45%	182	52%
High	83	55%	168	48%
Region				
Rural	69	46%	218	62.3%
Urban	81	54%	132	37.7%

Source: Survey Data

Table 3. Rationale of FGM in Rural and Urban Areas in The Gambia

	Rural – 218 (100%)	Urban – 132 (100%)
Traditional and cultural heritage	92	60
To prevent female promiscuity	62	35
To prevent clitoral growth	22	16
Enhance female fertility	65	36
Promote vagina cleanliness	56	24
Prevent clitoris infection	18	11

Source: Author's Survey results, 2016

From the Table above, the deep-rooted traditions and cultural heritage dominated the rationale for FGM practiced in line with the literature in both rural and urban areas followed by enhancing female fertility and to prevent female promiscuity. The least was to prevent clitoris infection.

Table 4. Suggested Strategies to Eradicate FGM

	Rural - 218	Urban -132
Public Education	35	56
Government Legislation	40	30
Eradication of the practice is unnecessary	25	14
	100%	100%

Source: Author's survey results, 2016

From the Table above, due to its deep-rooted culture, government legislation is considered as the most important step to eradicate FGM in rural areas whilst public education is preferred in urban areas. The campaign to end these practices has faced enormous obstacles the most important of which is the tenacity of tradition. Sudan attempted to eradicate infibulation in the 1940s. In Kenya, Daniel arap Moi's government has made it illegal. In Burkina Faso, Thomas Sankara's government tried to end it, but since Sankara's death, the practices continue in many parts of the country. The Gambia also put a ban on the practice in November 2015 and subsequently criminalized in The Gambia. This marks an important milestone in the country's journey to end FGM and ensure that the fundamental human rights of girls and women are protected and fulfilled It is likely that, even if a concerted campaign could be mounted by the World Health Organization, the eradication of "female circumcision" will take many years. However, the achievement of ending FGM practice in the Gambia places the country proudly among 26

other African countries that have banned FGM through legislation. Certainly, it comes after years of work to raise awareness among individuals and communities, reinforced by intense advocacy with decision and policy makers. As a result, where FGM used to be a taboo, the subject is now openly discussed in Gambian homes and communities. Nevertheless, positive steps are on the way. In Kenya, Kikuyu girls are undergoing rites of passage that mimic the old ways but in the absence of circumcision. Among the Bambara/Manding and Fulani communities of Malicounda, Sénégal,"in the months May to July 1997, the traditional period for genital cutting, no such operations were performed...for the first time in the community's history" (IK Notes World Bank No. 3 December 1998). This change of practice seems to have occurred after an educational NGO had emphasized health issues in the area. Word spread and the operations were discontinued in an even wider area. In December 1998, the government of Sénégal passed laws prohibiting the practice of "female circumcision".

The Joint UNFPA/UNICEF programmes for the abandonment of FGM or female circumcision (FC) played a pivotal role in this critical transition for the women and girls of The Gambia. Support from the joint programme allowed for the sensitization and training of traditional and religious leaders, men, women, children, policy makers, law enforcement agents and circumcisers on the health and human rights effects of FGM/FC. Once convinced, Islamic religious leaders and scholars became powerful advocates against FGM/C with influence at both the policy and community levels. FGM/FC has been successfully integrated into the health professional school curricula, and about 1,000 healthcare personnel have so far been trained. Their knowledge about the issue is systematically shared through health education sessions during antenatal services and outreach activities. The involvement of youth in the advocacy has been key in ensuring that future generations of girls and women remain uncut and protected from harm. Their use of social media platforms to communicate with fellow young people has amplified key messages on FGM/FC and widened the reach. The formal and informal media also have served as invaluable complementary tools in publicizing issues around FGM/FC to target groups as well as to the masses. Regular panel discussions on community radio as well as the dissemination of key messages across the country by trained traditional communicators using songs and drama at different fora, including weddings and naming ceremonies, have also been effective.

The different interventions conducted at the local level have prompted enough communities to reach a consensus and make public declarations to abandon FGM/FC. Since 2009, a total of 1,015 communities have publicly declared their rejection of FGM/FC; and 158 circumcisers have abandoned the practice, contributing to the reduction of the national FGM/FC prevalence from 92.2% to 25%. The United Nations takes very seriously its mandate to protect the rights of women and girls. Following the presidential pronouncement banning the practice, UNDP, UNHCR, UNFPA and UNICEF supported the development of an Anti-FGM/FC Bill that was used in the 2015 Women's Act Amendment criminalising FGM/FC. It is disturbing to note that yearly, millions of girls and women are subjected to FGM globally which not only violates their basic human rights, but also denies them their integrity and right to freedom from violence and discrimination. Victims and survivors of FGM have suffered disproportionately from pain through systematic cutting, health complications, social and economic vulnerability and lack of access to basic services. UNDP and other UN agencies will continue to support social mobilization efforts to end FGM/FC in The Gambia and elsewhere. In cultures where FGM/FC is part of a rite of passage into adulthood, we promote initiation without cutting. As such, positive aspects of the culture will be retained while harmful elements are left behind, Women's Bureau, (2015). These efforts, involving all actors including the Government and civil society, will create a lasting impact in the lives of girls and women in The Gambia. With increased awareness on its harmful effects, individuals and communities are working to ensure that the next generation of girls and women would no longer have to bear the consequences of FGM/FC.

DISCUSSION

The findings from this study revealed that the majority of the female respondents in the three communities surveyed were not only circumcised but supported the practice of female circumcision. Although over 76% of the respondents on average agreed that female circumcision is part of the traditional and cultural heritage in the communities surveyed, the view that female circumcision can enhance female fertility that will enhance childbirth were ranked second of all the reasons advanced for their desire to continue the practice. That female circumcision can prevent female promiscuity and clitoral growth were ranked as third and fourth salient rationales. As elicited from the study sample, the circumcision of young girls in the three communities is performed about few months after delivery of the infant. For the sickly female infant, circumcision can be postponed but must be performed before she attains puberty. With such a practice on girl children, they can be exposed to both physical and psychological trauma. In situations where female circumcision is performed by the unskilled traditional healer, who works under septic conditions and without prior hematological problem-related consideration, several complications can ensue. These include genital sepsis, septicaemia, patial labia fusion, hemorrhage, implantation dermoid, deep scarred tissues, apareunia dyspareunia, and tetanus (Adetoro & Ebomoyi, 1986; Taba, 1980).

The main justification for female circumcision was that the practice was part of their cultural heritage. In all communities, well over 66% of the persons interviewed did not feel female circumcision should be discouraged on any on the following grounds: pain, severe bleeding, interference with orgasm, tetanus infection, and complication of childbirth. The contention by a prominent African leader (Kenyata, 1959) has been that, by eradicating female circumcision, a fundamental African tradition will be destroyed or extirpated. The practice is harmful, and just as facial marks and scarifications have been allowed to disappear, female circumcision should be abolished. Home visitors and Primary Health care Centre (PHC) workers should assist women to identify and solve their most important problems. The issue of female circumcision can be effectively tackled by multidisciplinary teams in which women are motivated to be leaders. The rights of women are not only a question of justice but also of social progress. Collaboration with enlightened African women organizations such as the Association of African Women for Research and Development (AAWRD) can invest efforts in launching and supporting programs aimed at reducing or eliminating the excessive control that African men currently exert over their women counterparts. Additionally, nongovernmental

organizations such as GAMCOTRAP) and World Health Organization (WHO), UNICEF, and other international organizations in Africa, Europe and America, have prominent roles to play in enhancing the status of women in most African societies. In traditional and indigenous cultural settings, the ability to bear children is highly prominent in society. Quite often housewives engage in intra-familial competition in terms of the number and sex of children they are able to bear. Generally males are preferred, owing to property rights and the perpetuation of family names. So it is a fulfillment of the women's life to have children-without children she is nothing at all (Alausa, Ebomoyi, Parakoyi, Omonisi, Alade, 1995; Hosken, 1996). The respondents in this study were of the opinion that the practice of female circumcision was aimed at promoting sexual morality among women and enhancing safe delivery among women. Additionally, the practice was said to ensure infantile survival. Public health efforts directed at discouraging the practice of female circumcision must provide precise information capable of invalidating the erroneous views currently upheld about the essence of female circumcision, not only in The Gambia but also in most developing African countries. The various dangers associated with the practice must be made known. Sex education of women can assist in reducing the unwanted physical, psychological and social and mental torture inflicted upon young girls as a result of this practice.

Legislation considered the last resort, can also be adopted if people are sufficiently made aware of the dangers associated with female circumcision. The education of men, women, and traditional healers should create an awareness that would enable people to give up the practice of female circumcision in order to enhance the general health status not only of women but also of the community at large. In many counties, despite the existence of legal mechanisms to ban FGM, challenges and limitations in implementation persist and are primarily due to a lack of resources, skilled personnel, appropriate documentation as well as weak organisational capacity. Over the years, UNICEF's support to ending FGM has included research and high level advocacy with government partners, parliamentarians, Islamic religious leaders. UNICEF and UNFPA have continued to support the Government, civil society organisations and other development partners working towards the promotion and protection of children and women.

Conclusion

To conclude there are several factors that help to maintain female circumcision despite its dangers as highlighted in section 4 above. The following are the key factors still makes the practice relevant:

- Female circumcision is a deep-tooted culture going back to 6000 years across countries and cultures (64 B.C).
- Female circumcision is a primary condition for marriage in some communities practising it and hardly does a man marry an uncircumcised woman in fear of breaking the local social norms, for example among Kikuyu ethnic group in Kenya.
- The payment of the bride price to a girl's parents depends on a woman fulfilling the traditional norms of the community – female circumcision being the important one.
- Invocation of tradition to insist on the continuity of the practice, as a form of gender identity.
- Preserves virginity to protect family honour
- Misperception of FGM as a religious requirement.
- Ignorance of sexual and reproductive health

Female circumcision or FGM is deeply entrenched in the social, economic and political structures of the community that its abandonment is perceived as a loss of status and protection in society (UNICEF, 2007); With on-going sensitisation campaigns on the dangers of female circumcision, it is believed that women who underwent FGM were less likely to have their daughters circumcised. Indeed, the results of this study show that the practice of FGM is still high among ethnic groups in the Gambia and the sub-region, despite the two governments' active involvement in the fight against it. However, the low prevalence of FGM among younger women, urban dwellers, high socio-economic status and better education may be an indication of behavioral change. Efforts by Non-Governmental Organisations (NGOs), for example, The Gambia Committee on Traditional Practices Affecting the Health of Women and Children (GAMCOTRAP) and many other State agencies to challenge the prevailing social norm should be reinforced, and focus on organizing young women who have abandoned the practice of FGM. Their social network should be made aware of their rejection of the FGM practice. Concomitantly, awareness, education and female empowerment and skill building programs should be put into place to expose the lot to considerable health and human right violations against this brutal practice. Only through integrated community interventions can we unravel this deeply entrenched social practice. The banning of FGM by the authorities in The Gambia in November 2015 is welcomed but this needs to be complemented by incentive schemes and general education to eradicate such a human right and health issue once and for all.

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